Stafford Education & Enterprise Park
Weston Road
Stafford
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Telephone: 0300 123 1461

Our Ref: VP/TLR/FOI/0125/1166

3rd March 2025

Sent by email

Dear

FOI-0125/1166
Your request for information under the Freedom of Information Act 2000

Thank you for your request for information received on Wednesday 29th February 2025. We can confirm that the Staffordshire and Stoke-on-Trent Integrated Care Board can provide the following information.

An anonymised copy of this response will be made publicly available on the ICB website.

Will you please forward to me the following

All CQRM minutes held by Staffs & Stoke ICB with provider UHNM NHS Trust for full 2023/ 2024

All CQRM minutes with that same provider from April 2024 to date.

Please find attached the minutes as requested, please note that the names in the minutes have been redacted under Section 40(2) Personal information.

'This exemption covers third-party personal data where complying with the request would breach data protection principles and any of the principles in the UK GDPR.'

Should you require any further information or clarification regarding this response please do not hesitate to contact us. If you are dissatisfied with the response, you are entitled to request an internal review which should be formally requested in writing and must be within two calendar months from the date this response was issued.

To request an internal review

You can request an internal review by contacting the Staffordshire and Stoke-on-Trent ICB FOI team by emailing; staffsstokeFOI@staffsstoke.icb.nhs.uk or by post to the address at the top of this letter within 40 working days of the initial response.

If you are not content with the outcome of your internal review, you may apply directly to the Information Commissioner's Office (ICO) for a decision. Generally, the ICO cannot make a decision unless you have exhausted the Staffordshire and Stoke-on-Trent Integrated Care Board's FOI complaints procedure.

The ICO can be contacted at:

Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
Cheshire
SK9 5AF

www.ico.gov.uk

Yours sincerely

Vasileia Pitarokoili
Head of Governance

Meeting	UHNM CQRM
Venue	Microsoft Teams
Date/time	Thursday 20th June 2024, 12:00-14:00

Attendees:		
[redacted] (Chair)	Associate Director of Quality and Patient Safety, SSoT ICB	[redacted]
[redacted]	Senior Clinical Quality Improvement Assurance Manager, SSoT ICB	[redacted]
[redacted]	Assistant Director for Nursing, NHSE	[redacted]
[redacted]	Matron for Quality & Safety, UHNM	[redacted]
[redacted]	Associate Deputy Chief Nurse, UHNM	[redacted]
[redacted]	Head of Quality, Safety & Compliance Department, UHNM	[redacted]
[redacted] (Part meeting)	Associate Chief Nurse/Deputy Director (Infection Prevention & Sepsis), UHNM	[redacted]
[redacted]	Associate Director, Performance & Information, UHNM	[redacted]

In Attendance:		
[redacted] (Minutes)	Business Support Officer, SSoT ICB	[redacted]

Apologies:		
[redacted]	Strategic Clinical Director, SSoT ICB	[redacted]
[redacted]	Head of Cancer Services, UHNM	[redacted]
[redacted]	Deputy Medical Director, UHNM	[redacted]
[redacted]	Lead Nurse, Quality & Safety, UHNM	[redacted]
[redacted]	Chief Nurse, UHNM	[redacted]

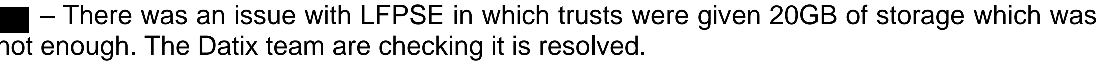
No	Item	Action Lead
1.0	**Introductions & Apologies.**	**Chair**
	███ introduced all to the meeting and announced apologies as noted above.	
2.0	**Declarations of Interest**	**All**
	None to declare.	
3.0	**ICB Leadership Compact**	**All**
	███ covered the leadership compact and all adhered.	
4.0	**Minutes from the previous meeting: 16th May 2024**	**All**
	Agreed as an accurate representation of the meeting.	
5.0	**Action Log from the previous meeting: 16th May 2024**	**All**
	Action 160 – **Monthly HCAI Report** – ███ has asked the Micro-Biology team to provide this update, they also send their own data to GP's. (Closed) Action 167 – **Pressure Ulcer Deep Dive** – This report will be provided at July's meeting. (Open) Action 171 – **104-day Harm Review Report Q4** – to be provided at July's meeting. (Open) Action 174 – **Complaints & PALS Report Q4** – to be presented at July's meeting. (Open) Action 175 – **Steps taken by GP's following JB Reg 28** – ███ (SSoT ICB) has updated ███ (SSoT ICB). (Closed) Action 176 – **Bi-Annual Establishment Review** – to be presented at July's meeting. (Open) Action 177 – **Sepsis Guidelines Update** – On this agenda, ███ (UHNM) will return in November. (Closed) Action 178 – **System C Vital Packs** – ███ has been pressuring System C but it does not appear that the Vital Packs will be updated for 12 months. ███ has been in contact with other trusts and looking for advice on how they are adapting to this news/change. The trust is taking this forward. (Closed)	
6.0	**Monthly HCAI Report (April 2024)**	███
	███ covered this item and highlighted key points: • There were no MRSA Bacteraemia reported in April however there was 1 in May. This patient had no previous UHNM contact, came from a care home and was positive on admission. The patient died but there were no lapses care, they passed away due to having multiple medical problems. • There were 14 cases of CDIFF with 10 x HAI and 4 x COHA, there were 3 clinical areas with 2 CDIFF cases, samples from these patients have been sent for ribotyping to identify if any transmission.	

	• NHSE are updating the time for apportioning CDIFF It is being changed so that the time of arrival rather than date, triggers admission timescales. • HCAI trajectory for 24/25 has not yet been determined by NHSE unlikely to come before general election. • There has been a few cases of measles. • There was a case of shingles in a member of staff which has been dealt with. • There are still patients coming in with Nora Virus, which is unusual of this time of year, isolation is being done well in emergency portals. There are no outbreaks. • There have been a few cases of Campylobacter. • There was a cluster of cases PCP cases in organ transplant cases, meetings are being held for these. Contacts have been identified and GP's of patients informed. • There have been national outbreaks for E-Coli and Listeria, surveillance is in place to keep better track of these. It was acknowledged by ███ that Sepsis is not at the required level quite yet, but it is improving. The KPI's in the Urgent Care portals are slowly improving. There continues to be the charts in the IPC report for avoidability of CDIFF. It was asked by ███ the new Midlands: Infection Prevention and Control Patient Safety Incident Response Framework Matrix guidance is going to be followed as UHNM currently categorise the unavoidable avoidability. This would focus on immediate learning, trends and themes. ███ responded saying that UHNM are doing a 3-month trial of looking at themes and learning immediately which means RCA's are not being done as usual. It has proven very useful to have the immediate receival of these themes. ███ mentioned that it would be useful for ███ to report the themes rather than just numbers, like in the Quality Report (Item 7). It was confirmed by ███ that the new PSIRF approach is going to be discussed soon internally, ███ asked if can update can be given when possible.	
6.1	<u>New Sepsis Guidelines Update</u> New NICE Sepsis guidelines were published in January 2024. The updated guidance is markedly different to the previous guidelines in 2016, and more sensitive to identify sepsis. System C who owns the Vitals system are reporting that they have no plans to update the sepsis module of the data capture system to the 2024 NICE sepsis guidelines until at least mid-2025. This is despite numerous requests to System C and escalation by the Chief Nursing Information Officer. ███ is in touch with other trusts and finding out what they are adapting. The Options appraisal paper for the Nice Guidelines Sepsis 2024 went to QSOG on Monday with the option to continue to push System C to carry out an update and trial the new guidance in ED. This is the chosen option going forward, it will then be fed back to QSOG. UHNM are currently working out how the guidelines/data can be reported as this will change. It will be trialled at both Royal Stoke and County ED Hospital. It means that it allows a longer period before anti-biotics are required, this also gives more time for staff to identify the most appropriate antibiotics. This may help to reduce the high rates of CDIFF.	

7.0	**Quality Assurance Report Summary (April 2024)**	██
7.1	Quality Assurance Report ██ covered this item and highlighted key points: • The formatting was changed for the report and praise was given that it is easier to read. Improvements have been seen around the induction of labour and maternity triage.Improvements also made to falls and falls with harm.It was discussed at QSOG on Monday that the diversional therapy roles introduced are proving to be very useful. • Duty of candour is not compliant with the 10-day internal target, but duty of candour is being completed. • Friends & Family Test for A&E remains below the 85% target of patients recommending the service but has improved again in April with 70.9%. • Timely observations are seeing big improvements, one of the main reasons is due to the IT system having been improved as before the Wi-Fi was unreliable in some areas of the trust buildings. This will be built into EPMA when it becomes available. • Mortality is still within expected ranges. It was raised by ██ that timely observations in the elderly care and respiratory ward are still quite low and seeing slow improvements. ██ answered by saying that the improved Wi-Fi should help with reporting data. With the IT issues being largely minimalised, it means any issues going forward should be almost exclusively to do with care. CPD Funding for 2 harm-free educators has been acquired, specifically to work with falls and pressure ulcers prevention. These staff will be in the wards and attending safety huddles meaning will work more on the ground floor with staff and a lot of the issues with timely observations can be more understood. ██ raised that there were several inconsistencies within the report on pages 7&14, ██ confirmed these will be sorted in the next report. ██ enquired about the bed rail safety alerts. ██ confirmed that this was recently discussed at the Patient Safety Group & QSOG, and progress is being made with good actions in place. One of the main issues was highlighted as being in relation to training packages for staff so ██ is working on getting these implemented. These issues will be reported through the Patient Safety Group and QSOG.	
7.2	CQC Action Plan Update This report was not provided therefore no update was given.	
8.0	**Monthly Performance Report Summary (April 2024)**	██
8.1	Monthly Performance Report ██ covered this item and highlighted key points: • 4-hour performance has seen improvements, sitting at over 70% for the last 3 months. • Ambulance holds have reduced. • Patients are moving through the system better than before. • 12-hour Trolley waits are coming down. • Cancer performance is improving.	

	• Cancer 28-day FDS and 62-day waits are showing improvements. • RTT patients/wait times are improving. • There was 1 104-week wait that returned from the private sector. The GP then provided incorrect guidance, but this patient has now got surgery booked. • 5 Cornea patients who were long waiters came back from Wolverhampton after being transferred for mutual aid. • 78-week waiters are being cleared at a good rate with only 23 at April. • 65-week waiters are on track to be cleared by October. • A few specialties are slightly over in terms of metrics but nothing critical. • EMT's are proving to be difficult, a specialist came in but has shortly moved on and the role will be re-filled ASAP. The ambulance protocol has been introduced which will help with times of high pressure for Category 1 & 2 patients waiting, it is to off load of 2 ambulances every 30 minutes until the pressure is reduced and the risk removed. The 'corridor' in the emergency department is utilised to support the risk of reducing the waiting ambulances. This decision/support system came from NHSE. ██ raised several key points within the report: • Slide 42 – diagnostic performance has seen improvement. • The data presented is very impressive, but it was asked whether patients between 52-65-week waiters may be prone to deterioration? It was confirmed by WS that these patients are protected. Nearly 3000 patients have come off the waiting lists since the initiative started. • The same praise was given about the new reporting format being much better.	
8.2	52+ Harm Review Report - April This report was not provided therefore no update was given.	
8.3	104-day Harm Review Report Q4 This report was not provided therefore no update was given.	
8.4	Emergency Department Digital Integration (EDDI) decommissioned by NHSE – UHNM solution There is to be no replacement system as of yet but business cases form part of the urgent business Centre. ██ will inform ██████ and ██████ as this came from SSoT ICB having concerns. ██ will raise at the ICB urgent care delivery group.	
9.0	**Emergency Department Monthly Assurance**	██
9.1	12-hour breach/ambulance handover delay harm review proposal update Ambulance hold harm reviews: There has been evidence to show that harm is identified as low/moderate and skin damage was low harm as well. Sepsis screening had a slight increase to 2 hours for a screening rather than 1. A discussion was held regarding the recent difficult situation that took place within the ED department when there was no movement and the Trust at critical incident. ██ raised the question of how is risk measured when it gets as bad as that? It needs to be clear what is being done as a system to ensure the right actions are in place.	

10.0	**PSIRF Learning (SI Update April 2024)**	▇▇▇
	The report provided covers both April-May 2024. ▇▇ covered the report and highlighted key points: The report is a mix of the previous SI report/system and the new report/PSIRF system. There are outstanding SI's but these are being closed as time goes on. The quarterly reporting data was also provided in the report. Reports are also being developed by external bodies. It was raised by ▇▇ that a discussion was held with internal groups saying that UHNM are being too cautious, and more assurance is needed to prove that the work is being done correctly. Cases have been taken through the risk management panel with brief descriptions/safety recommendations included for learning. ▇▇ confirmed that there are now 24 SI's open, compared to the previous 40. ▇▇ gave praise that the report gave lots of information. It was raised by ▇▇ that it doesn't feel like recommendation column is proving useful/being followed as well as it should. ▇▇ will send some critiques over to UHNM and ▇▇ confirmed that UHNM have noticed this as well going forward ▇▇ will send a quarterly SI/PSRIF report to CQRM.	
10.1	2023-6299 After Action Review for never event for closure approval This case was presented through RMP with actions and changes identified, which will be monitored. It was agreed that improvements need to be made and this should not have been categorised as a Never Event. ▇▇▇ agreed to downgrade.	
10.2	2022-23091 After Action Review for never event for closure approval RCA not received.	
11.0	**Forthcoming UHNM External Reviews**	▇▇
	There is going to be a BSII review on 1st/2nd July and ▇▇ will provide an update. MHRA will be coming to a review of the Pharmacy production unit from 25-27th June, but this may need to be moved as the service manager is on Annual Leave.	
12.0	**Any Other Business**	**All**
	There were several AOB to raise: ▇▇ – the Vitals system is having an upgrade and will be turned off for 8-hours and will be paper based for this short period. The system update will be cloud sourced. The update will take place at the beginning of July and will be live from 3rd July.	

	███– A big bed summer clean will be taking place on 26th June for 24-hours. The IT amnesty and estates will be added as well. ███ – A pathology upgrade was done in March and there has been noise from Primary Care with multiple items occurring. There are delays in receiving results which ███ has escalated. The ICB digital team are concerned that UHNM are proposing to close their post implementation working group without the Primary care issues being resolved. ███ will be putting this into the system quality report. UHNM have agreed to look onto this. **Action: ███ and ███ to investigate the issues with results Primary care are having since the upgrade to the Pathology system.** ███ – There was an issue with LFPSE in which trusts were given 20GB of storage which was not enough. The Datix team are checking it is resolved. ███– A mixed sex accommodation visit took place in CCU, and a walk around was done, and systems and processes explained. The report is with UHNM for factual accuracy checking.	 ███

<u>Next UHNM CQRM:</u>
Thursday 18th July 2024, 12:00-14:00
Via Microsoft Teams

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.

Your NHS partner for **improving, health** and **integrating care.**

Meeting	UHNM CQRM
Venue	Microsoft Teams
Date/time	Thursday 15th June 2023, 12:00-14:00

Attendees:		
███	Medical Director, Staffordshire & SSoT ICB	██
███	Associate Director of Quality and Patient Safety, SSoT ICB	██
███	Head of Quality, Safety & Compliance Department, UHNM	██
███	Lead Nurse – Infection Prevention, UHNM	██
███	Associate Director, Performance & Information, UHNM	██
███	Associate Chief Nurse/Deputy Director (Infection Prevention & Sepsis), UHNM	██
███	Lead Nurse, Quality & Safety, UHNM	██

In Attendance:		
███ (Minutes)	Business Support Officer, MLCSU	██

Apologies:		
███	Senior Clinical Quality Improvement Assurance Manager, Staffordshire & SSoT ICB	██
███	Head of Cancer Services, UHNM	██
███	Lead for Quality & Patient Safety, SSoT ICB	██

No	Item	Action Lead
1.0	**Introductions & Apologies**	**Chair**
	██ & ██ Co-Chaired and introduced all to the meeting.	
2.0	**Declarations of Interest**	**All**
	None to declare.	
3.0	**Leadership Compact**	**All**
	The leadership compact was covered and understood by all.	
4.0	**Minutes of the previous meeting**	**All**
	Minutes of the previous meeting agreed as an accurate representation.	

No	Item	Action Lead
5.0	**CQRM Action Tracker**	**All**
	Action 107 – █ has chased North Staffs and Cheshire for an update as was noted recently at QSOG. (Open) Action 119 – Safeguarding are aware and have done an investigation with no issues found, If there was an issue it would have been reported. (Closed) Action 126 – The VTE Deep Dive was presented the week before at the Steering Group, will be going to QSOG and Quality Governance. May be ready for July. (Open) Action 130 – End of Year CQUIN Report to be presented at July's Meeting. (Open) Action 131 – Action fed back to the Medical Division to improve Royal Stoke ED Sepsis compliance. (Closed) Action 135 – The National Staff Survey to be presented at July's meeting. (Open) Action 136 – █ wasn't able to attend but has provided the report post meeting, will be presented at July's meeting. (Open) Action 137 – █ provided a response for the Reg 28 Coroners Rule. (Closed)	
6.0	**Monthly HCAI Report**	**All**
6.1	There was only One MRSA bacteraemia, the meeting was held this week The patient had a long history of cance█ She had no lapses in care with UHNM so it was determined as unavoidable. Staff have been made aware of measles potentially coming to the area, UHNM are working with Stoke-on-Trent City Council to raise awareness of the MMR Vaccine. Mask usage has now been reduced in line with other providers nationally and regionally such as MPFT. **C-diff Action Plan:** • There were 9 Trust apportioned and 8 COHA cases of C difficile toxin infections (CDI) to report in April 2023. This means that UHNM is above the upper limit (17 versus a Limit of 9 – including COHA's) for the month of April. On day 15 (which is data lockdown day), an analyst at UHNM will make a report on beds days and what it means compared to national increase statistics. The new CDIFF specialist nurse is now in post and is educating staff on CDIFF. The trust has established a CDIFF task and finish group which will mainly look at the west building where most of the cases happen.	

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No	Item	Action Lead
6.2	**Sepsis Action Plan for Royal Stoke ED** Two areas of concern were highlighted: Anti-Microbial prescribing and patients with UTI's not having samples taken prior to anti-biotics.. Sepsis screening was recorded at 78% at the Royal Stoke ED, anti-biotics prescribed within the hour has also risen to 85%, there is still a considerable opportunity for improvement. It was confirmed by ███ that Sepsis is now on the Urgent Care Delivery Portfolio and ED Pathway, UHNM stated there was now a nominated consultant to lead on this. The investigations into Sepsis are still being done, April to October is partially done with the rest in progress as well. ███ noted that harm had led to an SI recently in relation to antibiotic management in ED. There is no Flu, RSV, Nora Virus & outbreaks	
7.0	**Quality Assurance Report Summary**	███
	Report (April's data) was agreed as read by all . There were lots of improvements noted across the board, including friends and family response rates and recommendations increasing from patients. A never event was reported in March in which a wrong screw was used during a surgery, a de-escalation has been requested. A comment was made by ███ that a de-escalation makes sense as it doesn't meet Never Event Criteria This is the first time the report has included data about patient safety alerts, SSoT ICB were thankful for this addition. There is one overdue case about the Phillips BYPAP and CPAP Ventilators, this is going through internal steering groups to be resolved, UHNM are waiting for a final risk assessment and exact number of patients using these items to close. Indicators for reporting on a divisional basis are being reviewed, trying to make the indicators more bespoke and show what really makes each division stand out. Wording is to be changed around targets/benchmarks, this will be changed over the course of a few months.	
7.1	**Quality Assurance Report** As Discussed above.	
7.2	**CQC Action Plan regarding Section 29a** This is next going to board, will be brought to the UHNM CQRM in August. An update was provided on the CQC Maternity visit in March 2023, the recordings have been amended and sent back with factual accuracy checks, of which there were a lot of changes. This will be published and sent to the SSoT ICB next week. A Meeting is being held in June with the CQC for consideration to remove the S31 notice related to ED	

No	Item	Action Lead
	It is suspected by UHNM that a visit is due to review the S29a at County Hospital regarding care of patients with MH needs **Action – UHNM to provide an update on the S29a in August.**	
8.0	**Monthly Performance Report Summary**	██
	There were no issues raised by SSoT ICB from the report. There were lots of positives raised by ██, page 30: 12-hour trolley waits have decreased as well 12 in ED, cancer waits reduced and RTT increasing. It was raised by ██ regarding page 11: Patients safety incidents, this was spoken about last month. This is more of a case of there being more activity, therefore creating more incidents rather than the mean actually increasing. The rate is very static over the last 6-9 months but there is still a strong mean rate.	
8.1	**Performance Report** As discussed.	
8.2	**104 day Harm Review Report Q4** ██ did not attend the meeting, ██ to chase and provide an update. To be deferred to July's meeting.	
8.3	**52-week Harm Review Report** It has been a while since an update due to winter pressures and industrial action that has taken place. It was reported that Cardiology is now on a new proforma, over the last few months 28/50 have been complete, alongside 25/60 for Neurology. ██ (UHNM) is talking to Senior Doctors about getting the forms completed regularly, although it can be very difficult when seeing lots of patients every day. This number is expected to increase by at least 10% up to April, with 1500 being closed in May. All divisions have given good assurance around the work that they are doing with on major concerns raised. 104-day waits are down to a handful of patients with this numbers continuing to decrease. It was confirmed by ██ that 78-week waits are going in the right direction, aiming to clear all 78-week patients by the end of July. It was confirmed that 65-week patients are also on track to cleared.	
8.4	**Radiology reporting backlog update (Adult + Paediatrics)**	

No	Item	Action Lead
	The radiology backlog report is still not ready, ███ has had to escalate this as it doesn't seem to be getting progressed. He will escalate	
9.0	**Emergency Department Monthly Assurance**	███
9.1	The panel took place, ███████ went through the data and plan along with reviews up to March which is summarised in the paper attached. It was agreed that current targets are not achievable, new proposals are being together on how the harm reviews can be done going forward. YNP (Your New Patient) & Corridor care are going to get a similar process so its all adaptable for ease, this is being worked on and will be finished soon. The processes still need to be streamlined which may take time. Targets need to be realistic and they will be discussed with ██ and ███ to make sure they're better aligned and can then be taken to the System Quality Group. **<u>12-hour Breach/Ambulance handover delays report</u>** As discussed above.	
10.0	**Serious incident Report (April 2023)**	███
	It was agreed that a new monthly meeting regarding the new SI system is held to bring everyone together	
11.0	**Mortality Q4 Report**	███
11.1	The SHIMI was raised by ██, it is now close to peer and national level, ███ is working to found what is driving the metrics. **<u>Coroners Regulation 28 Response – ████ Missed Bowel Injury</u>** Report Correspondence has been received, the transfer came from North Wales, was quite an old case with regulation 28. The issue was more to do with the rota around staff, a response is to be given to the coroner, UHNM and SSoT ICB are happy with the actions taken following the incident. UHNM have got plans in place and picked this up accordingly, ███ confirmed she will update the Urgent Care Quality Pathway.	
12.0	**End of Year CQUIN Report**	███
	Item deferred to the next meeting.	
13.0	**National Staff Survey**	███

No	Item	Action Lead
	Item deferred to the next meeting.	
14.0	**Forthcoming UHNM External Reviews**	**All**
	███ is making a visit to County Hospital next week.	
15.0	**Any Other Business**	**All**
	It was confirmed by ███ that UEC Quality Report was finished a few days before the meeting and UHNM data is more accessible than other providers ███ raised that she was worried that the Quality Improvement section didn't look very full, there are plenty of good news stories related to quality that should be highlighted. ███ asked that UHNM send more of these through. August's meeting is to be cancelled, with papers sent out and questions sent and answered.	

Next UHNM CQRM
Thursday 20th July 2023, 12:00-14:00
Via Microsoft Teams

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.

Meeting	UHNM CQRM
Venue	Microsoft Teams
Date/time	Thursday 18th July 2024, 12:00-14:00

Attendees:		
[redacted] (Chair)	Strategic Clinical Director, SSoT ICB	[redacted]
[redacted]	Senior Clinical Quality Improvement Assurance Manager, SSoT ICB	[redacted]
[redacted]	Assistant Director for Nursing, NHSE	[redacted]
[redacted]	Deputy Medical Director, UHNM	[redacted]
[redacted]	Lead Nurse, Quality & Safety, UHNM	[redacted]
[redacted] (Part Meeting)	Associate Chief Nurse/Deputy Director (Infection Prevention & Sepsis), UHNM	[redacted]
[redacted]	Head of Patient Safety, UHNM	[redacted]
[redacted]	Associate Director, Performance & Information, UHNM	[redacted]

In Attendance:		
[redacted] (Minutes)	Business Support Officer, SSoT ICB	[redacted]

Apologies:		
[redacted] (Chair)	Associate Director of Quality and Patient Safety, SSoT ICB	[redacted]
[redacted]	Head of Cancer Services, UHNM	[redacted]
[redacted]	Matron for Quality & Safety, UHNM	[redacted]
[redacted]	Associate Deputy Chief Nurse, UHNM	[redacted]
[redacted]	Head of Quality, Safety & Compliance Department, UHNM	[redacted]

No	Item	Action Lead
1.0	**Introductions & Apologies.**	**Chair**
	███ introduced all to the meeting and announced apologies as noted above.	
2.0	**Declarations of Interest**	**All**
	None to declare.	
3.0	**ICB Leadership Compact**	**All**
	███ covered the leadership compact and all adhered.	
4.0	**Minutes from the previous meeting: 20th June 2024**	**All**
	Agreed as an accurate representation of the meeting.	
5.0	**Action Log from the previous meeting: 20th June 2024**	**All**
	Action 167 – Pressure Ulcer Deep Dive – This item is being presented at this meeting. (Closed) Action 171 – 104-day Harm Review Report Q4 - This item is being presented at this meeting. (Closed) Action 174 – Complaints & PALS Report Q4 - This item is being presented at this meeting. (Closed) Action 176 – Bi-Annual Establishment Review - This item is being presented at this meeting. (Closed) Action 179 – Pathology System Upgrade – ███ updated that according to colleagues UHNM and ICB are working closely on this. ███ will discuss with this colleague and copy in ███ & ███ (Open)	
6.0	**Monthly HCAI Report (May 2024)**	███
	███ discussed key highlights from this report: • There was 1 MRSA Bacteraemia reported in May. A multi-agency meeting was held. ███ • C-Diff - There were 27 cases at the end of May. This years targets have not yet been received from NHSE or UKHSA. • ███ is working with SSoT ICB on reducing E-Coli. There is a lot of work on urinary Tract Infections, there is a paper going to UHNM IPC meeting about trends and themes identified. • Sepsis – Royal Stoke ED are continuing to be below target. UHNM will be moving to a digital system in ED from next week, new sepsis guidelines have been agreed at the Trusts Quality and Safety Oversight Meeting (QSOG) with implementation to happen in October once staff training is completed.	

	• There were ████ of PCP amongst organ transplant patients in which a multi-agency meeting was held. Control measures and contact tracing has been undertaken, including 3-month prophylaxis prescribed. Relevant contact patients and their GPs have been written to inform them. A follow-up meeting has been arranged, and to date no further cases have been identified. A few questions were raised by members in the meeting: ██ raised that there seems to be <u>a link that all the PCP cases are from MPFT.</u> ██ advised this had been looked at and the staff were working at different times and there were no links. ██ asked regarding <u>CDIFF RCA's</u> and the charts in the report referring to avoidability and if the new process had been agreed within the trust to follow the PSIRF concept– ██ confirmed that the process was agreed last time and will send the themes/results to ██ The report will be updated going forward. ██ raised that there are a <u>wide range of unclear cases</u>, some of which are quite old now. ██ confirmed that they are for UHNM to give the word that these cases can be removed. ██ asked if these can be labelled as avoidable and un-avoidable. ██ advised the new report will have monthly themes identified, a pilot was carried out in March and Q1 whereby identified themes can be targeted straight away. ██ confirmed that the 4 themes for HCAI are Anti-microbial, late sampling, cleanliness and dirty commodes. ██ advised the Trust is planning a commode day, whereby all wards will check cleanliness of commodes a buzz word will be used to highlight the issue. <u>HCAI Annual Report</u> ██ praised the report saying it was clear and very informative with strong governance processes in place for infection control.	
7.0	**Quality Assurance Report Summary (May 2024)**	██
	<u>Quality Assurance Report</u> ██ is on annual leave, so ██ covered this item and answered questions where possible. It was raised by ██ that the VTE risk assessments have dropped to 88.8% compliance, which is not a massive decrease but something to just note. Duty of Candour has also dropped which is strange as it has been consistently improving for a while. This will continue be monitored. ███ provided an update regarding the Never events dermatology deep dive: The PSI report came back in the previous week with a large action plan containing lots of detailed actions, which has received lots of comments/amendments. ███ met with the Divisional team to ensure there is time for the actions to be completed before scrutiny. The reviews should be ready to share with the ICB with the next 2 months. ██ commented that it was positive to see the maternity triage KPIs improving. <u>Pressure Ulcer Deep Dive</u> ██ presented the report.	

Hospital acquired Pressure Ulcers have been increasing, with slide 5 showing what is being done differently. The team are trying to think of the 4 big actions that all wards can take so they can all work closely on the same goals and can be monitored.

discussed the issues around the portals and raised whether a different approach is needed? Prompt cards are being developed for the ED team around skin damage and to help staff identify if patients are coming in with skin damage.

Your Next Patient – Seating is being looked at.

praised the report, saying page 3 had lots of very useful information.

Action – will provide an update in October on the current pressure ulcer situation.

<u>Complaints and PALS Report Q4</u>

The number of formal complaints has increased by 33%, the new triage process saw a potential 275 of those cases de-escalated. Only 108 of 5326 PALS informal complaints got escalated to formal complaints, proving the triage system is working well. Response time for complaints is in a downward trajectory which is good.
The Complaints policy has recently been updated and complaint complexity will be considered when setting response times.
A new escalation process has been put into place which will allow staff to respond in a timelier manner and better decide what the response time should be depending on the complaint.

The interpreter on wheels service has worked well, it has provided at least an additional 290 hours of interpretation that the trust otherwise wouldn't have had.

It was raised by that the page containing initiatives for Royal Stoke Ed doesn't include the values and behaviors of staff or pain relief which is a theme in Friends & Family test feedback month on month

<u>CQUIN End of Year Report 2023-2024</u>

gave highlights from the report:
red questions where possible.

discussed that the CQUIN's aren't as mandatory as they were although UHNM chose to do them. NHSE also confirmed that they are optional. UHNM had failed 5 of the ICB schemes and 1 of the specialized commissioning schemes and Clinical Frailty wasn't achieved. SF commented that Clinical Frailty is very important. advised it is being completed but UHNM did not have the electronic system stipulated by the CQUIN to collect the data.

<u>Bi-Annual Establishment Review</u>

covered this item and highlighted key points.

This review is conducted by the Deputy Chief Nurse every 6 months and 6 key areas were highlighted.

1. Ward Sister allocation remains at 0.4wte supervisory and 0.6 wte clinical time.
2. The Executive Team discussed the RCN guidance to uplift establishments to 25% and a decision was made to maintain the current 21.5% uplift.
3. The methodology used to conduct the review is in line with NHSE guidance. For additional assurance the Chief Nurse requested internal audit to assess the

	establishment review process against that guidance. The internal audit concluded that the Board could take substantial assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied and effective. 4. There has been significant focus on ensuring the establishments are correct and in line with guidance and stabilising our workforce through recruitment and retention. UHNM have continued to maintain 100% retention of newly qualified midwives for second year. 5. Several areas are under review and will be presented in subsequent establishment reviews. These include theatres, outpatients and allied health professionals. 6. Previous establishment reviews did not result in business cases being developed due to the number of vacancies at the time. The vacancies have now reduced so it is expected that Divisions will develop and submit business cases in line with the recommendations noted below. These business cases will then be subject to the usual prioritisation and governance processes. The reviews this time around are focused on in-patient areas and emergency portals. Future reviews are going to focus on theatre out-patients and allied health professional teams. raised that vacancies for registered midwives have been filled. However, in the Quality report is still showing vacancies. asked if we could have a further update on the establishment review to advise if recommended uplifts of staffing had been approved and impact where not approved. **Action – to check on vacancies for Midwives and Nurses as the Establishment review report states fully established and Quality report shows vacancies.** **Action – to provide update staffing establishment paper in October.**	
8.0	**Monthly Performance Report Summary (May 2024)**	
	Monthly Performance Report covered this item and highlighted key points: • A&E 4-hour performance rates are at 70%. UHNM are still having punch points and critical incidents due to the number of increased attendances mainly on Thursday/Friday nights. • UHNM are finding the process is now where it needs to be and UHNM can react quickly to any critical incidents. • 12-hour trolley waits are improving. • Ambulance turnaround times are improving. • Elective care waiters – There are 4 104-week waiters, of which 3 are corneas and is a T&O patient who went private but couldn't get the care they needed and didn't inform UHNM. • 78-week waiters – the numbers are now down to double digits and by September hopefully being down the 78-week waiters down to single digits or zero • By the end of next month 65-week waiters will soon be down to single digits or zero. • Lots of work/insourcing is being done to bring down non obstetric ultrasound waiters. • UHNM achieved the 28-day FDS.	

	52+ Harm Review Report - April • ███ gave highlights from the report UHNM are still working on the electronic version to complete harm review proformas, although it is proving to be difficult. • Proformas are still being promoted. ██ asked what the proformas are telling UHNM? Nothing has come back from the report. • Some specialties are performing much better than others. • April completion rates are 33%with an improvement in May to 57%. • Long waiters text reminder service has gone out again and going forward will go out monthly, Still working through the responses that come back. • UHNM are working on long waiters. There have been issues of staff pressing the wrong outcome result for a patient so these patients can sometimes go off the radar for UHNM. Validation and training is being put into place to help reduce this. ███asked what are the proformas telling UHNM about patients and their harm? ███ discussed that the reviews aren't highlighting anything out of the ordinary, its always difficult about deciding what harm actually is in relation to psychological and physical harm. 104-day Harm Review Report Q4 ██ is on annual leave so ██ covered this item and answered questions where possible. ██ asked if ██ could include which specialties had completed the reviews as currently not in the report. There could be some specialties not completing any 104- day harm reviews. **Action - ██ will ask ██ to include in future reports which speciality areas had completed harm reviews and how many.**	█████
9.0	**Emergency Department Monthly Assurance**	█████
9.1	12-hour breach/ambulance handover delay harm review proposal update There was no significant harm raised and ███has set up another meeting around extending the scope of the review process. ████ confirmed that there is no significant harm with ambulances yet. This item is to be changed to a verbal update going forward as an ED monthly assurance report is no longer written. **Action – ███to change item 9.0 to ED harm reviews (12-hour trolley breach/ Ambulance handover delay harm review, this item to verbal going forward).**	██
10.0	**PSIRF Learning (SI Update May 2024)**	██
	██ is on annual leave so ████covered this item and answered questions where possible. A question was asked by ██about a patient on page 10 (319094) who was waiting for a chest drain, whether the patient was in ED or on a ward. ████ confirmed the patient was in ED. Chest strains are usually inserted by an SHO in ED, however in acute medicine the SHO must be trained. This is all around new curriculum for acute medicine which doesn't contain chest drain competency within it. If the patient is stable enough, they'd go to the plural clinic. There can be difficulty on deciding who does the chest strain if the Acute Medicine staff member doesn't have the clinical skills at that point.	

	Guidance is now becoming necessary for ultra-sound patients. discussed generally in the report regarding safety recommendations that aren't actions. advised that actions wouldn't be seen in this report actions are made afterwards from the recommendations.	
11.0	**Mortality Review Report**	
	is on annual leave so covered this item and answered questions where possible. • There have been improvements in HSMR. • SHMI is seeing an increase but is still well within targets. highlighted that attendance at the Mortality Review Group is good. The number of reviews completed is showing to be a consistent increase over the years. A new system Mortality Group is being set up. asked if the Medical Examiner will be reporting on the learning from deaths within hospitals and if there was a system wide meeting to feedback to confirmed that is setting up a system mortality group, which is in its early stages, but UHNM would have key people invited including and	
12.0	**Quality Assurance Report – Royal Stoke and CCU Mixed Sex Accommodation**	
	covered this item and highlighted key points: • The visit staff went to Critical Care regarding the MSA breaches, as the UHNM Chief nurse wanted to ensure they were compliant with national reporting of MSA breaches. Historically there at been a verbal agreement with the CCG not to report in CCU. • SSoT ICB followed the relevant guidance and did a supported visit. • Reporting of MSA breaches in CCU began in May for this, and information has been collected regarding which specialties have patients waiting the longest in critical care for a ward bed. The only issues picked up was that there is no toilet/bathroom for patients once well enough to use. The CCU Matron is making a business case to convert a bathroom to a shower room, however this is a lengthy process due to it being a PFI building. agreed it was a good visit and the report will be shared now internally at the ICB.	
13.0	**Forthcoming UHNM External Reviews**	
	discussed the CQC visit that took place on 4th July to review County Hospital against the 29a warning notice around meeting Mental Health assessments. The initial letter was positive and UHNM are waiting for the final report. UHNM had to submit a data request list on Monday with hopes that CQC will lift the S29a warning notice.	
14.0	**Any Other Business**	**All**
	It was agreed that August's meeting is be stood down due to quoracy. No papers will be circulated for August.	

Next UHNM CQRM: **Thursday 19th September 2024, 12:00-14:00** **Via Microsoft Teams**		
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.		

Your NHS partner for **improving, health** and **integrating care.**

Meeting	UHNM CQRM
Venue	Microsoft Teams
Date/time	Thursday 20th July 2023, 12:00-14:00

Attendees:		
(Chair)	Lead for Quality & Patient Safety, SSoT ICB	
	Senior Clinical Quality Improvement Assurance Manager, SSoT ICB	
	Associate Director – Quality Assurance & Improvement, SSoT ICB	
	Lead Nurse, Quality & Safety, UHNM	
	Head of Cancer Services, UHNM (part meeting)	
	Head of Quality, Safety & Compliance Department, UHNM	
	Associate Director, Performance & Information, UHNM	
	Associate Chief Nurse/Deputy Director (Infection Prevention & Sepsis), UHNM (Part Meeting)	

In Attendance:		
(Minutes)	Business Support Officer, MLCSU	

Apologies:		
	Medical Director, Staffordshire & SSoT ICB	
	Associate Director of Quality and Patient Safety, SSoT ICB	

No	Item	Action Lead
1.0	**Introductions & Apologies**	Chair
	chaired & introduced all to the meeting.	
2.0	**Declarations of Interest**	All
	None to declare.	
3.0	**Leadership Compact**	All
	The leadership compact was covered and understood by all.	

No	Item	Action Lead
4.0	**Minutes of the previous meeting**	**All**
	The first paragraph didn't make sense so ██ will re-word this and other points. Attendance list change – ██ attended but was put down under apologies.	
5.0	**CQRM Action Tracker**	**All**
	Action 107 – ██ provided an update on the Human Tissue Report. There was one minor short fall which was the recording of freezer temperatures when the temperature was changed but this is not a major concern. There was one minor item picked up as an action for the team. (Closed) Action 126 – ██ provided an update that the VTE Deep Dive is still going through internal governance processes the Medical Director has requested some report amendments. The report will be provided at Septembers meeting. (Open) Action 130 – The CQUIN report will be provided with the August papers. (Open) Action 135 – National Staff Survey has just come back from committees. ██ to circulate and be re-circulated with August papers. (Open) Action 136 – ██ provided an update on the 104-day report. (Closed) Action 138 – the CQC Action Plan will be provided with August papers. (Open)	
6.0	**Monthly HCAI Report**	**All**
	██ advised that the HCAI annual report is due Monday according to the contract, but has been finished early therefore provided on today's agenda. ██ is happy to take any questions at the next meeting. ██ spoke through the report and points highlighted below: ██ advised that there was an MRSA Bacteraemia in May, which was a very complex patient. ██ ██████ A Post infection Review (PIR) meeting was held and a number of lapses in care were identified of which actions have been put into place to rectify. Therefore, it was deemed as avoidable. The IPC team are visiting the area carrying out spot check audits. At the end of May there were 16 Hospital acquired infections C-DIFF and 18 COHA. CDIFF has increased nationally. A task and finish group has been set up for the west building as this is where there is an increase in cases, finding so far are over prescribing of antibiotics for UTI's without a urine sample and was sending samples late. A CDIFF dedicated nurse is now in place. ██ confirmed that UHNM are linking with Birmingham and Derby to share information.	

No	Item	Action Lead
	It was mentioned by ███ that Virosol Wipes are at a shortage so regular detergent wipes are being used in the meantime, these wipes are now being removed and replaced by the virosol as made a difference when they were introduced in 2012. There had been a few outbreaks with Norovirus across the Trust. Sepsis screening has decreased again in Royal stoke ED. A paper is going next week to QGC with an action plan put in place by the department. The Sepsis team are providing lots of support and there has been a slight increase in June but it is still not where it should be up to. A emergency consultant has been nominated as a sepsis champion.	
7.0	**Quality Assurance Report Summary**	███
                              7.1	The report was taken as read by all. The report has been through the Quality Governance Committee. It was mentioned by ███ the bed day/falls have increased. ███ re-assured that the increase is within expected ranges and will always go up/down each month, it slightly peaked above the average, but it is of no major concern. Actions from June have reduced these numbers. Staff in ED are being encouraged to do comfort rounds and document when they are with patients and what could cause falls to try and see these issues in advance/put these vulnerable patients in observable areas. A diversional therapist has been appointed for each ward in the west building to help reduce falls across the board, The John Hopkins Mobility Challenge is also being done with patients to try to prevent de-conditioning. The Duty of Candour has been improving and has seen a further improvement in June. It was confirmed by ███ that internal discussions have been taking place around Duty of Candour and 10-day targets. The 10-day targets came from the old NHS contract and isn't actually in the current T&Cs but ███ has continued internally with the same 10- day standard. Pressure ulcers have been improving considerably over the last few months with lapses in care also reducing. It was highlighted by ███ that timely observations are improving but still far from the target. The main causes are being looked at on a weekly basis under a meeting held by the Chief Nurse. The CATH lab is also a focus as they don't use Vitals to record observations, therefore when audited on the ward looks like they have been missed when the patient is away from the ward. The audit and electronic system is being reviewed to take into account when the patient is away and if can be recorded. **Action - A point was raised by ███ before the meeting that agency staffing costs seems to be increasing and have been for a long time.** **Agency is often used for specialist areas where it would take a while to recruit for.** **The trajectory is for agency costs to be reduced, ███ has agreed to provide an update following the meeting on the increase.** **<u>CQC Maternity Report</u>** As part of the national programme, the CQC are visiting maternity units. The visit to UHNM was on 7th March. It was said by ███ to be a very difficult visit with CQC issuing a Section 29a for	

No	Item	Action Lead
	Emergency Triage Process' and Induction of Labour. A draft CQC report was received which contained lots of factual inaccuracies. The CQC have amended it and sent it back and it has since been published. ███ reported that Staff were upset by the CQC ratings and evidence is being gathered to submit this week to hopefully get the Section 29a notice removed, the CQC would then be invited back to inspect again in the hope that the ratings may be reconsidered.The maternity service is ~~still~~ rated overall as requires improvement. The Section 31 notice in ED regarding triage of patients within 15 minutes has been removed, it had been in place since June 2019.	
7.2	**CQC Action Plan Update** As mentioned above. Action plan to be shared next month.	
7.3	**ICB Quality Visit – County Hospital Report** ███ advised the report reflected improvements seen, audit and training data and some areas which still need improvement. The Trust had responded to the recommendations made by the ICB. New audits will be done in August to include talking to staff. ███ has agreed to provide the audit results when they are ready. ███ agreed ███ could share the report with the CQC	
7.4	**VTE Deep Dive Report** To be provided in August.	
8.0	**Monthly Performance Report Summary**	███
8.1	**Performance Report** It was agreed that the report was taken as read. A question was asked by ███ regarding the risk scoring system within the radiology section of the report and reporting back logs on page 41 and a lot of the action remain the same each month. It was confirmed by ███ that there is different risk factors for different divisions, However she would ask for an update from Radiology on the risks and actions being undertaken. **Action – ███ to obtain an update on risks and actions for non-cancer/routine radiology reporting.** 78 & 104-week waits are reducing and will be further reduced by June/July. 78-week waits are at around 130-140. 104-week waits will hopefully be down to 0 by August. The 78-week waits are being focused on to get these down to zero ASAP. 64-week waits are the next target is to get to 0. It was confirmed by ███ that Harm Reviews are reported in a different report, however a report has not been provided this month due to the meeting being cancelled as a review of the harm review process is being undertaken. ███ informed all that the RCA has been changed to a 2 page	

No	Item	Action Lead
	proforma from a 16 page document. UHNM are looking at a new process where divisions can create the information and put it all into one report. Some proformas are being completed, going forward the forms which are to be pre-populated by the divisions to help save time for clinicians carrying out the review. This allows for divisions to own the process and identify themes and trends for their specialties which will be of benefit when commencing PSIRF in October. █ has agreed to share contact details for colleagues at Coventry & Warwickshire with █ so they can enquire about how that organisation does their harm review process.. █ has confirmed that there will be a report showing all major increases/reductions in August, to be presented at Septembers meeting along with validation processes and a SOP. The SOP will show how to categorise different levels of harm as different areas do it in different ways; █ advised that MPFT have a SOP which makes clear what harm and risk there are where possible. It was highlighted by █ that 12-hour breaches for May have increased to 665 with 4-hour targets decreased. █ advised that it seems that when a staff strike finishes, the numbers of ED attendances tend to go up and have done in general over the last 6-8 weeks. There was no specific cause found. There had been no issues with Covid-19. Currently only 30 inpatient cases across the Trust. **Action – several pages from the report were overlapped and difficult to read, █ to Check**	
8.2	<u>**104-day Harm Review Report Q4**</u> During Q4 22/23 – January to March 2023, there were 111 patients who received first definitive treatment over 104 days on their pathway. This is a reduction of 19 patients since the previous quarter. Most of the breaches were due to inadequate capacity in surgical and oncology. There are also some tumour sites who recorded a higher number of treatments over 104 days compared with others; Urology and Skin have recorded the most breaches with 28 and 22 respectively for the quarter. January was the highest month with capacity issues. It was highlighted by █ that Harm Reviews need to be included in the report, not just the process behind it. A summary of the process behind how this data is fed back into internal governance systems would be useful. The volume of breaches and the harms dealt with need to also be included. The number of patients treated in Q4 reduced from previous due to the number of pressures at the time as well as the number of open/closed pathways reducing. **Action – There was a SOP included in the Harm Review but ICB were unable to open it, █ to re-circulate.**	
8.3	<u>**Independent Review of waiting list management, Data and Reporting**</u> As discussed above in 8.2	
8.4	<u>**Review of 52-week Harm Process Update**</u> As discussed above in 8.2	

No	Item	Action Lead
9.0	**Emergency Department Monthly Assurance**	██
	It was confirmed by ██ that there is a local agreement in the contract that 10 RCA's are completed a day. . Ambulance handover delays are improving. Due to the 12-hour breaches increasing significantly. A new process is to be proposed. The Trust are keeping track of serious incidents. ██ and ██ are talking with the deputy chief nurse about how the process will work in the future. Internal discussions about how best provide assurance., ██ and team are currently working on a proposal to bring forward.	
9.1	**12-hour Breach/Ambulance handover delays report** No report this month- whilst process under review. ██ advised Harm Reviews have been completed up to the end of March 2023 **Action - ██ has agreed to work on a proposal for 12-hour trolley breach and Ambulance hand over delay harm reviews to bring to CQRM.**	
10.0	**Serious incident Report (May 2023)**	██
	It was confirmed by ██ that 13 SI's were closed during May which was a decrease from April. There has been a further reduction in June with 80 SI's open. It was noted by ██ there were 36 SI's with the ICB for review and ██ asked if this meant that they were in the closure process not that they were actually awaiting ICB action. ██ confirmed they were in the overall closure process. **Action – ██ to provide an overview of what SI's are overdue. ██ and ██ to meet to briefly go through SI's.**	
11.0	**End of Year CQUIN Report**	██
	Report not ready, will be provided in August.	
12.0	**National Staff Survey**	██
	The report went to the Trust board in April. People and ODT teams have put together an engagement plan. Action – ██ has agreed to circulate the National Staff Survey and it will be re-circulated in August.	
13.0	**Medical Device Outcome Registry**	██
	It was raised by ██ that the letter had not been received by the Trust, although it was dated September 2022. It was confirmed by the MDSO officer that it had not been discussed at any groups. The Register was supposed to have launched by May 2023 but it is not yet ready. ██ has agreed to pick this up and take it to the Medical Device Steering Group.	

No	Item	Action Lead
14.0	**Forthcoming UHNM External Reviews**	**All**
	It was confirmed by ██ that the Leighton Hospital HTA license has come through as a tabletop review. There were no issues identified with a formal inspection due to soon take place. UHNM became involved because of the Pathology network and it relates to how it is set up at Leighton Hospital. ██ has agreed to provide the Leighton Hospital Report.	
15.0	**Any Other Business**	**All**
	None.	

Next UHNM CQRM
Thursday 21st September 2023, 12:00-14:00
Via Microsoft Teams

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Your NHS partner for **improving health** and **integrating care**

Meeting	UHNM CQRM
Venue	Microsoft Teams
Date/time	Thursday 21st September 2023, 12:00-14:00

Attendees:		
(Chair)	Associate Director of Quality and Patient Safety, SSoT ICB	
	Lead for Quality & Patient Safety, SSoT ICB	
	Deputy Medical Director, UHNM	
	Lead Nurse for Infection & Prevention, UHNM	
	Lead Nurse, Quality & Safety, UHNM	
	Head of Cancer Services, UHNM (part meeting)	
	Head of Quality, Safety & Compliance Department, UHNM	
	Associate Director, Performance & Information, UHNM	
	CNIO / Assoc. Deputy Chief Nurse, UHNM	

In Attendance:		
(Minutes)	Business Support Officer, MLCSU	

Apologies:		
	Medical Director, Staffordshire & SSoT ICB	
	Senior Clinical Quality Improvement Assurance Manager, SSoT ICB	
	Associate Chief Nurse/Deputy Director (Infection Prevention & Sepsis), UHNM	

No	Item	Action Lead
1.0	**Introductions & Apologies.**	**Chair**
	introduced all to the meeting & announced apologies.	
2.0	**Declarations of Interest**	**All**
	None to declare.	
3.0	**ICB Leadership Compact**	**All**
	covered the leadership compact and all adhered.	
4.0	**Minutes from the previous meeting: 20th July 2023**	**All**
	Agreed as an accurate representation of the meeting.	

5.0	**Action Log from the previous meeting: 20th July 2023**	All
	Action 126 – Quality Assurance Report provided in the meeting papers. (Closed) Action 130 – The CQUIN report is going to the Trusts internal meeting QGC and will be brought in October. (Open) Action 131 – Sepsis Deep Dive was deferred by the Trusts internal meeting QCG. (Open) Action 135 – The National Staff Survey was circulated with August papers. (Closed) Action 138 – The CQC Action Plan was provided for this meeting. (Closed) Action 140 – ███ confirmed he is still waiting for the Radiology reporting and has chased the supplier of the report, he will provide an update when ready. (Open) Action 141 – The overlapping pages were amended by WS. (Closed) Action 142 – ███ will provide the SOP to be re-circulated. (Open) Action 143 – A meeting was held, and an actioned list was made. (Closed)	
6.0	**Monthly HCAI Report (July 2023)**	**All**
	The report was complete up to the end of July. There were 67 CDIFF's recorded which is above projection of 34. These were largely occurring in the west building so a task and finish group has been set up to review. The age group mostly affected was older people concerning Antibiotics and UTI's. There has been good engagement with Clinicians at West building around this with close liaison to the Health Community around CDIFF and UTI's. It was confirmed that there are 2 reported MRSA blood stream infections. The sepsis deep dive around ED has been deferred by QCG. The flu and vaccination campaign started on Monday 18th September and has been well received with a number of people booking in, figures will be provided as this progresses. It was identified that the CDIFF table did not match one of the tables in the report with the chart on page 2 stating there was no CDIFF in July whilst other charts were reading 12 CDIFF's in July. ███ agreed to amend. ███ noted that CDIFF had been discussed at the System Quality Meeting but there was no attendance from UHNM. Positive feedback was given as improvement has been seen.	
6.1	**Sepsis Deep Dive Report** Report deferred by QCG. A verbal update went to QCG and the Deputy Chief Nurse asked to make amendments to the report. There was one patient safety alert for an Opioid related event which went to the Patient Safety Group and with agreed sign off.	
7.0	**Quality Assurance Report Summary (July 2023)**	███
7.1	**Quality Assurance Report** Sepsis was highlighted in the report. • The number of falls remains consistent but the number of falls with harm is decreasing.	

	• The number of incidents are increasing with staff encouraging to report. Moderate harm and above incidents are in the long term mean which is positive. These patients are still to be reviewed regularly. • SI's were detailed in the papers with several incidents closed whilst 15 more were raised. • No never events reported. • Maternity Friends & Family are seeing a downwards trend, text messaging has been introduced which is hoping to provide an increase in response rate. UHNM are aware that complaints are quite high in Maternity Services which have been further driven by recent national press reports. Maternity staff and birthing people are being listened to closely for feedback with considerable background work going on. • Patient experience report is going to QCG and will be presented at Octobers Meeting.
7.2	**CQC Action Plan Update** The CQC Action Plan went to the Quality Governance Committee and Trust Board last month. There were some actions in the document which have been there since 2019 although CQC are satisfied with actions, S31 was lifted and 29a has been removed. Training compliance is being closely monitored and kept in line with governance processes. The biggest feedback by CQC was regarding the medical wards having adequate storage space It was requested that these actions are recognised in the risk register. The Speech and language service needs to be progressed as it is not developing as expected. UHNM will need to make their progression plan clear along with the actions from the Nutrition board. Speech and Language audits are ongoing with a number of red areas turning green. There was a Brachytherapy inspection made by CQC which UHNM were notified of in advance under the Health & Safety Act. A warning notice was issued around the governance of documentation and the authorisation of therapy by practitioners, a few minor points of factual accuracy were sent back. UHNM will need to provide assurance that actions from the warning notice have addressed. **Action – ███ agreed to provide ███ with the CQC feedback for the Brachytherapy inspection.**
7.3	**VTE Deep Dive Report** It was made clear that the VTE Deep Dive Report is a Draft. The VTE Steering Group requested a deep dive on the Thrombosis Service. Clinicians at the Quality Oversight Group asked if there was any connection between patients acquiring hospital acquired Thrombosis and long waits in ED. VTE risk assessments are being completed and this data is received by the Quality Oversight Group, then QCG and then CQRM. The data discussed was from December to February. There is a new VTE risk assessment in progress. **Action**: Updated VTE report to be sent to October CQRM
7.4	**CEF Summary Report** The CEF Summary Report has been to the Quality and Safety Oversight Group and is due at the Quality Governance Committee. UHNM staff have worked with the Chief Nurse on the CEF Framework to provide clear criteria on how awards are given. It is expected that more bronze awards will be received under the new criteria as it is being made more difficult to achieve the platinum awards. Two wards have been identified as bronze this month: 101 and 113.

	A supportive meeting is held with the Chief Nurse and members of staff from the multi-disciplinary ward team to address identified concern and how the action plan can be progressed at a better rate. [redacted] confirmed that any wards that are bronze are assessed after 3 months to make sure they can progress to the next level if they are able to make rapid improvements. [redacted] thanked UHNM for allowing ICB to join in on the visits and for UHNM being nominated for the HSJ award. The reports was praised as being well written with issues being spotted. Teams must be congratulated. [redacted] asked if the bronze reviews would affect workload? It was confirmed by [redacted] that they would and this is being monitored by [redacted].	
8.0	**Monthly Performance Report Summary (July 2023)**	[redacted]
8.1	**<u>Monthly Performance Report</u>** Several aspects of the report were highlighted, these include: RTT Elective Care and 104-week waits. Last month 104-week waits went down to 1 patient, looking at getting this down to 0 in October. There is still work ongoing with 7 or 8 work streams in place. 78-week waits are coming down however industrial actions affected 65-week waits with these planned to be down to 0 by 2024. All patients that do breach 65-week waits will have appointments made as soon as possible although as mentioned it is becoming increasingly difficult with industrial action. National meetings are held several times a week with NHSE. A&E still have fluctuating days but ambulance holds are much better than they were. [redacted] noted that wait trajectories are looking much better but the wait in outpatient waiting lists remains high. [redacted] requested that more detail is given on patient complaints/harm/experience and wait times. Funding has been given to help cut down waiting lists including how to contact the patients more effectively and consistently to provide assurance that they have not been forgotten and are still on the waiting list without it being overwhelming to the patient. Re-attendance rates have been higher since April 2022 although the report does not provide clarity on what is being done/the impact this is having which needs to be included in the harm reviews. Concern was raised by the group as Harm Review workshops are being cancelled and therefore harm reviews are not discussed, these need to be put back into place. The SOP for 52-week RTT's has been complete. A level of assurance was gained as a proforma was completed for each directorate with breaches, outcomes and lessons learned. **Action – All RTT 52-week data is to be collated into 1 large report, this can be brought to this meeting or a separate meeting with ICB.** **<u>104-day harm review report Q1</u>** The paper for Q1 is to follow the meeting. June's data has only just been reported due to how the cancer publications work. Q1 for 23-24: • 79 patients were treated beyond 104 days which is 32 less than the previous quarter and then 11 before that. • The number of active patients has decreased by around 40 over the last half of a year. • The tumor sites challenged has remained the same.	

8.2 8.3	• SATH robot support is being given across the region. • Skin capacity inhouse is being funded. • Anyone who is a known red flag is seen immediately. • Booking & Endoscopy is a focus area and themes remain the same with multiple diagnostics being seen. A conversation took place about harm reviews: ███ is meeting with Clinician leads and will be discussing their processes and how work can be progressed further. It was confirmed that no more complaints have been received around fit testing. **Action – ██ to provide highlights on the conversations with Clinicians and their processes around 104-day cancer waits.** **52-week harm review process** As discussed above .	
9.0	**Emergency Department Monthly Assurance**	██
 9.1	. **12-hour breach/ambulance handover delay harm review proposal** . The member of staff dedicated to 12 hour trolley breach harm review process reporting/data has left which has required ██████ to review and re-vamp the process making it easier whilst keeping it meaningful. ███████ discussed potential harm from patients waiting in ED, including falls and pressure ulcers and how this is monitored so that no harm is missed. UHNM want to introduce a process that identifies any patients who have had long waits in ambulances/ED that may have come into harm. The harm review workshop helped to show how UHNM can implement a process to capture these events. This process would need to manageable and monitorable	
10.0	**Serious Incident Report (July 2023)**	█████
      10.1	It was confirmed by ██ that actions have been taken and signed off in July's report with a reduction in numbers. Reporting remains via the SI framework and falls are still the largest category of SI's. Outstanding SI's have been addressed that need to be closed with 11 closed in August. There have been 4-5 closures this week which is positive. Three Never events have been submitted to the ICB whilst waiting for the final approval of RCA. Numbers that had increased due to Covid-19 are now coming down. **Serious Incident Report Q1** As discussed above.	

10.2	**Recording responses to patient safety incidents during transition to LFPSE and PSIRF** █████ confirmed that they are happy with the transition phase as UHNM are ahead of many trusts in developing their plans and processes. UHNM are also joint working with other local trusts which is very positive as this is not happening in all areas. There is no NHSE extension yet for LFPSE but NHSE are sending out communications about the sign off.	
11.0	**Patient Experience Report Q1**	██
	Will be submitted to October's meeting.	
12.0	**CQUIN Update 2022-2023**	██
	Will be submitted to October's meeting. Action: add to October agenda	
13.0	**Forthcoming UHNM External Reviews**	**All**
	It was confirmed by ██ that PSIRF Plan will be sent to ██ prior to submission to October's trust board.	
14.0	**Any Other Business**	**All**
	Notification of Prevention of future death from Coroners submitted to ██ requesting information on medical reasoning.	

Next UHNM CQRM:
Thursday 19th October 2023, 12:00-14:00
Via Microsoft Teams

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.

Meeting	UHNM CQRM
Venue	Microsoft Teams
Date/time	Thursday 19th September 2024, 12:00-14:00

Attendees:		
(Chair)	Strategic Improvement Lead for Quality & Patient Safety, SSoT ICB	
	Senior Clinical Quality Improvement Assurance Manager, SSoT ICB	
	Head of Nursing, UHNM	
	Head of Quality, Safety & Compliance Department, UHNM	
	Lead Nurse, Quality & Safety, UHNM	
(Part Meeting)	Associate Chief Nurse/Deputy Director (Infection Prevention & Sepsis), UHNM	
	Associate Director, Performance & Information, UHNM	

In Attendance:		
(Minutes)	Business Support Officer, SSoT ICB	

Apologies:		
	Strategic Clinical Director, SSoT ICB	
	Associate Director of Quality and Patient Safety, SSoT ICB	
	Assistant Director for Nursing, NHSE	
	Head of Cancer Services, UHNM	
	Matron for Quality & Safety, UHNM	
	Associate Deputy Chief Nurse, UHNM	
	Deputy Medical Director, UHNM	

No	Item	Action Lead
1.0	**Introductions & Apologies.**	**Chair**
	■ introduced all to the meeting and announced apologies as noted above.	
2.0	**Declarations of Interest**	**All**
	None to declare.	
3.0	**ICB Leadership Compact**	**All**
	■ covered the leadership compact and all adhered.	
4.0	**Minutes from the previous meeting: 18th July 2024**	**All**
	Agreed as an accurate representation of the meeting.	
5.0	**Action Log from the previous meeting: 18th July 2024**	**All**
	Action 179 – Pathology System Upgrade – A response has been received. More Datix have been submitted by GP's and have been shared with UHNM. An upgrade to the system has been completed. Agreed to close and ICB to raise in future if further concerns reported by primary care. (Closed) Action 180 – Pressure Ulcer Deep Dive – This item will be presented in October. (Open) Action 181 – Midwifery and Nursing Vacancies – UHNM have a net zero for band 5's vacancies. A waiting list is in place for students to fill gaps from local Universities. Band 6's are advertised internally only and with 12-month fixed term development programmes. There is a programme in place with the NMC for Health Care assistants who are qualified in their own Country but don't meet the English language standards. This is fast tracking 2-8 registrants a month. (Closed) Action 182 – Staffing Establishment Report – This item will be presented in October. (Open) Action 183 – Speciality Areas – ■ will chase ■, to be presented in October. (Open)	
6.0	**Monthly HCAI Report (June/Julys 2024)**	■
	■ discussed the report and highlighted details below: • New trajectories have been received from NHSE and have been increased as there is now a cohort of patients classed as hospital acquired in the virtual wards. Reports will be updated from August. • There were no MRSA Bacteraemia in June. • There were 38 cases of CDIFF YTD which is above trajectory. The new trajectory is now 15 cases per month and in recent years the meaning of hospital acquired infections has changed. • There were 23 cases of Covid-19 which is lower than usual for UHNM, although there is a new strain circulating. • Cases of Chicken Pox, Measles and Pertussis have been seen. I.	

	UHNM have now begun their Winter Planning, training will start to be circulated for Flu, norovirus and CDIFF infections. Pilot of updated NICE Sepsis guidelines in ED have been put on hold as the ED are implementing the Vitals electronic system. The Trust has identified this as a priority to implement. There will be more attention paid to sepsis screening and to anti-microbial prescribing in ED. The 3 main factors for CDIFF increases identified were late sampling/samples not being sent, anti-microbial prescribing and commode cleaning. There is also an initiative for commode cleaning and work to reduce the number of commodes where not required on wards. There were 8 suspected cases of Monkeypox but were all found to be negative cases. ███ asked if E-Coli have a new case trajectory and ███ confirmed that it has now been increased to 240 cases. ███ confirmed that IP colleagues in the ICB are leading work on E-Coli, and there is work ongoing on catheter care and catheter care and patient hydration in the Trust.	
7.0	**Quality Assurance Report Summary (July 2024)**	███
	<u>Quality Assurance Report (July 2024)</u> ███ discussed the report and highlighted details of July's report: • Improvements have been seen across most metrics. • Induction of labour/midwifery and other similar areas are achieving targets. Partial assurance is being given around achievement of targets until consistently achieved. • Harm from falls is decreasing. • Hospital acquired Pressure Ulcers are decreasing. • Lapses in care for pressure ulcers are decreasing. • VTE performance is below target due to date and time not being properly recorded on forms, work is being done to improve this. • There have been 5 Never Events in December 2023. • Focus is being continued around timely observations. • Future reports will include KPI's for piloting Martha's Rule. • Learning from thematic reviews will be shared. On the quality dashboard there are various icons around variation/assurance that didn't display correctly. The target has been achieved for the last 7 months. This will be fixed with August's report. ███ mentioned that timely observations are Improving but it is very slow. ███ asked if Medications patient safety events with moderate harm have a PSII, ███ advised that some may have PSII, but others will get a response and some sort of review. E.g. Thematic reviews are being done for adverse drug reactions. Duty of Candour indicators has hugely improved. There is continued support around wards rated as bronze CEF awards, there is lots of work on-going. ███ discussed that the timely observations and said the percentage in the report is overall. A dashboard is being worked on to break down to low, moderate and high triggers. A dashboard will be available to teams to give an indication of which observations aren't being completed. All wards that in the bronze co-hort have seen significant improvements. Teams are also being supported where there is a lack of devices and issues with wifi.	

8.0	**Monthly Performance Report Summary (July 2024)**	███
	Monthly Performance Report (July 2024) The report was taken as read. ███ confirmed that UHNM are working hard to decrease the number of 65-week waiters, the number is now down to around 260 and UHNM are working with NHSE on this. More work is being done around data quality and training on RTT which will allow for highlighting those who haven't had any training/make mistakes. If staff have not been trained by December, then their access to the system is to be revoked. UHNM are working with a company called MBI to go through the system to make sure all patients are on the right outcomes/pathways. Once the 52+week plus patients are dealt with, patients under 52-weeks will be the next targets. UHNM have now completed the 65-week waits for checking and will be doing validation for 52-week waiters. The national mandate is for this to be complete by March 2025. It has become more difficult with ERF funding rarely being given. UHNM sent a text message service to patients and around 5700 removed themselves from the waiting lists. The focus around elective performance has been difficult this week but UHNM are recovering from busy days much better than they used to. Diagnostics are now at 68%. The biggest issue is none obstetric ultra-sounds waits and endoscopy. Cancer waits are doing well and have met within 28-day targets but the 62-day targets have declined slightly. ███ highlighted that the use of agency staff has increased from 2.5% to 3.3%. **New Action – ███ will find out why agency numbers have increased when staffing fully established.** 52+ Harm Review Report (June/July 2024) The harm review is still being completed manually until the new Careflow system is ready, which won't now be until February 2025 due to delays. No psychical harm identified; however psychological harm difficult to identify. Some specialties with large co-horts of patients struggling to complete any harm reviews. ███ suggested a focus on ophthalmology as none completed in June and July.	███
9.0	**Emergency Department Monthly Assurance**	███
	ED Ambulance Handover Delay Harm Reviews ███ is leading these meetings, and the TOR is being reviewed, as well as trying to aligni processes with UHDB and other trusts. Meetings are being held with NHSE. A joint meeting to agree scope and terms of reference is scheduled in a few weeks' time. SJR's will be completed for patients if they are waiting 12-hours or longer in ED. 12-hour breach/ambulance handover delay harm review proposal update As discussed above.	

10.0	**PSIRF Learning (SI Update July 2024)**	■
	The report was taken as read and ■ highlighted key points: There have been significant changes to FPC (financial pay control). There were 6 PSII's logged in July, details cab seen from page 7 onwards. It is highlighted in section 2 that there have been 18 new instances that had triggered a PSRIF response. These cases go through the risk management panel and the report includes the steps of actions taken. There were not any Never Events recorded in July, although there have been 2 reported in August that occurred in July so will show on next month's report. At the end of July there were 21 open PSII's which has now decreased. A description of actions and steps taken is included in the report. Dermatology Never Event: and themed review & 2024/6889 Extensive actions are being worked through and photography issues have been identified. From the photos it is not always clear which lesion is supposed to be the centre of attention and the photos are not clear enough to show where it is. The whole team are doing a human factor training session today off-site including nursing and support staff. The use of WABA and consultant connect is being reviewed by digital support to ensure everyone is using the same steps, this will help to improve the current photo process. Health Harmonie do pre-assessment photography which is different to the photography taken in hospital. UHNM are working with Health Harmony to ensure the same systems are used and types of images. Update on Never Event 2024/6889 ■ discussed the Never Event in which a patient was prepped, and the wrong leg was operated on. Information was shared with Executive's, and it was agreed the way the PSII was logged sounded like it was ok as the patient required the other leg operated on. Duty of Candour was complete with the patient and no harm was identified. A PSII is being completed and learning will be shared. It was advised that the surgeon has done a reflection on the incident.	
11.0	**Mortality Review Report**	■
	This report is going through the internal review process and will be provided once ready.	
12.0	**Feedback from ICB people and communities' assembly**	■
	It was asked that this information was brought to this meeting by UHNM colleagues. There was a situation in which members of staff were spotted using mobile phones while working, despite being told not to. ■ mentioned that staff do use various devices which could have been those. **New Action ■ will feed this back to ED staff and ■ will feed back to ICB staff and staff who attended the assembly. Both ■ and ■ will give an update.**	■
13.0	**Forthcoming UHNM External Reviews**	■
	The Human Tissue Authority is coming to visit orthopedics.	

	MHRA recently did a visit to the Pharmacy department. The report has been received and the Pharmacy Team are checking it over for factual accuracy. This will be presented to the Clinical Effectiveness group in October **New Action – ███ will provide an update in November on the MHRA Pharmacy visit report.**	███
14.0	**Any Other Business**	**All**
	███ raised that there is a learning event on October 14th and asked if ███ could present. ███ advised she would ask patient safety partner if would s support and would be completing a presentation on how patient safety partners are used in the Trust	

Next UHNM CQRM:
Thursday 17th October 2024, 12:00-14:00
Via Microsoft Teams

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.

From:

Subject: *URGENT* UHNM CQRM STOOD DOWN
Date: 19 October 2023 11:54:00
Attachments:

Dear all

Please note that todays UHNM CQRM has been stood down.

Please do not join the call.

Thank you

Kind Regards

(Please note that if I respond outside of your own working hours I do not expect a response, Please reply when it is convenient for you. Wellbeing is important)

Email:

Staffordshire and Stoke-on-Trent Integrated Care Board
Stafford Education & Enterprise Park, Weston Road, Stafford, ST18 0BF

A group of people in a circle Description automatically generated with low confidence

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Meeting	UHNM CQRM
Venue	Microsoft Teams
Date/time	Thursday 17th October 2024, 12:00-14:00

Attendees:		
(Chair)	Strategic Improvement Lead for Quality & Patient Safety, SSoT ICB	
	Senior Clinical Quality Improvement Assurance Manager, SSoT ICB	
	Local Maternity and Neonatal Quality and Safety Midwife, SSoT ICB	
	Assistant Director for Nursing, NHSE	
	Matron for Quality & Safety, UHNM	
	Interim Deputy Chief Nurse Operations, UHNM	
	Head of Quality, Safety & Compliance Department, UHNM	
	Lead Nurse, Quality & Safety, UHNM	
(Part Meeting)	Associate Chief Nurse/Deputy Director (Infection Prevention & Sepsis), UHNM	
	Associate Director, Performance & Information, UHNM	

In Attendance:		
(Minutes)	Business Support Officer, SSoT ICB	

Apologies:		
	Strategic Clinical Director, SSoT ICB	
	Associate Director of Quality and Patient Safety, SSoT ICB	
	Head of Cancer Services, UHNM	
	Head of Nursing, UHNM	
	Associate Deputy Chief Nurse, UHNM	
	Deputy Medical Director, UHNM	

No	Item	Action Lead
1.0	**Introductions & Apologies.**	**Chair**
	■ introduced all to the meeting and announced apologies as noted above.	
2.0	**Declarations of Interest**	**All**
	None to declare.	
3.0	**ICB Leadership Compact**	**All**
	■ covered the leadership compact and all adhered.	
4.0	**Minutes from the previous meeting: 19th September 2024**	**All**
	There was 1 change made to the minutes: There have been 5 Never Events since December 2023. 1 in December, 2 in January, 1 in February and 1 in March.	
5.0	**Action Log from the previous meeting: 19th September 2024**	**All**
	Action 180 – Pressure Ulcer Deep Dive – A deep dive has not been undertaken however a verbal update on the work being undertaken and will be discussed in this meeting. (Closed) Action 182 – Staffing Establishment Report – This report has now gone to UHNM internal committees and will be brought to this meeting in November. (Open) Action 183 – Speciality Areas – Not due, this item will be brought to Novembers meeting. (Open) Action 184 – Agency staffing numbers increase – agency staff are being used in theatres to reduce waiting lists. (Closed) Action 185 – Staff assembly phone usage concern – ■ has fed back to matrons and vitals have been introduced into ED so device usage will increase. ■ has fed back to the ICB Head of Governance. (Closed) Action 186 – MHRA Pharmacy Visit – The visit is in November. (Open)	
6.0	**Monthly HCAI Report (August 2024)**	■
	■ took the report as read and highlighted key details: • There 2 MRSA Bacteraemia, 1 at the beginning of August and 1 at the end. Meetings were held for these to review the cases, ICB and NHSE were also present, and the cases were deemed as unavoidable. • There were 61 cases of CDIFF Year To Date (YTD) which is under the trajectory of 75. The new trajectory will be updated in the Quality report from September. • E-Coli continues to increase and the ICB have been given a grant to investigate why this increase is happening. UKHSA are also carrying out a piece of research on causes. There has been an increase nationally particularly in the Community.	

	• There was a Noro-Virus outbreak on ward 12, now under control. The strain was a G2 variant. • Winter respiratory testing has commenced from last week for COVID-19 and now includes an array of other respiratory testing. • Epox preparation is place and action cards have been circulated to staff/teams and the pathways are shared with Community colleagues. • There was a potential measles case but was found to be negative. • Sepsis in ED has dropped from July, but it is still better than it was. • Anti-biotics administered within the hour has improved. • Vaccinations have started and are ahead of schedule compared to 2023. • Funding has been secured for opportunistic patient attending outpatients, especially those with chronic conditions. This will begin on 1st November 2024. • Covid-19 is on the rise again and the trust are watching this closely. ■ asked what was being done to improve compliance as the Sepsis KPI's had not been met for a long time at Royal Stoke ED which was a concern. ■ advised that the New NICE guideline's for Sepsis is not being implemented at Royal Stoke as is currently too risky to try and implement at the same time as implementing vitals as there would be too many changes at once. ■ is leading on the improvement work and is focusing on anti/biotics administration within the hour. There is a dashboard recording any incidents relating to SEPSIS. Maternity anti-biotics within the hour currently has ongoing work as well, MEWS is being worked on and will be captured by vitals. ■ asked out of interest in terms of neonates there had been several cases of MRSA and Pseudonyms. ■ confirmed there had been cases there were 4 cases of MRSA colonisations of which 2 were linked and 2 weren't. The Pseudonym water system is checked every 6 months.	
7.0	**Quality Assurance Report Summary (August 2024)**	■
	Quality Assurance Report (August 2024) ■ took the report as read and highlighted key details: CDIFF has been covered in Item 6, and the new target will be reflected in September's report. Improvements are being seen across the board with the big ones being assurance around induction of labour and pressure ulcers developed under the trust. The trust has not achieved the friends & family for ED target but are seeing responses to F&F improve. Sepsis has been discussed earlier with Inpatients screening and Antibiotic administration improving, However ED screening continuing to reduce. It was noted that within the report there are new slides in Clinical effectives. These have been added to eventually capture patient outcomes. These are still being worked on by the clinical effectiveness workstream. These will be updated in the future once the indicators and reporting are decided. Timely observations aren't at target but are slowly improving, explanations around what is being done will be presented. The trust is working with CNIO and divisions to help with these improvements. This is also being reported through the CEF award criteria.	

	███ asked about the CEF self-assessment tool and if any feedback has been received. ███ confirmed that it is being trialed in bronze areas and they are reporting any findings. Actions are being updated onto the Datix. The goal is for some of the feedback to be cascaded to the rest of the trust and feedback has been positive so far. ███ asked about the update to the complaints policy that appears to have been put into place. ███ confirmed that an update/overhaul had been completed. A lot of changes were made. One of the biggest issues around complaints is how long it takes the trust to formally respond due to capacity and the complexity of some complaints. A formal escalation process is now in place and teams are being made aware of the changes. The complaints escalation process can go all the way to the Chief Nurse and Medical Director if needed. There is also a triage process in place, some have standard responses back such as car parking, with some being diverted to Matrons or PALS to resolve informally. It will show in the final draft stage and will be issued shortly. CQC Action Plan The CQC Action Plan went to the Trust Board in August. The last full CQC inspection took place in 2021. Some actions are now old and need to be removed, these are those actions that it was agreed they should be monitored through the BAU processes. Key issues are around speech and language services at County Hospital. Two posts have been put into place and this has reduced the time from referral to review by a noticeable amount. The trust is happy that this answers the CQC concern. We are continuing to collect and monitor data and once happy the action will be closed. Actions related to ███ are left open and the S29a notice at county was removed. The trust has not yet received the updated report. ███ asked about the Maternity CQC Action Plan and ███ confirmed that Maternity had its standalone Quality Governance Committee (QGC). ███ will check for updates as these are given often. The standalone maternity QGC has now been stood down. The actions for Maternity have now changed and Maternity is now part of routine QGC discussions. ███ later in the meeting confirmed that Maternity CQC action plan for Q1 went to QGC in August 2024. CQUIN Statement Position ███ highlighted that CQUIN's are non-mandatory, but the Trusts Quality Committee agreed they would like to continue to receive updates on the 7 CQUIN's from last year. There were originally 11 and there are 4 new ones, in total the trust will keep monitoring/updating 7. ███ is meeting with colleagues to confirm if other schemes can be monitored through the annual audit program. The decision will be fed back to the governance committee. ███ advised there seemed to be a gap in the transition to adult services. ███ advised she would raise this when she met with the Chief Nurse to see if this CQUIN was one to consider. Pressure Ulcer Deep Dive There were 2 slides included in the Quality report on Pressure Ulcers. ███ took these as read and highlighted key details: One indicator is pressure Ulcers developed under UHNM 's care by per 1000 bed days and the other Pressure ulcers with lapses in care by per 1000 bed days. These indicators are not having spikes that we saw particularly over the last 12 months, so steady progress is being made. The trust has appointed two more Harm Free Care Educators which gives the trust more ability to respond to areas that are struggling during the month. ███ confirmed that they have only been in post since September and are already seeing an impact despite the Quality	

	Committee questioning whether two more staff in a large organisation can make a noticeable difference. The trust is introducing the Purpose T tool and staff are being made aware of it and how to use it. The Chief Nurse is constantly challenging staff to make sure improvements are being made. Staff from another smaller hospital trust are having great results when it comes to pressure ulcer improvements and the trust will be going there to see what it is they're doing. Some of these improvements can also be combined with the A3 improvement work. ██ asked about PurposeT and ██ confirmed that the new tool will be updated weekly as opposed to the waterlow tool which was daily. <u>Patient Experience Report</u> ██ took the report as read and highlighted key details: The report provides updates on types of complaints received, work with our Patient Safey Partners and patient leaders. The Complaints policy and the escalation process are the drivers for responding in a timelier manner as discussed previously in this meeting. A lot of complaints come from the ED portal. ██ highlighted that mixed sex accommodation breaches in critical care are being reported externally and are included in this report. There are on average of around 100 breaches per month. There is a piece on work with specialties and the site Managers to see if anything else can be done to step down the patients quicker. ██ and ██ gave praise to the report and said it is always interesting to read and very informative. <u>Q1 CEF Summary Report</u> ██ took the report as read and highlighted key details: The trust is visiting two areas a week, 17 in total were visited in Q1 of 2024. There are various changes in wards ratings. One of the Bronze wards meet monthly with the Department of Nursing. There are good processes in place with the patient leader. The Trust have been looking at what the top contributor are to the wards being awarded a bronze rating. The top contributor in the safety domain is to issues is related medicine management, the next contributor being documentation. The team have worked with pharmacy to create a list of top 10 for the Wards to implement. The self-assessment tool is proving to work well used by the wards rated as Bronze. There is no bronze care in domains and the maternity and delivery suite has gone from bronze to gold. Bronze areas are visited in 6-month intervals, all other areas are every 12 months. ██ discussed that the ward criteria for the CEF process is quite tough. ██ raised that the trust have caried out 2 mock CQC visits so far the aim being to check the CEF process to see if findings are similar, the two so far showed this to be the case, so it is showing that it works and it gives good insights to wards. ██ praised that the report and concept is very good, alongside the engagement from wards and departments being good. Staff are awarded for good ratings. There are platinum badges.	
8.0	**Monthly Performance Report Summary (August 2024)**	██
	<u>Monthly Performance Report (August 2024)</u> ██ took the report as read and highlighted key details: • There are currently no 104-week waits.	

- There were 13, 78-week waiters in September, there should be 4-5 in October.
- There were 218, 65-week waiters in September, there should be just over 100 in October.

There is now a big concentration around 52-week waiters, we have heard that we are expected to not have any over 52ww at the end of the financial year, but there is a lot of work to do to achieve that. To get the numbers as low as possible the trust are planning to get first contacts and 1st appointments by the end of December.
The trust is working with outside sources to bring non-obstetric ultrasounds waits down, but this is proving difficult. discussed that the diagnostic KPI was improving but over recent months there has been a steady decline. answered that this has largely been down to retirements and staff leaving. The Trust are working with several outside sources to get extra capacity.

Non-elective cases ED 4-hour target is still achieving 75-77% per month, and there are still 12-hour breaches but these are reducing. The NHS winter period has already begun so times will get more difficult.

discussed the Cancer 28-day FDS and this is improving month on month with 77.5% in August. confirmed that the target by the end of 2024 is 80%. The 62-day backlog was improving but has recently declined.

asked about the Trust implementing the early ambulance handover within 45 minutes. We are trying to implement but the reporting done by WMAS measures in intervals of 15, 30 and 60 minutes and change the way they send their data which makes it difficult for the trust to get consistently get accurate/reliable data. This is being worked on.

<u>52+ Harm Review Report (August 2024)</u>

took the report as read and highlighted key details:
- The trust is seeing an increase, and the completion rate is at 60%. There are some specialties now completing that weren't previously.
- Some Senior clinicians aren't happy about time spent on reviewing these cases, but it provides assurance from a trust point of view that patients haven't come to harm.
- The trust are still tryingto progress to moving the process electronically but have been having issues with Iportal. Hopefully the Trust are creating finances to purchase a new server in the near future which will help.

praised that is a good report and always easy to read through.

9.0	**Emergency Department Monthly Assurance**	

<u>ED Ambulance Handover Delay Harm Reviews</u>

provided an update of the current situation within the trust.

There were 4 delays over September and reviewed each one.
The Iportal for documentation has helped a lot. For 1 patient there were 7 moves before they left ED. 4 of 12 cases have been reviewed so far and no pressure damage has been identified. There have been 21 cases so far already in October of patients delayed up to 7 hours. Some of these patients are outside of the 7-hour window by a few minutes. Documentation has improved massively since February. has been shared the process with UHDB.

	■ was at the harm review meeting last week the scope and TOR hasn't yet been agreed. The process has been raised for discission to the executive level. Fundamental care visits are being debated and ICB would start doing these and including Burton Hospital as well as UHNM ED's. <u>12-hour trolley breach harm reviews/Mortality reviews</u> There is a section in the mortality report which covers this. SJR's have been completed on patients who waited over 12-hours in ED during February	
10.0	**UHNM Serious Incident/PSII Highlight Report**	■
	Report not received. ■ gave a verbal update: There have been 9 new PSII's, 3 of which were Never Events occurring between July and September. The report will be provided for November's meeting. Going forward it has been asked that this is changed to Quarterly, rather than monthly. This will align with the PSIRF process and Trust reporting. **New Action – ■ will add this report to November's agenda.** <u>Never Events Deep Dive Report</u> This report was around learning and thematic reviews, as well as wrong site surgeries and wrong lesion removal. Cases were presented at the risk management panel and the team developed an over-arching action plan. The Skin team are having an away day. Reporting is being taking through internal groups and ■ and a Specialist Surgery Directorate is writing the report. **New Action – ■ will add this item to November's agenda.**	
11.0	**Mortality Review Report**	■
	■ took the report as read and highlighted key details: The report has gone through the Mortality review group and internal groups. It provides a summary of key actions that were agreed at the Mortality review Group. It was confirmed that most of the mortality indices have changed through the year and had new actions put into place with learning identified. SHIMI and HSMR are still in line with expected reporting and HSMR is slightly better. The completed reviews for the 12 hour or more within the ED department have shown that the long waits did not contribute to their outcome or their death. We have also added to the report updates from the Medical Examiner team including good practice which are fed back to mortality leads. The membership of the mortality review group to include the head of medical examiner service and also mental health liaison. ■ asked regarding a Coroners REG28, the ICB had seen which was sent to Burton Hospital and UHNM. ■ advised he hadn't seen it. ■ agreed to lease outside of the meeting with ■. There have been no other coroners Reg 28 received for Q1.	

	■ praised the report and liked the learning included from the directorate. The Q2 report will see other specialties that have been the Mortality Review Group, including neonates. ■ will send the coroner report to ■	
12.0	**ICB Quality Assurance Visit Report UHNM – AMU/FEAU August 2024**	■
	■ advised the visit took place at the end of August to review processes in place for 'Your next patient' (YNP) on FEA and AMU. Minor recommendations were made and ICB are going back on October 31st to visit the medical wards to see processes in place for receiving YNP. ■ praised that staff on the wards who understoodthe processes very well.	
13.0	**Forthcoming UHNM External Reviews**	■
	There were no comments made.	
14.0	**Any Other Business**	**All**
	There were no comments made.	

Next UHNM CQRM:
Thursday 21st November 2024, 12:00-14:00
Via Microsoft Teams

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.

Meeting	UHNM CQRM
Venue	Microsoft Teams
Date/time	Thursday 16th November 2023, 12:00-14:00

Attendees:		
(Chair)	Medical Director, Staffordshire & SSoT ICB	
	Senior Clinical Quality Improvement Assurance Manager, SSoT ICB	
	Quality Improvement Support Manager, SSoT ICB	
(part meeting)	Designated Nurse for Looked After Children, SSoT ICB	
(part meeting)	Lead Nurse for Infection & Prevention, UHNM	
(part meeting)	Head of Cancer Services, UHNM (part meeting)	
	Deputy Chief Nurse, UHNM	
	Deputy Medical Director, UHNM	
	Lead Nurse, Quality & Safety, UHNM	
	Head of Quality, Safety & Compliance Department, UHNM	
	Associate Director, Performance & Information, UHNM	

In Attendance:		
(Minutes)	Business Support Officer, SSoT ICB	

Apologies:		
	Associate Director of Quality and Patient Safety, SSoT ICB	
	Associate Chief Nurse/Deputy Director (Infection Prevention & Sepsis), UHNM	

No	Item	Action Lead
1.0	**Introductions & Apologies.**	**Chair**
	introduced all to the meeting and did introductions for	
2.0	**Declarations of Interest**	**All**
	None to declare.	
3.0	**ICB Leadership Compact**	**All**
	covered the leadership compact and all adhered.	

4.0	**Minutes from the previous meeting: 21st September 2023**	**All**
	Agreed as an accurate representation of the meeting.	
5.0	**Action Log from the previous meeting: 21st September 2023**	**All**
	Action 130 – End of year CQUIN Report received and read. (Closed) Action 131 – Royal Stoke ED Compliance is on this agenda. (Closed) Action 140 – ███ is still chasing for an answer, will provide an update week of 20th November. (Open) Action 142 – SOP re-circulated. (Closed) Action 144 – VTE Deep Dive included on agenda. (Closed) Action 145 – ███ provided the Brachytherapy report to ███ Confirmation was received that the CQC are happy to close the improvement notice as they are happy with UHNM responses. (Closed) Action 146 – ███ to review collating all 52-week data into one report outside of the meeting with ███ (Open) Action 147 – 104-day report on this agenda. (Closed)	
6.0	**Monthly HCAI Report (September 2023)**	███
	The Report was spoken through by ███ with points highlighted: • MRSA Bacteraemia is 0. • CDIFF is still a concern, there were 20 in September. The trajectory is 51 YTD, the total is 104 YTD so largely above trajectory. The new CDIFF nurse is now in post. Their role is reviewing patients and education to staff. Multi-discipline meetings are now held weekly. Task and Finish group established in the west building. UTI increase is being investigated. Co-amoxiclav is being investigated as this is commonly used among UTI patients. Curb-65 score has been embedded into anti-microbial plan. UHNM are working with other trusts to share practices. A terminal clean of the west building was complete along with a back-to-basics cleaning day which was covered under the CDIFF action plan. • E-coli is not seeing a reduction, not identified a cause for increase. • Covid-19 numbers are going down. • RSV has been seen in adults and children. • There were 2 adults and 1 child in patients with flu. • 1 Ward with diarrhoea and vomiting. • The Vaccine campaign for Flu & Covid-19is still ongoing but is not in the same place as last year. Roaming vaccines have been initiated to increase the uptake. • A deep dive into COHA cases around anti-microbial prescribing is going to be launched. Patients are often getting diarrhoea within 28-days. 10 patients will be picked at random.	

	Sepsis Deep Dive Report Report was taken as read with points highlighted: • Key themes/risks are covered in the report. • A focus was made on ED's around education and spot-checking documents. • A deteriorating patient review is to be complete with staff to improve compliance. • Actions were listed in the report which will help assess the impact along with a reporting mechanism for Sepsis. It was raised by ███ that the actions will help in the short-term, but electronics/IT will be most beneficial in the long term. • Once Vital packs/eMPA (electronic prescribing & Medicines administration) have been sorted then the actions will change. It was mentioned by ███ that Vital packs are not in ED and the process of discharging and transferring in ED needs to be sorted. Solutions for ePMA will be put into place soon as the fix date is April 2024. • ED not using vital packs. UHNM are not sure whether to adopt the new guidance for SEPSIS as it has not been officially released yet. A 1 hour-timeline for anti-biotics isn't long enough to diagnose issues. The new guidance is a 3-hour window. • SSoT ICB Quality leads will be going to the UHNM Royal Stoke ED at the end of November, and this will be a good way to get a better look at the challenges and actions being taken. • An error was found in the report, Maternity is 100% compliant for Sepsis. **Action – Sepsis update will be brought back in January to this meeting.** **HCAI Quarterly CDIFF Action Plans** As discussed above.	
7.0	**Quality Assurance Report Summary (September 2023)**	███
	Quality Assurance Report Report taken as read with points highlighted: • Moderate harms and other similar statistics are going down in numbers and rates. • Falls are reducing. • Duty of Candour compliance went down but has now gone back up again since the report was published. • No Never Events reported during September. • Family & Friends score is the same for ED with actions listed. Themes have been the same for the last 12 months, responses are fed back to divisional and directorate teams. Responses from patients are being pushed with QR codes in place, text messaging and paper copies in the wards. The patient experience report has the full summary. • It was highlighted by ███ that timely observations on wards 78 & 230 both have low compliance. ███ confirmed that ward 78 has older patients and these patients do not need frequent observations as are mostly medically fit, the Trust are looking to see if there is a way to record daily observation on the electronic system. Ward 230 is a concern; it is now under new leadership who are working on these timely observations. Support is being provided by the corporate team. • It was raised by ███ that slide 39 shows an increase increasing usage of agency staffing numbers. ███ advised it is due to agency staffing numbers are high in specialised areas such as Critical Care and Theatres, but these are hard to fill posts and will be filled in time.	

	IHA (Looked After Children Backlog) • The data is provided by the Community pediatrics team. • Data was received from MPFT which included a brief oversight in terms of IHA compliance. UHNM's IHA compliance target is 85% but it is currently at 13%. Large concerns are being raised in terms of risk to SSoT ICB & UHNM. Capacity has been identified as the main issue. ████ confirmed that the lead for vulnerable people raised this concern as well, a meeting will be going into diaries with all interested parties to create an improvement plan and improve compliance. An update will be given at the next meeting. • It was also noted that there has been a large in influx of children into the area who will require assessment in the last 4 weeks. An update was given by ████ on the IHA for the LAC meeting: ████ has confirmed she is waiting for the availability of ████ (Lead for Unaccompanied Asylum-Seeking Children) and a meeting will be arranged with an update to be given at the next meeting. **Action – ████ to provide an update on IHA's at the next CQRM meeting.**	
8.0	**Monthly Performance Report Summary (September 2023)**	████
	Monthly Performance Report ████ took the report as read. • There is a single 104-week wait patient and UHNM plan to treat this next month. • In a position to eliminate of most of the 78-week waits. There was supposed to be additional money coming through, however the Trust have not received it. It needs to be discussed on what can be done with the current budget. • Additional funds were looking to be acquired for Neurology, but these have not been found. A paper went to the Executive Team to hopefully acquire this budget which will also help with the 78-week waits. • 65-week wait patients are to have their first outpatient appointment by the end of the year and most of these patients are on track to achieve this. The Neurology business cases should help with this. It is being planned that 65-week wait patients will all be seen by the financial year aside from a few outliers. • Gastroenterology patients are being sent to an external company who are taking 200 patients a week to help reduce numbers. Another external company is being out-sourced for support with Endoscopy. • A&E has been challenging the last few weeks, there has been some days on level 4 and ambulance waits have increased. • The cancer service is working towards the 28-day diagnosis standard. Nationally working towards 70% diagnosed within 62 days. The Trajectory is supplied in this paper. • Cohorts are being looked at. Mass texts are being sent to patients still needing appointments to provide re-assurance they are still on waiting lists. • Deep dives are being done into long waits. • It was confirmed that all patients are clinically prioritised, the longer waiting patients also get prioritised.	

	104-day harm review report Q1 The paper for Q1 (April-June) was sent which included data on open pathway for patients waiting over 62-days and 104-days. ███ spoke through the report and highlighted key details: • Compared to November 2022, getting back to the same position on open pathways at 104-days. 62-day waits peaked in June but are coming down again. • Closed pathways – patients being treated beyond 104-days, 82 patients received treatment for Q1. The data was also given which tumor site that they went to with reasons also given in the report. • Starting to see medical and complex reasons for not being treated, there are a few with patient choice being the reason but its minimal. • The volume of patients being treated for 104-day has decreased compared to January. • Patient choice is a big factor on the Urology Pathway. It was raised by ███ that there needs to be a dedicated paper on harm reviews as there is not much mention of it in this report. ███ confirmed this is being worked on with clinicians. The SOP that is in place describes what cancer services do but the harm review SOP is not included. Work is still being done on the SOP that will standardise harm reviews within the trust. SSoT ICB have been asking for these harm review for a long period of time and questions are being received from Executives and planned care about the current position and what the process is. ███ and ███ are supporting ███ with getting this into place, an update will be given for the paper at the next meeting. **Action: To include harm reviews for 104-day cancer patients undertaken and process to the paper in December CQRM** **52-week harm review process update** ███ reported the process for 52-week harm reviews was reviewed and it was decided it was not working as well as intended so the SOP has been reviewed. The plan is to have the data auto populated with patient demographics and the forms will be put onto the system portal. This data will be available to both Clinicians and staff. Clinicians will be automatically emailed with the data of how many patients they have that require a harm review. It will also be shown how many patients a Clinician had and how many they have completed. ███ met with the Clinical Teams and Executives this morning and they are very happy with the new processes. It was worked out that if all 52-week patients were distributed out to Clinicians they would have around 15-20 each per month. The Lead Nurse for Quality also reported that the Trust were confident that any moderate harms were captured through the current SI framework process. **Action – 52-week wait update report to be provided at Decembers meeting by ███**	
9.0	**Emergency Department Monthly Assurance**	███
	███ discussed this with the Divisional Medical Directors and Governance leads, No issues were raised.	

	12-hour breach/ambulance handover delay harm review proposal update [redacted] advised that themes around care not being given in ED and were not necessarily about the harm. The process being used is Pre Covid-19 so this needs to be updated. The new revised version is in its early stages. A proposal will be given at what sample size will be reviewed, update at next meeting. It was mentioned by [redacted] that UHNM may end up doing a sample from each specialty as it can feed into other audits and save time. It was raised by [redacted] that the Surge and Recovery plan is facing constant 12-hour delays. [redacted] advised the proposal is currently going through internal governance processes and an update will be given at Decembers meeting. **Action – update to be given by [redacted] on the proposal to change 12-hour breach harm review process.**	
10.0	**Serious Incident Report (September 2023)**	[redacted]
	Never Events for review to closure: Report taken as read. • 3 NE's closed recently. • There were 66 open Serious Incidents as of the report but there are now 50 open, therefore 16 have been closed. • PSIRF was soft launched in October. **2023-9207** This case was a wrong site surgery. The wrong lesion on the scalp was removed. A new process has been put into place and photography is used to mark the correct lesion. UHNM are compliant with this SOP. It was agreed that the Never Event could be closed.	
11.0	**Forthcoming UHNM External Reviews**	[redacted]
	A Regulation 28 notice was issued from the coroner due to tissue liability. [redacted] confirmed she has received the notice (prevention of future death) and is pulling together a response. Some evidence was misconstrued, and this is being highlighted by [redacted] The case is a patient presented to [redacted] with a [redacted] following being transferred to the [redacted] and later had returned to [redacted]. The coroner had stated there was a delaying the review by the Tissue Viability Nurse on arrival back to UHNM. The current Quality report showed there were 27 significant pressure ulcers recorded, [redacted] asked if there has been an increase? It was confirmed by [redacted] that there has been an increase in numbers and hopefully PSRIF will help with these in the timely action reviews. Other trusts processes are being reviewed. These numbers do go up every winter, but it is higher than average this year. However, the Grade 3 and 4' pressure ulcers and DTI's are going down whilst grade 2's are going up. UHNM are focusing on ulcer management and prevention whilst following best practice.	

	Action – [redacted] to share the coroner response letter when completed – January.	
12.0	**Any Other Business**	[redacted]
	TOR The Terms of Reference were discussed as they always are on an annual basis. • Attendance from all parties is correct. • Meeting dates to be amended. • CQRM's will continue. • [redacted] is on the same line as the Medical Director/Deputy Medical Director, to be amended. Business Cycle • [redacted] and [redacted] to review and check it is complete. [redacted] mentioned the bed blitz that is currently ongoing. There is a focus on beds and what is being done with them and how they are cleaned. This has been a large piece of work and a shown a better perspective. The methodology for this can be used in other places. SSoT ICB staff to ask colleagues internally if anything similar has been done before and share any information identified to [redacted]	

Next UHNM CQRM:
Thursday 21st December 2023, 12:00-14:00
Via Microsoft Teams

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.

Meeting	UHNM CQRM
Venue	Microsoft Teams
Date/time	Thursday 21st November 2024, 12:00-14:00

Attendees:		
(Chair)	Strategic Improvement Lead for Quality & Patient Safety, SSoT ICB	
	Senior Clinical Quality Improvement Assurance Manager, SSoT ICB	
(Part meeting)	Cancer Manager, UHNM	
	Local Maternity and Neonatal Quality and Safety Midwife, SSoT ICB	
	Interim Deputy Chief Nurse Operations, UHNM	
	Head of Quality, Safety & Compliance Department, UHNM	
	Lead Nurse, Quality & Safety, UHNM	
(Part meeting)	Cancer Senior Data Analyst, UHNM	
(Part Meeting)	Associate Chief Nurse/Deputy Director (Infection Prevention & Sepsis), UHNM	
	Associate Director, Performance & Information, UHNM	

In Attendance:		
(Minutes)	Business Support Officer, SSoT ICB	

Apologies:		
	Strategic Clinical Director, SSoT ICB	
	Associate Director of Quality and Patient Safety, SSoT ICB	
	Assistant Director for Nursing, NHSE	
	Head of Cancer Services, UHNM	
	Deputy Medical Director, UHNM	

No	Item	Action Lead
1.0	**Introductions & Apologies.**	**Chair**
	■ introduced all to the meeting and announced apologies as noted above: ■ (SSoT ICB) ■ (SSoT ICB) ■ (UHNM) ■ (UHNM) ■ (NHSE)	
2.0	**Declarations of Interest**	**All**
	None to declare.	
3.0	**ICB Leadership Compact**	**All**
	■ covered the leadership compact and all adhered.	
4.0	**Minutes from the previous meeting: 17th October 2024**	**All**
	Agreed as an accurate representation of the meeting.	
5.0	**Action Log from the previous meeting: 17th October 2024**	**All**
	Action 180 – Pressure Ulcer Deep Dive – This will be provided when ready. (Closed) Action 182 – Staffing Establishment Report – This report is every 6 months, and Staffing Quality is every 3 months. This was asked for last time for assurance for business cases and is currently going through internal governance processes. When it is ready it will be brought to this meeting. The Quality and Staffing Report now includes the CEF report additionally this can be provided at the next CQRM as well. (Open) Action 183 – Speciality Areas – This item is on the agenda for discussion. ■ highlighted that it states how many areas but not which ones. (Open) Action 186 – MHRA Pharmacy Visit – ■ has not seen a report yet, will follow up with the Pharmacy Team. (Open) Action 188 – Q1 PSII Report – This item is on the agenda for discussion. (Closed) Action 189 – Never Events Deep Dive Report – This item is on the agenda for discussion. (Closed)	
6.0	**Monthly HCAI Report (September 2024)**	■
	The report was taken as read and ■ discussed details of the report: • MRSA Bacteraemia is at 0. • CIFF cases are 78, of the 90 YTD limit. • There has been a lot of Norovirus cases from the Community and several wards have started restrictions already. • Covid-19 cases have reduced, with Flu and RSV taking over. There are 12 Flu patients and 27 RSV patients. • Monkeypox training is ongoing.	

	• Sepsis Inpatient areas achieved KPI, ED has improved on screening from 77% to 80%. ED focussing on anti-microbial prescribing. • Vaccines to date 3700 administered for flu and 2700 for Covid-19.. 13 patients have been given the opportunistic Vaccines when attending outpatients. The trust are reporting lower uptake each year but this is in line with other trusts, with Flu uptake being the most popular. There is a UHNM colleague roaming and offering vaccines and targeting the under-65 risk groups. asked about Maternity sepsis antibiotic administration compliance as only 33% in the Quality Report. will pick this up with /Colleagues and it will be added into the HCAI report and it will be included in November's paper. confirmed that there has been no concern raised at internal ICB meetings. **New Action – will speak to colleagues around the low compliance for antibiotic administration following sepsis screening compliance in Maternity.** <u>HCAI Quarterly CDIFF Action Plans</u> raised that IPCC is from September. raised that nurse cleaning responsibilities have been ongoing for a while. confirmed that the posters have gone out, reminding staff of who is responsible for what. The Estates Team is leading on this and are re-enforcing this. This will apply to CDU when it opens.	
7.0	**Quality Assurance Report (September 2024)**	
	took the report as read and discussed details of the report. The trends and themes for the month of September are fairly consistent with no red flags to raise, there is an overview from the Chief Nurse and Medical Officer at the start of the report. There are a number of indicators that UHNM are going off track but there have been improvements with medications with patient Harm, E-Coli and ED Sepsis. The trust are trying to improve timely observations in all areas where possible. There was 1 Never Event reported due to wrong site surgery. There has been inconsistencies around NE's. There was a CQC inspection in July and the CQC have now confirmed the S29a notice was removed. The trust has received the draft CQC report for factual accuracy checking and some areas have moved from "Requires improvement" to "good". Mixed sex breaches are now included in the quality report although there are only 4-months of data points and will change as SPC rules carry on. raised that there are issues with timely observations that all take place within the west building. confirmed that the issues were to do with Wi-Fi although this was not stated in the report. <u>CQC Action Plan</u> took the report as read and discussed key details: The executive summary includes assurance seeking for older actions, one of which being infection prevention measures being a focus. is providing spot checks for ED.	

	███ discussed that aim of the action plan is to shut down older actions and monitor them through business as usual processes. Action A5 discusses the processes behind ED. The Head of Nursing is working to ensure all risks are on the risk register and the Speech and Language therapy service at the County Hospital is waiting for new staff to start. There were some Should Do actions noted: timely response of formal complaints are to be included in the executive performance reviews for the divisions. The trust is hoping to close the action plan and work from their self-assessment/CQC standards. ███ praised that the report is very good and it is very clear on what the trust are focusing on, and the actions taking place. ███ will provide an update on maternity actions outside of the meeting. Staffing & Quality Report This report has been deferred to January's meeting. (Decembers was cancelled). Staffing & Establishment updated Report This report has been deferred to January's meeting. (Decembers was cancelled).	
8.0	**Monthly Performance Report (September 2024)**	███
	███ took the report as read and discussed key details: • 4-hour performance sits just below 70% for the first time in 7-months. It is currently on track to be over 70% this month. • There has been a slight increase in 12-hour ED waits. • Ambulance hold waits for Cat 2 have gone from average for the year of 43 minutes to 27 minutes. • Diagnostics is sitting at around 55% and non-obstetric ultrasounds is one of the bigger issues with longer wait times due to staffing and capacity. The external company being used was not hitting targets, so a new provider has been found and it is on track to clear the backlog by April 2025. • There were 3 x104-week breaches, all of which have been treated. • 78-week waits is down to about 12 cases. • 65-week waits are down to around 100, and the national ask is to be at zero by the end of the financial year, UHNM have advised NHSE that they won't br able to achieve this. • The regional/national ask is to clear 52-week waits by the end of March 2025. The trust had cleared 500 cases last month. One of the biggest issues is around finance. ███ asked what are the trust doing about diagnostics? A company called HASAN is being worked with to clear these. The main issues are around staffing levels and issues with recruiting, hence going external for support. This is the 4th company to try and clear the backlog of non-obstetric ultrasounds. The wait times for Pathology are also due to staffing. There were significant waits a while back, there have been some improvement but still delays.	

	52WW Harm review Report █ confirmed that all specialties have submitted a harm review this month. An electronic template has been developed, however the trust is currently having issues with I-Portal, until this is resolved the trust will be continuing with paper-based system. No significant harm has been reported. 104-day Cancer Harm Review Report █ took the report as read and discussed key details. The report covers Q1 of this year, with the Q2 report being finalised. RCA's are circulated to clinical leads to be presented in MDT's, and to comment whether clinical harm has come to patients. In Q1 there were 78 patients treated over 104-days. The usual issue is capacity, especially in Surgical areas. There are always lots of complex patients who require extra diagnostics and support to get them ready for treatment. The main factor is down to capacity of the hospital. Urology is the main contributor, we see this month on month, along with late referrals from other units although these patients are always treated later. The majority of treated patients underwent surgery, followed by systemic chemotherapy. This data is presented at the Cancer Services Strategy Group to review the RCA's. Colorectal and head/neck services are the are not carrying out the reviews, so these are being escalated. There was no harm identified in Q1, but only 28 of 78 have currently been reviewed. █ asked how these cases are escalated. █ assured that they are passed onto the Chief Nurse and Medical Officer. █ asked if these cases are still asked for by NHSE, █ answered that they don't ask for directly as they are no longer a requirement. An RCA is produced for events patients. ICB and UHNM will ask colleagues if NHSE have asked for these at any point. █ raised that it is a big undertaking and would help for NHSE to see this data and its improvements. █ mentioned that patients treated at the trust often tend to follow the same themes, so there is a reluctance, and that a thematic review may be useful. These numbers are submitted nationally so NHSE are aware, and they are discussed every fortnight. **New Action – █ will find out if ICB colleagues are asked for 104 days + patient cancer harm reviews from NHSE. █ will investigate the UHNM side.**	█
9.0	**Emergency Department Monthly Assurance**	█
	ED Ambulance Handover Delay Harm Reviews The ICB and Trust had a meeting this morning to discuss how many harm reviews and at what time frame of the delays to be completed. A target of 6-hour handover delay is not achievable due to the volume so it was agreed to stay at 7-hours. There were 92 7-hour breaches in September, with 54 already in November. There are 74 cases to review from October. If a patient has gone home with no obvious harm, it is put down to delays within the service. It is best to put something rather than nothing. █ wants the report to go the Chief Executive Board, and ED harm reviews will go through QSOG and QGC every month at UHNM.	

	raised that SSoT ICB will be doing a fundamentals of care and patient experience visit from January. will agree the process with colleagues and may be able to provide an update at the next meeting (January 2025). 12-hour Trolley Breach Harm Reviews/Mortality Reviews As discussed above.	
10.0	**UHNM Serious Incident/PSII Highlight Report**	
	took the report as read and discussed key details: From Q2 has changed the report slightly to include more information to enhance the internal discussions. There were 9 incidents reported in November which met the criteria for reporting on the STEIS system. They were all reviewed via internal processes. were referred to Maternity Newborn Safety Investigations and will be completed by them externally with UHNM's input. were following review and completion of neo-natal mortality review tool following still births neonatal loss. were wrong site surgery events. Within the report during the same quarter 34 cases have been reviewed at risk management panel of which 10 were signed off. There are still 7 incidents open on STIES under the old serious incident framework with work ongoing to close. Within the report, a historical chart was included to compare SI's changing to PSIRF. The report gives a summary. The paper went to the Quality Governance Committee. Section 2 includes the main aims of PSIRF and proportional responses. Page 15 shows the breakdown of different PSRIF responses from UHNM through-out the year. After action reviews are the main response from UHNM. Page 17 onwards gives a summary of cases that have gone to the risk management panel and the breakdown of cases. This time assurance is added onto actions, with learning and recommendations included in the report. The executive summary includes the assurance assessment that every report follows. The trust has seen a reduction in the number of open incidents. asked about the PSRIF response kit. assured that every single fall is still being reviewed and assessed. Never Events Deep Dive Report raised that this report has been taken through the Quality Governance Committee and Patient Safety Group. There were a number of wrong site surgeries and wrong lesions removed. The report details how these NE's are looked at thematically and the issues of those cases investigated. 10 cases across Plastics and Dermatology were observed, the cases ranged across the County Hospital and Royal Stoke, from January 2021 onwards through to October this year. There have been 370 Never Events across the country, of which 48% were wrong site surgery in the last 12-months. UHNM have 10 cases from 2021 until now which in perspective isn't very much. An Overarching action plan has been created for the dermatology Never Events, of which 14 actions were identified. receives regular updates in relation to the service and implementation of actionsas it goes through internal meetings regularly. The progress is also shared with the Quality Governance Committee.	

	It was confirmed that these NE's likely would not have happened if the current actions and measures were in place. The Trust had checked the action to see if would have prevented each Never event occurring. Lots of the actions within the report are big system changes and will take a long time. ███ assured that these measures are working as it has already prevented 2 potential NE's from happening. The trust are using LocSSIP's checklists. ███ will provide an update with the Quarterly Report. ███ asked if all 14 actions are time scaled? ███ confirmed they are.	
11.0	**Regulation 28 – Report to prevent future deaths**	███
	███ had been unaware of the Regulation 28 as had been on sick leave however the Trust are completing the response, and the deadline is early December. It can then be shared at CQRM.	
13.0	**Forthcoming UHNM External Reviews**	**All**
	The MHRA report was received, UHNM are pulling together a response/action plan. ███ will share this once ready.	
14.0	**Any Other Business**	**All**
	It was agreed by the chair and all members that December's meeting is stood down due to Quoracy. This is the last meeting that ███ will be attending as they are leaving the trust. A huge thank you was given to ███ for all of the support that they have given to this meeting and to UHNM and wished them all the best.	

Next UHNM CQRM:
Thursday 16th January 2025, 12:00-14:00
Via Microsoft Teams

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.

Meeting	UHNM CQRM
Venue	Microsoft Teams
Date/time	Thursday 21st December 2023, 12:00-14:00

Attendees:		
(Chair)	Associate Director of Quality and Patient Safety, SSoT ICB	
	Senior Clinical Quality Improvement Assurance Manager, SSoT ICB	
	Deputy Chief Nurse, UHNM	
(Part Meeting)	Associate Chief Nurse/Deputy Director (Infection Prevention & Sepsis), UHNM	
	Deputy Medical Director, UHNM	
	Lead Nurse, Quality & Safety, UHNM	
	Associate Director, Performance & Information, UHNM	

In Attendance:		
(Minutes)	Business Support Officer, SSoT ICB	

Apologies:		
	Medical Director, SSoT ICB	
	Head of Quality, Safety & Compliance Department, UHNM	

No	Item	Action Lead
1.0	**Introductions & Apologies.**	**Chair**
	introduced all to the meeting & announced apologies.	
2.0	**Declarations of Interest**	**All**
	None to declare.	
3.0	**ICB Leadership Compact**	**All**
	covered the leadership compact and all adhered.	
4.0	**Minutes from the previous meeting: 16th November 2023**	**All**
	Agreed as an accurate representation of the meeting.	

5.0	**Action Log from the previous meeting: 16th November 2023**	**All**
	Action 140 – MPR – [redacted] is still chasing for an update, and this has been escalated higher. (Open) Action 146 – RTT 52-week date – Superseded by action 150 to collate harm reviews into one report. (Closed) Action 148 – Sepsis will be discussed in January. (Open) Action 149 – IHA's – UHNM colleagues are meeting with SSoT ICB and Stoke-on-Trent Council staff to address concerns Carry over to January meeting. (Open) Action 150 – 52-week harm review report – on the agenda -Paper not received. (Open) Action 151 – 12-hour breaches – on the agenda. (Closed) Action 152 – A response was sent by UHNM following the coroner Regulation 28. It claimed issues with the tissue viability team not seeing patients within 6 hours of admission which is incorrect, patients would have a pressure ulcer risk assessment within 6 hours carried out by a registered nurse. There were also other points that were corrected. [redacted] will share the signed response. (Closed) Action 153 – was on the agenda but the report was not provided. To be brought to January's meeting. (Open)	
6.0	**Monthly HCAI Report (October 2023)**	[redacted]
	[redacted] covered highlights from the report: • There were no MRSAb reported in October. CDIFF is at 115 YTD at the end of October. There may be progression of numbers reducing going into December. Lots of work is being done around anti-microbial prescribing at the front door and wards. E-coli has been increasing, so re-introducing data collection so themes can be found. Work restarting on Hydration etc. There have been possible links to patients waiting for abdominal surgery. • There has been an outbreak of CPE, there are 17 cases with no harm. There has not been a new case for 22 days. Control measures are in place and wards are going to be bombed with hydrogen peroxide. • Staff vaccinations are being done up to the end of January, Flu up take has improved but still 3% below last year. • [redacted] asked if the meetings for C-diff avoidability were being held for RCA's as report is only up to July [redacted] advised RCA's were completed and a meeting had been held during November. [redacted] reported the Sepsis visit by [redacted] and [redacted] (SSoT ICB) was very positive with ED seeing improvements.	

7.0	**Quality Assurance Report Summary (October 2023)**	
	Quality Assurance Report was not present, so the report was presented by Highlights: • Pressure Ulcers were discussed as shown in the report, pressure ulcers are being closely monitored. • VTE deep dive will be taken to the quality governance committee then brought back to this meeting. • Watching incidents regarding 'Your Next Patient'. • Friends and Family feedback is lower than expected so feedback is being pushed by staff. QR codes are promoted to be used. • Timely observations are a focus. • New guidance will be released regarding DTIs is expected early 2024, which will allow new forms of reporting to be created. • Category 2 pressure ulcers have increased and DTI's again. These themes/trends are being raised with senior staff. • It was raised by that the never event on page 17 is more of a serious incident than a never event. This was discussed and agreed to be debatable. • asked if an update good be given at the next meeting about the Medication incidents causing moderate harm in October. **Action – It was asked by that Medicine incidents with moderate harm have and update provided at the next meeting.** **CQC Update/CQC Action Plan** provided an overview: This action plan went to the UHNM Trust board, a lot of work has been done on the action plan to get it to this point, as there were actions going back to 2021. Actions which had a clearly defined monitoring process, which is Business as Usual through existing governance, have been archived. The Executive summary includes the associated risks and the Business-as-usual items. There remain 2 main areas of concern, still speech and language therapy at the County Hospital. Immediate actions to redeploy resources are in place. The S29a notice on risk management of patients with Mental Health needs, this was discussed at the quality governance committee and UHNM are confident that improvement have been made. Ward sisters/Matrons are doing out of hours visits with staff. The Maternity action plan regarding the S29a notice is being worked on consistently. There are 6 must do actions, 2 ideally to be done actions and 1 complete. 2 are on track with 5 being problematic. asked if the CQC had responded to the S29a at County Hospital following the last evidence submission. It was confirmed by that nothing had been received back however the Trust thinks a visit is going to take place in early January. Paper documentation has been taken out and it has now all gone electronic. **Action – it was asked by that raise SALT resources at County Hospital as community provisions is also an issue and being looked at with** **Initial Health Assessment Recovery Plan** As discussed above. Action 149	

	Patient Experience Report Q2 █ provided a summary of the 2022 inpatient survey results: UHNM scored about the same as the national average in all but 1 question, however had a decrease in scoring compared to the previous year for 3 questions identified as those being most important to patients, one being communication. Feedback will be given to the Divisions. • The report was praised by █ for being clear and concise. The comments on the spiritual team were nice to see. It was raised by █ that on page 62, the FEAU patient satisfaction was at 62% which is considered low, it was mentioned by █ that the area has a fast throughput of patients who are complex, so the feedback is usually difficult for staff to obtain therefore responses are often low. █ raised it was positive that patient safety partners are attending the Care Excellent Framework.	
8.0	**Monthly Performance Report Summary (October 2023)**	█
	Monthly Performance Report A brief overview was given by █: • There is █ patient at a 104-week wait who is waiting for a █ which is coming from █. • 78 & 65-week waits were coming down, but some additional funding has now been lost in recent weeks alongside some additional endoscopy funding. It will be difficult to continue the progress as before. █ asked if patients on the waiting list were still being validated clinically. █ raised that text messages have been sent to 40k patients and around 4k have felt that the hospital experience has changed. The next mass text is at the end of January. Clinical validation is also being carried out. **104-day harm review report Q2** █ did not attend, and no report was provided. **52-week harm review process update report** █ reported UHNM are in the currently streamlining the process to make it easier for clinicians to complete harm reviews, working with the information technology team on this. It has been agreed to go back to also sending out paper copies so it can be better tracked of how many copies are sent and how many are returned. It would be useful to be able to pick out consultants rather than just the administration teams.	
9.0	**Emergency Department Monthly Assurance**	█
	As discussed below.	

	12-hour breach/ambulance handover delay harm review proposal update █ and █ are working with UHNM colleagues on creating proformas for clinical teams to complete harm reviews. █ advised that the process up to march this year, that there was no new learning from the reviews undertaken and it was just focusing on fundamentals. A new pilot proforma based on the 52ww harm review proforma is going to be completed on █ patients during January, a selection of different patients will be picked for variety. █ advised that although there have been no serious incidents reported relating to long waits in ED and mindful of the implementation of PSIRF due to the time delay of no harm reviews being undertaken she would be providing an update to the Urgent care board.	
10.0	**Serious Incident Report (October 2023)**	█
	Report was taken as read. There were 8 incidents in October with a potential NE. Formally closed 8 SI's. Protected characteristics now included.	
11.0	**Regulation 28 – Report to prevent future deaths**	█
	█ explained a response had been sent back to the coroner to reflect that the NICE guidance stated that a patient should be assessed by a registered Nurse within 6 hours of admission and not a TV nurse specialist. The signed response letter to be shared with ICB.	
12.0	**Forthcoming UHNM External Reviews**	█
	A CQC visit is expected early January.	
13.0	**Any Other Business**	All/█
	█ raised that the Trust were creating a dashboard relating staffing issues, and asked if the ICB were aware of anywhere else who had created one. █ will reach and pass across information/contacts. It is being discussed as to whether CQRM's will continue taking place, but █ thinks these meetings are very useful. TOR For info, amended after the last discussion. Business Cycle None.	

Next UHNM CQRM:
Thursday 18th January 2024, 12:00-14:00
Via Microsoft Teams

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.

Meeting	UHNM CQRM
Venue	Microsoft Teams
Date/time	Thursday 18th January 2024, 12:00-14:00

Attendees:		
███ (Chair)	Strategic Clinical Director, SSoT ICB	███
███	Senior Clinical Quality Improvement Assurance Manager, SSoT ICB	███
███	Quality & Improvement, SSoT ICB	███
███	Matron for Quality & Safety, UHNM	███
███	CNIO Associate Deputy Chief, UHNM	███
███ (Part Meeting)	Associate Chief Nurse/Deputy Director (Infection Prevention & Sepsis), UHNM	███
███	Deputy Medical Director, UHNM	███
███	Head of Quality, Safety & Compliance Department, UHNM	███
███	Associate Director, Performance & Information, UHNM	███

In Attendance:		
███ (Minutes)	Business Support Officer, SSoT ICB	███

Apologies:		
███ (Chair)	Associate Director of Quality and Patient Safety, SSoT ICB	███
███	Lead Nurse, Quality & Safety, UHNM	███

No	Item	Action Lead
1.0	**Introductions & Apologies.**	**Chair**
	███ introduced all to the meeting & announced apologies.	
2.0	**Declarations of Interest**	**All**
	None to declare.	
3.0	**ICB Leadership Compact**	**All**
	███ covered the leadership compact and all adhered.	
4.0	**Minutes from the previous meeting: 21st December 2023**	**All**
	Agreed as an accurate representation of the meeting.	

5.0	Action Log from the previous meeting: 21st December 2023	All
	Action 140 – is chasing for an update and has escalated for support. An update will be given in February and is going to email the request as well as a support. (Open) Action 148 – A sepsis update was brought to this meeting. (Closed) Action 149 – has received an email update from the Divisional Manager has reported a locum Dr is being recruited to for 3 months to help with the backlog, but additional funding would be required. It was raised by that the current rate is 30 children a month are being looked at, but the capacity needs to be at around 45. All trusts/ local authority is needed around the table. (Open) Action 150 – no report was provided but a verbal update was given. (Open) Action 152 – one letter and response was received. The case for has not quite yet been sorted with the response still being reviewed but will be sent to SSoT ICB once ready. (Open) Action 153 – the 104-day harm review report is still being put together. Reports have been submitted before, but the harm review aspect was not included in the report. Meetings are being held by the Trust regarding the harm review process and intentions will be shared with SSoT ICB. (Open) Action 154 – has amended the report and provided an overview of Medicine. (Closed) Action 155 – SALT Provision – was thought to be doing this, but they are not the deep dive was dietetics. (Closed)	
6.0	Monthly HCAI Report (November 2023)	
	Emyr covered highlights within the report: • No MRSA Bacteraemia but there has been one reported in January. • The Trust remains above target for CDIFF, there has been lots going on with task and finish group. • There are HAI that have been identified in November. • There are 7 COHA cases that have been identified in November. • There has been a trust wide cleanliness focus. • Lots of work done on anti-microbial prescribing. • UTI's have been treated with Co-amoxiclav is being looked into as there is over prescribing without urine samples sent. It was confirmed that the Sepsis metrics are on target except Royal Stoke ED. Data collection has been started for E-Coli with checks for hydration and there is a dedicated nurse now in post. To identify any themes contributing to the increase. There was an outbreak of CPE (carbapenemase-producing Enterobacterales) on the Renal ward, but the ward has now been bombed with hydrogen peroxide. No further cases have been reported since the end of November.	

	UHNM are liaising with Birmingham Hospital on how they handled their Measles outbreak. A clinical advisory group is meeting on Tuesday to discuss this further.	
6.1	**ICB Quality Visit Report – Royal Stoke ED Focused Visit Sepsis** and carried out a quality visit to the Royal Stoke ED due to Sepsis screening compliance consistently underperforming. Highlights from the visit included: • Lots of time was spent talking to staff about initiatives that are being taken and wards were walked through. Patient flow through the department was inadequate which was creating a bottleneck in ED. • There are challenges with clinicians completing documentation when it gets busy in ED. • Manual audits are often time consuming therefore the sample size was not high enough. • New NICE guidance is out at the end of January, guidance for 1,3 & 6-hour time limits are a maximum (rather than an aim) for each risk level, including 'Probable and possible' sepsis. • It was raised by that s team have worked well with the ED team to sort out the issues in ED, The Trust are currently waiting for updated NICE guidance. The company running VITALS will not be able to update the vitals system to include the sepsis until 18 months-time which is too late. UHNM are looking at an alternative may have to be found. It was raised by that the digital screening for Sepsis in ED was last recorded at 100% at County site. Going digital has helped a lot and is a huge achievement. She needs to check the audit results to ensure she has interpreted correctly. There is a focus on sepsis training in Maternity. It was requested by that an update is given once the updated NICE guidance has been released and progress on the Sepsis screening pathways.	
6.2	**Sepsis** As discussed above.	
7.0	**Quality Assurance Report Summary (November 2023)**	
7.1	**Quality Assurance Report** The report was covered by with highlights discussed: • The assurance grid was included and includes detail of when patients PASS, HIT or FAIL. • There has been a positive trend with several indicators. Numbers are much better for moderate harm incidents which will be reflected in next month's report, and falls have slightly increased. • There were 11 Serious Incident's recorded and no Never Events, Duty of Candour is nearing 100% with only cases outside of the 10-day time frame for a follow up letter. • Timely observations have improved in December.	

	• Hospital acquired pressure Ulcers have increased however lapses in care has reduced. • Friends & Family Test for A&E remains below the 85% target of patients recommending the service. The November figure has continued to decrease below the mean rate but there has been an increase in the raw number of responses received but with increased activity the rate has dipped to 8%. UHNM is 33rd out of 124 Trusts nationally for response rate, which is improvement from previously reported 37th. • 31 cases of Hospital Associated Thrombosis (HAT) were identified November 2023 and investigations are in progress. A review was previously completed, following the increase in HATs from December 2022-February 2023, and discussed at the Trusts QSOG. This is to be represented following additional information relating to ED length of stay and its potential impact on immobilisation being included. The report can be brought to this meeting following QSOG. **Action – VTE deep dive report will be brought to Februarys meeting.**	
7.2	**Initial Health Assessment Recovery Plan** ███ met with the ICB looked after children's named nurse and ███ SSoT ICB) prior to the meeting it was agreed that the ICB would escalate internally and have a system meeting with UHNM, MPFT, LA, ICB to discuss a way forward.	
8.0	**Monthly Performance Report Summary (November 2023)**	███
8.1	**Monthly Performance Report** The report was presented by ███, highlights were discussed: • Targets are not being hit but some improvements are being made, ED 12-hour + waits are going down slightly. 4-hour performance is at 65% which is an improvement on last month. • Major work is being done around Endoscopy and wait times/how things are booked and the number of patients going through. UHNM are working with an external company on this with extra weekend clinics. • The 78-week position was discussed with around 100 patients still in waiting., but this number is predicted to come down next month as well as industrial actions having an impacts and more industrial action potentially to take place. • 65-week waits have seen the biggest impact from industrial action with the chance of more industrial action becoming a concern. • Cancer targets are stable currently. There is a process in place for harm review for 52ww+ patients on completion of pathway, which was changed to electronic, but it seemed to be long winded: therefore, reverting back to paper based. Proformas were sent back to divisions with samples being asked of 30 and above. There will be a report coming next month on the outcome and number of harms proformas. The report will show the reviews given in January for elective and non-elective patients. • 30k patients on the waiting list were sent text messages being asked for feedback if their condition has changed and do they want to remain on the waiting list.	

8.2 8.3	**52-week+ Harm Review Report** The report was not provided. But will be written for Feb meeting. **104-day Harm Review Report Q2** The report was not provided.	
9.0	**Emergency Department Monthly Assurance**	■
9.1	**12-hour breach/ambulance handover delay harm review proposal update** ■ raised concerns regarding the ambulance handover delay harm review proformas that ■ has distributed to address concerns raised by NHSE around the increase in ambulance handover delays and the need for harm reviews. ■ advised that the questions within the proforma were similar questions to UHNMs previous process whereby not much learning was identified. ■ asked ■ to respond to ■ email around her concerns and would let ■ know as well.	
10.0	**Serious Incident Report (November 2023)**	■
	■ covered highlights within the reports: • There were 11 incidents, 9 of which were falls, ■ in diagnostics and ■ in maternity. • Rate of SI's has been consistent with no significant trends. 18 RCA's have been closed with 58 still open. • The SI framework will not be followed from November as the trust has commenced PSIRF implementation from 1st December 2023 A monthly report will still be completed but they technically will not be SI's and will be under PSRIF. The report will reflect the new PSIRF process. ■ advised that as the Trust migrates to PSRIF, all the current SI's will slowly be closed. These SI's will be reviewed, and learning will be shared as examples. The trust will be going live on 1st February reporting to LFPSE alongside PSIRF. This will allow for ■ etc. to be able to have read only access to patient safety incidents reported by UHNM on to LFPSE. Reports will still be provided with trends, themes and learning identified. ■ raised that the less than usual amount of SI's have been sent through for closure since the Christmas s break and ■ is going to check this.	
11.0	**Mortality Report Q2**	■
	■ covered highlights from the report: The mortality indicators are all within expected ranges, SHMI remains in line with expected range for national reporting and has shown slight improvements in recent months. HSMR remains slightly better than expected. It is being investigated how the sharing of learning/learning from SJR's can be improved across the system. The completion rate of SJR's seems to be lower than previous years. SJR's are monitored by specialty internally so it's known what specialties should be targeted. This report being quarterly gives a better reflection of actions/changes and the impacts made.	

11.1 11.2	**<u>Coroners Reg 28 – ███</u>** The Trust have now completed the coroner response letter and is waiting for internal sign off. **Action – To share Coroners Reg 28 – ███ response letter at February's CQRM.** **<u>███████████ trust response</u>** The response letter back to the coroner was shared, the letter advised the coroner; As a point of clarification on the issues that you have raised in Point 1 of your letter, regarding the fact that 'it was crucial that patients who were at risk of developing pressure ulcers, had ulcers already, or had developed them whilst in hospital, saw the Tissue Viability Team as soon as possible, and usually within 6 hours'. The NICE Pressure Ulcer Quality Standard (QS89) dated 2015: Pressure Ulcer Risk Assessment in Hospitals and Care Homes with Nursing, states that people admitted to a hospital or care home (with nursing) have a pressure ulcer risk assessment within 6 hours of admission. This is an important point of clarity, which differs from your statement that patients should be seen by the Specialist Tissue Viability Team within 6 hours of admission. Other actions taken by the Trust can be seen in the letter enclosure.	
12.0	**Forthcoming UHNM External Reviews**	██
	There are no external reviews aside from the anticipated CQC review around Mental Capacity at County hospital and Maternity. ██ asked ██ is he had received the email about ICB quality visits ██ ███ said they were in the process internally of looking at which areas would be of benefit to visit.	
13.0	**Any Other Business**	**All**
	No AOB to raise.	

<u>Next UHNM CQRM:</u>
Thursday 15th February 2024, 12:00-14:00
Via Microsoft Teams

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.

Meeting	UHNM CQRM
Venue	Microsoft Teams
Date/time	Thursday 15th February 2024, 12:00-14:00

Attendees:		
(Chair)	Strategic Clinical Director, SSoT ICB	
	Senior Clinical Quality Improvement Assurance Manager, SSoT ICB	
	CNIO Associate Deputy Chief, UHNM	
	Associate Chief Nurse/Deputy Director (Infection Prevention & Sepsis), UHNM (Part meeting)	
	Head of Quality, Safety & Compliance Department, UHNM	
	Lead Nurse, Quality & Safety, UHNM	
	Associate Director, Performance & Information, UHNM	

In Attendance:		
(Minutes)	Business Support Officer, SSoT ICB	

Apologies:		
	Associate Director of Quality and Patient Safety, SSoT ICB	
	Quality & Improvement, SSoT ICB	
	Matron for Quality & Safety, UHNM	
	Deputy Medical Director, UHNM	

No	Item	Action Lead
1.0	**Introductions & Apologies.**	**Chair**
	As noted above.	
2.0	**Declarations of Interest**	**All**
	None to declare.	
3.0	**ICB Leadership Compact**	**All**
	covered the leadership compact and all adhered.	
4.0	**Minutes from the previous meeting: 18th January 2024**	**All**
	Agreed as an accurate representation of the meeting.	

	███ job title is be updated and there is a small typo to be rectified.	
5.0	**Action Log from the previous meeting: 18th January 2024**	**All**
	Action 140: To be closed and picked up via the agenda. (Closed) Action 149: ██ informed that there is an MDT meeting arranged for Childrens and Young People on 28th Feb to discuss. (Open) Action 150: To be closed and picked up via the agenda. (Closed) Action 153: To be picked up via the agenda. ███ advised that an update still hasn't been received from April and he will escalate this to her line manager. (Open) Action 156: This has been delayed due to recent declared critical incidents, once this has been updated and presented internally it will be shared with SSOT ICB. (Open) **New Action - To add VTE Deep Dive Report as an agenda Item for March.** Action 157: Included in the papers. (Closed)	██
6.0	**Monthly HCAI Report (December 2023)**	██
	███ covered highlights within the report: • No MRSA Bacteraemia was report in December. █ cases have been reported for January but are unrelated and investigations are ongoing. • Suspected Measles cases have reduced. • There was a CPE outbreak on the Renal Ward but have been no further cases and the outbreak will be closed at 3 months from the date of the last positive case. • Sepsis – 72% in Royal Stoke in screening and 35% on antimicrobials within the hour. • C.Diff is 141 cases against 76. ███ advised the new Sepsis guidelines have been published, he has met with the Sepsis team last week and it is not straight forward to implement the new Sepsis guidelines. ███ and █████ are preparing the paper that will go to QSOG on how to implement the new guidelines. The 3 current options are: 1. Stick with the current process until vitals can catch up with the new guidelines. 2. Go back to paper screening. 3. ED are keen to implement new guidelines and do a trial there however, there will be incompatibility if the patient is admitted. ███ advised that a case was received regarding a patient with ███████████ and the consultant identified that they missed ███████████ and had missed the window for it which potentially gave the poor outcome. ███ advised that they are involved in the investigation, but a Sepsis screening had been done. On the back of this ███ has asked the Sepsis team to develop a live dashboard for an awareness of any serious incidents or situations of potential harm. ███ advised that SSOT ICB would be interested to see how the plans develop and how the ICB can support as a system.	

	███ and ███ to pick up outside of the meeting. **New Action – ███ and ███ to discuss the plans for the new Sepsis Dashboard** ███ added that the necrotising fasciitis had been recorded on STEIS as a PSII and a review is being undertaken. The review will go through the risk management panel and learning, and outcomes will be shared with SSOT ICB. ███ advised that C-.Diff themes are not picked up until 2-3 months later and proposes that RCAs are suspended for the moment and replaced with a live dashboard so that themes can be tackled straight away including themes for COHA's. ███ informed that there was a case received against ███ recently ███ who had been discharged, known as C-.Diff. and a repeat specimen was carried out by the patients GP, a day after the 28-day treatment threshold, which triggered a new case. However, C-.Diff tests are not repeated to see if it has cleared as this is monitored via the patients' symptoms. ███ recommended that ███ wrote a paragraph to be included into the GP communications letter. **New Action – ███ to write a paragraph on repeat C.Diff testing for ███ to include in the GP communications letter.** ███ that UHNM need to improve antimicrobial prescribing at the front door of ED and has asked ███ and the antimicrobial team to speak to the teaching hospitals that are in the top two quartiles to see what they are doing differently. ███ enquired as to whether there is new guidance coming out regarding PSIRF and Infection Control. ███ advised that there is new guidance that came out on Tuesday 13th February. ███ informed that any new guidance regarding C.Diff may rectify RCA reporting and the dashboards can be reflected in next year's contract reporting. ███ advised that the Childrens department did their bed cleaning on Monday and UHNM are waiting for a date for Maternity to do theirs.	███ ███
7.0	**Quality Assurance Report Summary (December 2023)**	███
7.1	Enclosures 7.0 and 7.1 were taken as read with the following highlights. • ███ never Event was recorded, which is also included in the SI report, regarding a ███. • Duty of Candor compliance has dipped slightly. • Patient safety alerts are doing well with 1 overdue at the time of the report, which was being led by SSOT ICB. • There are challenges with Sepsis and meeting targets in Royal Stoke ED as discussed earlier. • ICP indicators are showing a positive improvement. • There has been an increase in the number of incidents but a decrease in the numbers of moderate harm.	

	• An improvement continues to be seen in falls, due to the teams work around falls management and fall risk assessments and mitigation. • There has been a reduction in medication incidents. would like to understand what sight SSOT ICB will have of serious incidents. advised that the monthly reports would continue and anything PSII will be notified on STEIS and also have access to UHNMs LFPSE portal. noted that notifications are sent out by the ICB Patient safety team on a weekly basis, which will receive. advised that NHSE are going to build a PSIRF section into LFPSE. raised concerns regarding a ward that still has less than half of the patients getting timely observations. advised that there have been issues with how the observations have been recorded within Vital Pack and some technical issues around how it pulls information out. informed that the problem is vitals are being recorded retrospectively instead of in real time. There have also been some issues with the network and Wi-Fi however, UHNM are having a new Wi-Fi network in Spring to help with system demands. noted the deteriorating patient reviewer in ED and would like to understand what the role is and how it functions. explained that it was developed by the Sepsis team in ED to think about how patients who are at risk of sepsis or significant rapid clinical deterioration are reviewed quickly. The deteriorating patient lead can be alerted and will come within 10 minutes. This process was brough in to address some of the Sepsis concerns and is audited. leads on this in ED and can be invited to attend CQRM to present further information. **New Action – to attend March CQRM to present information on the deteriorating patient reviewer function.** noted that the report states that mortality rates are going down and would like clarity as to whether they are still within range. confirmed that they were within range and there are no concerns, but it is the way that it is reflected within those SPCs.	
8.0	**Monthly Performance Report Summary (December 2023)**	
8.1	The Monthly Performance Report Summary for December 2023 and Monthly Performance Report were taken as read with the following queries. enquired into elective care and whether the industrial action has impacted on the longer waiters or cancer waits. advised that the industrial action has not impacted on the cancer waits but the biggest impact is on the 65 weeks plus patients. The action has not impacted the 104 weeks plus patients and they are still being pushed though and aim to have them all completed by the end of the month, the 78-week waiters remain static. Planning is being done for the further upcoming industrial action in at the end of February 2024. It is currently drafted that the 65-week waits are cleared by September 2024.	

8.2	**52-week+ Harm Review Report** The report was taken as read with the following highlights. • 32% of harm reviews were completed for December. • The biggest outlier was Trauma, Orthopedics and Respiratory medicines. It has been suggested that for a sample, if there was anything less than 30 to do them all and anything above 30, they should complete at least 30%. There has been some good feedback and ■ has spoken with ■ around further engagement. • The 141 completed all came back no harm and were all competed by consultants. • UHNM are still in the process of doing this electronically but there is currently no timeline associated with its implementation. ■ will provide an update around timescales at the next CQRM. ■ enquired as to whether any harms have been recorded in the long waiters. ■ informed that they have not identified any from the reviews undertaken. He also added there is an active review. UHNM are still doing the texts for long wait patients to see if they still want to be on the waiting list or if their condition has changed etc.	
8.3	**104-day Harm Review Report Q2** The report was not provided. ■ enquired as to whether the 104-day Harm Review Report will be provided in March. ■ advised that he is unsure and requires internal escalation which he will undertake.	
8.4	**Radiology Reporting Backlogs Update** ■ noted that the ongoing concern is around the Thoracic area which seems to have gone backwards and would like to understand if there are any reasons for this. ■ advised that the focus was more on cancer reporting but will get an update from Dionne as to their plan to get back online. **New Action – ■ to provide an update on radiology Thoracic reporting**.	■
9.0	**Emergency Department Monthly Assurance**	■
9.1	**12-hour breach/ambulance handover delay harm review proposal update** ■ advised that the Terms of Reference for Ambulance wait reviews for all patients over 7hrs has been agreed with ■ A weekly reporting process into SSOT ICB with agreed proformas is in place and there are fortnightly review meetings. ■ and ■ are leading on the process for patients who have died and had a 12 hour wait in ED through the SJR process. They continue to pick up harms through their usual processes for patients who have experienced 12hour waits and have been admitted to wards. ■ request that the outputs of that group are brought to CQRM.	
10.0	**Serious Incident Report (December 2023)**	■
	■ covered highlights within the report:	

10.1	• ▇ New incidents were recorded on STEIS, ▇ falls and ▇ around the never event, which is having its own local PSII, and the learning and outcome will be shared both internally and externally. • There are approx. 46 open incidents which is a reduction on the previous month. • Learning and outcomes of reviews will be shared. ▇ enquired as to whether the Never Event can be officially closed. ▇ and ▇ are happy to formally close the Never Event included within the papers.	
11.0	**Coroners Reg 28 – ▇**	▇
11.1	**Coroners Reg 28 Trust Response – ▇** ▇ advised that the response has been sent from UHNM back to the area coroner around the concerns that were raised. There has been no further correspondence or follow up from the coroner. ▇ has also supplied a copy of the NHSE response for information and assurance. ▇ noted that ▇ had enquired into a PFD case that had been received into the Trust yesterday regarding letters being received from the Trust to the GP without doses of drugs, often out of time scale and left on the competency of the family to advise the GP. A response is being formulated and will be brought back to CQRM.	
12.0	**Forthcoming UHNM External Reviews**	▇
	Nothing to discuss	
13.0	**Any Other Business**	**All**
	▇ advised that she is working with ▇ and ▇ on revising UHNMs validation of mixed sex accommodation breaches in critical care, as historically it has never been reported externally on patients who remain in critical care in a mixed sex accommodation area, greater than four hours after the decision is made that they're fit to transfer. Once the process is in place a quality visit will be carried out by the ICB during April. ▇ advised that UHNM were asked by CQC some queries about the ambulance holds. ▇ and ▇ spoke to the CQC to explain the data and the CQC are going to engage with UHNM around the issues the Trust were seeing. They were also enquiring around processes in place for ED corridor care and your next patient. The CQC also announced that they were planning to visit ED at County Hospital and Review the Section 29a, but due to industrial actions the visits have been postponed. The visit is welcomed as improvements have been made in both areas and they feel it will be enough to lift both notices.	

Next UHNM CQRM:
Thursday 21st March 2024, 12:00-14:00
Via Microsoft Teams

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.

Meeting	UHNM CQRM
Venue	Microsoft Teams
Date/time	Thursday 21st March 2024, 12:00-14:00

Attendees:		
(Chair)	Associate Director of Quality and Patient Safety, SSoT ICB	
	Senior Clinical Quality Improvement Assurance Manager, SSoT ICB	
	Associate Director Performance & Business, UHNM	
	Lead Nurse, Quality & Safety, UHNM	
	Associate Chief Nurse/Deputy Director (Infection Prevention & Sepsis), UHNM	
	Chief Nurse, UHNM	

In Attendance:		
(Minutes)	Business Support Officer, SSoT ICB	

Apologies:		
	Strategic Clinical Director, SSoT ICB	
	Head of Quality, Safety & Compliance Department, UHNM	
	CNIO Associate Deputy Chief, UHNM	
	Associate Director, Performance & Information, UHNM	
	Quality & Improvement, SSoT ICB	
	Matron for Quality & Safety, UHNM	
	Deputy Medical Director, UHNM	

No	Item	Action Lead
1.0	**Introductions & Apologies.**	**Chair**
	introduced all to the meeting and announced apologies as noted above.	
2.0	**Declarations of Interest**	**All**
	None to declare.	

3.0	**ICB Leadership Compact**	**All**
	███ covered the leadership compact and all adhered.	
4.0	**Minutes from the previous meeting: 15th February 2024**	**All**
	Agreed as an accurate representation of the meeting.	
5.0	**Action Log from the previous meeting: 15th February 2024**	**All**
	Action 149 – ███ spoke to the ICB's Designated Nurse Looked after Children who has informed that the MDT has not yet gone ahead as struggling to get the Local Authority and system partners around the table. It has been escalated to the ICB's Associate Director for Safeguarding as wait times have deteriorated again in January. To be brought back to CQRM if necessary. (Closed) Action 153 – no update has been received on the 104-day Harm Review Report. ███ is going to chase ███ for an update. (Open) Action 156 – the VTE Deep Dive is on the agenda. (Closed) Action 159 – ███ and ███ have not yet met to discuss the Sepsis Dashboard. (Open) Action 160 – ███ has confirmed he is waiting for the Dr he is working with to create a draft. (Open) Action 161 – DPR will be brought to April's meeting. (Open) Action 162 – A paper on Thoracic radiology reporting backlog will be circulated. The Deterioration/backlog build up came from Workforce and the gaps in the team. The consultant was on long term sick but has now returned. A new Doctor is also starting in 4 months although outsourcing is being considered. (Closed)	
6.0	**Monthly HCAI Report (January 2024)**	███
	The report was taken as read. ███ provided an oversight of the report: There were ███ MRSA Bacteraemia which were discussed. ███ MRSA Bacteraemia – The PIR meeting has been held; ███ It was deemed as avoidable. The patient passed away but not due to the MRSA bacteraemia.	

MRSA Bacteraemia – It was deemed as avoidable and UKHSA has agreed to pick this up with the family.

MRSA Bacteraemia – then developed an MRSA.

Key details of the report were discussed:

- There have been 12 CDIFF cases in January and these are above trajectory.
- RCA's have been stopped as the data being given was 3 months late. The Trust want to work with real time information.
- 2 key themes have been identified – anti-microbial prescribing at the front door, mainly around UTI's and samples not being sent timely, and patients then being given Co-Amoxiclav. The other theme is around community acquired Pneumonia, the curb score was not being done and patients were also being given Co-Amoxiclav not the correct antibiotic.
- Late sampling has come up recently and work is ongoing to remind staff.
- There are lots of reviews ongoing with CDIFF.
- Benchmarking is being done several other trusts across England to compare how they are handling CDIFF cases.
  E-Coli bloodstream infections are high.AR confirmed work is being done around hydration with summer coming up and seams are being collected.
  Covid-19 inpatient cases Have reduced to 30.
- Flu inpatient cases is sitting around the 30 mark, with staff flu vaccinations continuing until next week.
- RSV got adult case.
- Sepsis has been confirmed at 80% which is an improvement. 60% for anti-biotics within the hour.

There is lots of pressure on ED with patients being admitted with Norovirus. There are 3 wards currently closed. FEAU has had to be closed which is affecting ED. The strain was confirmed as the G2 strain which is proving to be resistant.

A fungus was found in 2 theatres, and these were the cleaned and a disinfectant bomb. Everything was swabbed and the affected equipment was cleaned twice.
Every theatre across the trust is being inspected to be on the safe side. The ventilation system is being checked by maintenance.

A question was asked by regarding the plan following the IPC PSIRF matrix being published. Wording within the IPC report and RCA process needs to be reviewed. advised the ICB Strategic Infection Prevention and Control Lead held a meeting with all providers to look at PSRIF. has asked that to arrange a meeting with the ICB IPC Lead to ensure oversight processes are the same.

enquired around flu vaccines – advised those this is the last week of vaccinations, and they are currently working on next year's vaccination plan. stated that the E-Coli position has been declining over time with increasing numbers being reported so a plan needs to be put into place.

	It was discussed by ███ that before Covid-19 there were staffing shortages and the resistant organism nurse function was removed. Just before Christmas of 2023 the role was filled again by the same member of staff from before. The current plan is to get a baseline of themes. IPC Colleagues in other areas were spoken to and themes don't appear to be different at other trusts. The current themes appear to be UTI's, hydration and Catheter's for the elderly. Cystitis with E-coli is being looked at. Along with looking at cholecystectomy waiting list times and whether they are a factor. **Action - ██ to arrange a meeting with the ICB IPC Lead to ensure oversight processes are the same as other PSIRF oversight processes.**	
7.0	**Quality Assurance Report Summary (January 2024)**	██
7.1 **7.2**	<u>Quality Assurance Report</u> The report was taken as read and covered by ██████ due to ███ not being in attendance. ██ enquired about PSI's and the moderate harm increasing significantly with tissue viability seeing a minimal change. ███ advised a lot of the harms were medication incidents and work is being completed by the Pharmacy Team to try and reduce this. ██ enquired about the pressure ulcer section of the report. ███ confirmed that a deep dive is being done to look at Your Next Patient pressure ulcers and the findings will be shared. It was explained that this was asked for internally due to the ambulance waits in the corridor, the pressure this can cause needs to be reduced so staff are being trained on this. Details will be shared once progress has been made. ███ raised that the report states there are 0 MRSA Bacteremia in January, it was explained this is, due to the time that the reports are pulled it did not match up. Shimmy is also in red, but the assurance grid says it is within expected range. ███ will update this. There is 1 overdue PSI which is now being signed off. **Action: ███ to share Pressure ulcer deep dive on Your next patient** <u>CQC Action Plan Update</u> It was confirmed that papers have gone to the quality governance committee and some actions that have remained on the action plan have been there since the 2021 CQC visit. Lots of these are monitored through business as usual. Work is ongoing. Some actions have been taken as far as possible; it is being made sure that any risks associated are mitigated. Example being the lack of storage in the medical wards so unnecessary items are gotten rid of. Speak and Language therapy have had 2 additional band 6 posts put into place at County Hospital with a service review to follow. Section 29A the risk management of patients with mental health needs in medicine at County Hospital – Focused education and awareness raising continues although there have been significant improvements in the nursing team there are still occasions where medics are not completing assessment. The Trust are collecting further evidence today to submit to CQC however it won't be sufficient for the CQC to remove the notice carrying out a table-top review therefore the CQC will be required to carry out an onsite visit.	

	The CQC also conducted a focused visit to Maternity Services in March 2023 and concerns were raised in two areas: timeliness of maternity triage and management of induction labour. This resulted in the Trust being served with a Section 29A Warning Notice- Maternity progress is being made with enough evidence for the CQC to carry out table-top reviews. If Maternity have a tabletop review, then the CQC rating can't be changed only warning notice removed. Therefore, CQC would need to come in to do a visit and change the rating. CQC visited ED last week, but it was a standard national visit, not due to any concerns. There was a query around the number of patients in the corridor going up to 18 but this did not happen. The final report is being worked on with the percentage of compliance being a focus and the report will be shared once ready.	
7.3	Deteriorating patient reviewer (DPR) Function This item was deferred to April's meeting.	
7.4	Complaints & Pals Q3 Report The report was taken as read and covered by ▇▇ due to ▇ not being in attendance. Complaints leads/patient safety partners are being used to help and drive the improvements. Friends & Family is focusing on improving the internal target of 30% responses, using technology to help with this. CQC informal enquiries are being included in the report going forward as these are received regularly. ▇ gave praise to the report as they thought complaints would increase with the backlog increasing but they haven't which shows PALS must be doing well. Triages are also doing well. ▇ raised a query around ward 230 as it went into double figures. It was discussed that this ward is under review as it had a change of leadership and has a bronze rating. Ward 228 also saw an increase from 4 in 3 months, to 9 in 1 month so this ward is being focused on.	
7.5	VTE Deep Dive Report An increase was seen in Hospital Acquired Thrombosis (HAT), this is being monitored by Dr ▇▇ VTE lead. The Deep Dive has shown that prescribing of prophylaxis in ED needed to be improved by the ED team and specialty teams due to the long waits. It can be seen there has been a reduction in HAT cases compare to last winter even though pressures and wait times are high in ED. Hopefully a further winter spike in cases will be unlikely given the areas of focus, the ED leadership team are putting actions into place. The deep dive also confirmed that lots of the patients with HAT have respiratory conditions or Covid-19. QGC agreed to close various actions and monitor them through normal channels.	
8.0	**Monthly Performance Report Summary (January 2024)**	▇
8.1	Monthly Performance Report The report was taken as read and covered by ▇ due to ▇ not being in attendance.	

	An update was given on the current position: • A&E 4 hour wait KPI reported 64.2% in January, but it has now increased to 69.4% in March, partly due to the opening of the Clinical Decision unit (CDU). This means an extra 12 beds are available for a short period of time. There is further work to be done at the County Hospital. • 12-hour trolley waits were at around 1263 for January but are down to 430 in March, being around 100 less per week. • Elective Care RTT – 78-week waiters are down to 66-71 from 143 in January. 65-week waits are starting to be targeted, coming down from 1300 in January to 900 in March. • The cancer backlog has come below the end of year target with faster diagnosis sitting at 75% which is the national target. It was raised by ███ that the 62-day referral to treatment is the lowest it has ever been. ███ advised it has improved from around 400 in January to 250 in March. It was mentioned in the report that UHNM are trying to protect cancer services in winter planning. The County Hospital target is lower than it has ever been and trying to get performance up to 80%. MH advised there is a lot of work is being done around none-admitted patients. ███ asked about the Urgent re-attendance rates as is 9%, ███ advised have been sent to UHNM colleagues to review, it was questioned whether they were appropriately recorded. Introducing CDU will slightly increase numbers due to the number of short stay patients increasing.	
8.2	<u>52+ Harm Review Report</u> Long waits are closely monitored, and annual planning is taking place to look at next year's activity. It is likely that the 52-week+ long waiters' number will remain static. Harm reviews are being done via text messaging, but the questions asked to patients are being reviewed as UHNM need to be able to act upon responses so a well worded question is needed. ███ advised the word RCA needs taking out of the report. Concern was raised by ███ as the report says there is no harm or detrimental outcome for patients, but this does not seem right. ███ has agreed to take this to the patient safety specialist group regarding harm reviews to see what other areas are doing. ███ wanted to clarify that the harm reviews went electronic but are now going back to papers. If less than 30 patients are completing the pathway, then all have a harm review. If over 30 harm reviews are done, then only 30 are reviewed so the numbers don't make sense/go to waste. Targeted completion needs to be higher, and the report needs changing to show this. ███ will feedback to ███ **Action – ███ will raise 52ww wait harm reviews with the Patient Safety Specialist Group to identify what other Trusts are doing.** **Action – ███ will discuss changes to the 52-week Harm Review Report with ███**	
8.3	<u>104-day Harm Review Report Q3</u> This report was not provided.	

9.0	**Emergency Department Monthly Assurance**	[redacted]
  9.1	A new process is in place although it is early yet but seems to be going well at the moment. **12-hour breach/ambulance handover delay harm review proposal update** As discussed above.	
10.0	**Serious Incident Report (January 2024)**	[redacted]
           10.1	This report was taken as read. The SI backlog is at 30 overdue, 12 are falls and 8 are maternity. A few are Never Events waiting for action plans to be completed. This will take longer than originally thought due to industrial action and emergency care pressures. It was raised by [redacted] that a learning process/update sheet is needed to show what learning is to be taken from PSII's. So that those reported on STEIS can be closed once PSII completed **Action – [redacted] will approach [redacted] to see how a thematic approach can be taken for closing PSII's.** Mortality Assurance Report Q3 The report was taken as read. Mortality indicators within range. It was mentioned by [redacted] that CDU's have been recently introduced so this will help the mortality position as there will be lots of low-risk patients.	
11.0	**CQUIN Performance Report Q3**	[redacted]
	The report was taken as read. [redacted] advised there has been a national confusion regarding Prompt switching of Intravenous to oral antibiotic *(aim is for a low % <40%)* as the targets have been flipped by NHSE and are lower than this year at 40%. It is wanted that fewer patients are receiving anti-biotics after a trigger point and there are still some of the same actions in place. 4 CQUINS under section 4 were concerned regarding compliance but reasons need to be included as to why these concerns are being raised. Improved collaboration between the Radiology & Vascular Team is taking place to help with CQUIN's. NHSE have taken on CQUIN 2 as a national improvement project, [redacted] enrolled UHNM into the first phase.	
12.0	**Letters – Marthas Rule Implementation**	[redacted]
	Action - Expressions of interest for Martha's Rule are coming out next week so these will be passed along to SSoT ICB.	
13.0	**Forthcoming UHNM External Reviews**	[redacted]
	It is expected a CQC visit will be taking place soon.	

	SMOAG was discussed – the quality review of the national team for maternity had no concerns raised. Ratings and improvements are better than other trusts. At the last SMOAG, UHNM had targets of 95% but other trusts did not have targets at all, but their rates were between 80-90% so UHNM have set a new target of 85%. Health Watch reviewed Renal Dialysis at County & Royal Stoke as there have been cases of patients contacting regarding transport difficulties. EMED have their own action plan in place and UHNM are doing work around this where possible.	
14.0	**Any Other Business**	All
	There were no AOB to discuss.	

Next UHNM CQRM:
Thursday 18th April 2024, 12:00-14:00
Via Microsoft Teams

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Meeting	UHNM CQRM
Venue	Microsoft Teams
Date/time	Thursday 18th April 2024, 12:00-14:00

Attendees:		
████ (Chair)	Strategic Clinical Director, SSoT ICB	██
████	Senior Clinical Quality Improvement Assurance Manager, SSoT ICB	██
████ (Part meeting)	Head of Cancer Services, UHNM	██
████	Matron for Quality & Safety, UHNM	██
████	CNIO Associate Deputy Chief, UHNM	██
████	Head of Quality, Safety & Compliance Department, UHNM	██
████	Lead Nurse, Quality & Safety, UHNM	██
████ (Part meeting)	Associate Chief Nurse/Deputy Director (Infection Prevention & Sepsis), UHNM	██
████	Deputy Medical Director, UHNM	██
████	Associate Director, Performance & Information, UHNM	██

In Attendance:		
████ (Minutes)	Business Support Officer, SSoT ICB	██

Apologies:		
████	Associate Director of Quality and Patient Safety, SSoT ICB	██
████	Associate Director Performance & Business, UHNM	██
████	Quality & Improvement, SSoT ICB	██
████	Chief Nurse, UHNM	██

No	Item	Action Lead
1.0	**Introductions & Apologies.**	**Chair**
	[redacted] introduced all to the meeting and announced apologies as noted above.	
2.0	**Declarations of Interest**	**All**
	None to declare.	
3.0	**ICB Leadership Compact**	**All**
	[redacted] covered the leadership compact and all adhered.	
4.0	**Minutes from the previous meeting: 21st March 2024**	**All**
	Agreed as an accurate representation of the meeting with the following amendments: • Amended the font at the top of page 5. • Section 13, The abbreviation SMOAG be written as System Maternity Oversight Assurance Group (SMOAG)	
5.0	**Action Log from the previous meeting: 21st March 2024**	**All**
	The following action updates were discussed: Action 153: This action is on the agenda to be discussed. Agreed to close this action. Action 159: [redacted] and [redacted] agreed to organise a date for a meeting. Action 160: [redacted] agreed to check if the report will be sent to GPs. Action 161: [redacted] has emailed [redacted] to ask when he is able to attend CQRM. Action 163: [redacted] confirmed the PSIRF meeting took place and process communicated to [redacted] Agreed to close this action. Action 164: This action will be updated at the next CQRM. Action 165: [redacted] will discuss this action at the next Patient Safety Specialist Group. [redacted] agreed to review the 'no harm' wording within 52ww report. The group agreed to merge action 164 and 165 together. Action 166: [redacted] has completed this action and agreed for it to be closed. Action 167: The Pressure ulcer deep dive is due in June 2024. Therefore, not yet due.	
6.0	**Monthly HCAI Report (February 2024)**	[redacted]
	The report was taken as read. [redacted] provided an oversight of the report: There was no MRSAb reported in February 2024. The three in January 2024 were discussed and found two were avoidable and one was unavoidable. A learning alert was issued as the two avoidable both had missed screening issues.	

	Key details of the report were discussed: • The February CDIFF cases are above trajectory. • RCA's have been stopped and the Trust are looking at themes. These themes are being processed quickly so actions can be put in place faster. • Current themes are Anti-microbial prescribing around UTI's and community acquired pneumonias work is ongoing. • Benchmarking is being done with several other trusts across England to compare how they are handling CDIFF cases. All well performing CDIFF Trusts has electronic prescribing though UHNM doesn't yet have this in place. • All Sepsis areas has achieved apart from Royal Stoke emergency department. There is an options appraisal paper discussing the new NICE Sepsis guidelines for next month. • Covid cases are low and there is a reduction in flu cases. • There has been an increase in Norovirus cases in March 2024 with cases coming from community. The emergency portals and wards are doing well isolating these patients early to prevent outbreaks. • There has been one suspected Measles case and it was confirmed as negative. Since November 2023 there has been thirty suspected Measles cases and seven were confirmed as positive. • [redacted] [redacted] noted the HSJ publish an article concerning coroners' prevention of death around Sepsis screening. [redacted] enquired if any actions will be taken from this article. [redacted] agreed to review the article and respond. **New Action: [redacted] to review the HSJ article on prevention of death round Sepsis screening and let [redacted] know of any actions.** [redacted] asked for an update on the Sepsis NICE implementation and electronic screening in ED. [redacted] confirmed discussions are ongoing due to the Trust digital system will not allow the required update to implement the new guidance. [redacted] has talked to other Trusts who use the same Sepsis system to decide. [redacted] noted the updated paper guidance will be decided by the Trust in the options appraisal if to go live in ED or not as the rest of the Trust would be using the current documentation. **New Action: A further update on sepsis options appraisal to be provided in May.**	 [redacted] [redacted]
7.0	**Quality Assurance Report Summary (February 2024)**	[redacted]
7.1	<u>Quality Assurance Report</u> The report was taken as read. [redacted] provided the key highlights of the report: • Never event was reported in February due to incorrect lesion being removed. PSII will be conducted and a review of previous reported dermatology cases and actions. • Failed to meet internal 10-day target for duty of Candor. • Friends and Family didn't meet the 95% target. [redacted] enquired on the effect of YNP (Your Next Patient) on ward-based care. [redacted] reported [redacted] will discuss the pressure ulcers deep dive at the next meeting and if anyone reports an incident, the datix asks if it relates to the next patient. [redacted] noted they will review to see if there	

	was an increase on incidents or outcomes for patients. ▇ confirmed the deep dive will review YNP and corridor care. ▇ noted most of the quality indicators had improved and no wards were under 50% for the patient observations audit and compliance was slowly improving.	
8.0	**Monthly Performance Report Summary (February 2024)**	▇
8.1 8.2 8.3	Monthly Performance Report ▇ provided the following summary of the performance report: • 104-day backlog had reduced with praise from NHSE for improvement of reducing long waiting times for cancer. • A&E 4-hour target has improved with over 70% in March. • RTT is in tier one. • 104 weeks, there are still several patients recently has been received from private sector as didn't meet their criteria. • 78 weeks will be at twenty at the end of this month with issues due to patients on wrong pathway. • 65 weeks target was to be 0 by the end of March, it has now been changed to September. All patients are being reviewed to make sure all patients have a first seen contact by the end of July 2024 so they can hopefully be treated by end of September 2024. ▇ noted the RTT slide showed 31k patients validation forms were sent out and enquired if the 2,090 forms received back has been investigated. ▇ confirmed the forms has been sent to the relevant specialities and are contacting patients to identify the change. ▇ noted the patients were selected as random across the whole waiting list. 52+ Harm Review Report ▇ reported the 52ww harm review report wasn't ready for this meeting and agreed to email it to the group prior to the next CQRM. **New Action: ▇ to provide the fifty two-week harm review report before the next CQRM.** 104-day Harm Review Report Q3 ▇ circulated the Q2 report and agreed to discuss Q3 report as it wasn't available for this meeting. The summary for Q3 was: • There were 88 patients referred for cancer and treated over the 104 days. Main delays were due to capacity. • Patient choice was less of a factor compared to Q2 and made up 3.4% of breach reasons in Q3. • Patients on an open pathway has decreased to 64 patients from this weekend. • Reduction of breaches throughout the quarter. • 60% of treatments beyond 104 days were surgical treatments. • In Q3 there was twenty reviews with none identified as harm. • Actions are taking place to allow more harm to review each month. ▇ enquired how patients are selected for harm reviews. ▇ noted UHNM send all of them out to be reviewed by treating clinician to decide if harm has occurred. There is no selection process. ▇ noted engagement is required for harm reviews by clinicians.	 ▇

	■ enquired on the longest waits and if they are reviewed. ■ agreed to include this information in the Q4 report. ■ confirmed questions are asked if there has been any additional harm due to the long wait and will include this in the report. **New Action: ■ to include data on the longest waits and review process for the 104-day harm review Q4 report and any additional harm due to the long wait time.** ■ noted the embedded documents could not be opened. ■ stated she has sent the embedded word documents separately. ■ raised that consideration should be given to the wording within the report, as it states no harm, may be consider no change to patient outcome or treatment plan as a result of the delay. ■ stated the Q4 report should be ready for the July 2024 CQRM. **New Action: ■ to add the Q4 104-day harm report to the June 2024 CQRM.**	■ ■
9.0	**Emergency Department Monthly Assurance**	■
9.1	<u>**12-hour breach/ambulance handover delay harm review proposal update**</u> The recent meeting to discuss Emergency Department Monthly Assurance was cancelled as there was no cases to review due to not receiving NHS numbers. WMAS information was delayed and there been none since 4th April 2024. Agreed to delay this discussion until the next CQRM.	
10.0	**PSIRF Learning (SI Update February 2024)**	■
	■ is developing the report and agreed to provide it prior to the next CQRM.	
11.0	**PLACE Overview Report & Actions**	■
	Report taken as read. ■ highlighted that UHNM achieved above the national average for each of the domains and top six of Trusts for cleaning. It was noted in the action plan that some ward areas don't display dementia clock date and time. This is being review with the estates department.	
12.0	**Reg 28 Coroners Response 2024-0077 JB**	■
	■ noted he has contacted legal services for the response to the regulation 28 request. ■ agreed to send the original letter to ■ once available. **New Action ■ to circulate Reg 28 response for ■**	■
13.0	**Forthcoming UHNM External Reviews**	■
	No external reviews identified. ■ noted CQC had carried out a follow up visit to ED and are awaiting the report. No significant concerns were flagged at the visit.	
14.0	**Any Other Business**	**All**
	No other business was raised.	

<u>Next UHNM CQRM:</u>
Thursday 16th May 2024, 12:00-14:00
Via Microsoft Teams

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.

Meeting	UHNM CQRM
Venue	Microsoft Teams
Date/time	Thursday 16th May 2024, 12:00-14:00

Attendees:		
(Chair)	Strategic Clinical Director, SSoT ICB	
	Strategic Improvement lead for Quality & Patient Safety, SSoT ICB	
	Speciality Doctor in Emergency Medicine, UHNM	
	Deputy Chief Nurse, UHNM	
	Head of Quality, Safety & Compliance Department, UHNM	
(Part meeting)	Associate Chief Nurse/Deputy Director (Infection Prevention & Sepsis), UHNM	
	Associate Director, Performance & Information, UHNM	

In Attendance:		
(Minutes)	Business Support Officer, SSoT ICB	

Apologies:		
	Associate Director of Quality and Patient Safety, SSoT ICB	
	Senior Clinical Quality Improvement Assurance Manager, SSoT ICB	
	Head of Cancer Services, UHNM	
	Matron for Quality & Safety, UHNM	
	CNIO Associate Deputy Chief, UHNM	
	Deputy Medical Director, UHNM	
	Lead Nurse, Quality & Safety, UHNM	
	Chief Nurse, UHNM	

No	Item	Action Lead
1.0	**Introductions & Apologies.**	**Chair**
	■ introduced all to the meeting and announced apologies as noted above.	
2.0	**Declarations of Interest**	**All**
	None to declare.	
3.0	**ICB Leadership Compact**	**All**
	■ covered the leadership compact and all adhered.	
4.0	**Minutes from the previous meeting: 18th April 2024**	**All**
	Agreed as an accurate representation of the meeting.	
5.0	**Action Log from the previous meeting: 18th April 2024**	**All**
	Action 159 – Sepsis Dashboard – This action can be closed. (Closed) Action 160 – Monthly HCAI Report – ■ will speak to a colleague for info. (Open) Action 161 – Quality Report – ■ has attended and will provide an update. (Closed) Action 164 – Patient Safety Group Harm Reviews – Can be closed. (Closed) Action 167 – Pressure Ulcer Deep Dive – Due to be presented in June. (Open) Action 168 – HSJ Article – Was circulated. (Closed) Action 169 – Sepsis Update – An update will be given in this meeting. (Closed) Action 170 – 52-week Harm Review Report – Was circulated. (Closed) Action 171 – 104-day Harm Review Report Q3 – Due to be presented in June. (Open) Action 172 – 104-day Harm Review Report Q3 – duplicate and can be closed. (Closed) Action 173 – Reg 28 JB – On agenda. (Closed)	
6.0	**Monthly HCAI Report (March 2024)**	■
	■ highlighted key points from the agenda: • There are ■ MRSA bacteraemia. ■ was avoidable and ■ was unavoidable. A learning alert was given to the avoidable incident. There has been a case of MRSA bacteraemia which has been identified as a North American strain, it is unclear where this has come from. The other incident came from a care home patient who was positive on admission. A meeting has been organised with ICB/NHSE. • Benchmarks were done with other trusts on CDIFF, and they are all electronic. • SSoT ICB are leading the work as a health economy on E-Coli, whilst reviewing their own cases. • There have been no Nora-virus outbreaks.	

- There has been suspected case for Measles.
- Pertussis is being put together into a pack.
- There was an outbreak on Ward 124, but this is now cleared and can be closed.
- of PCP infections in solid organ transplant patients. There was an outbreak in 2018 so guidance has been taken from this.

New Sepsis Guidelines Update

highlighted key points for this item:

The Sepsis guidelines paper went to QSOG, and a discussion took place around this.

It has been discussed that there is an issue with System C and their development of the vital packs. They are unable to develop the updated vital pack until 2025. UHNM have 3 choices:

- Leave as is. Stay as they are with Vital and old guidance.
- For the whole trust to go back to paper versions.
- Or Update guidance for ED but that means that the rest of the trust will be using old guidance.

It was said strongly by that UHNM do not want to go back to paper versions so that option was immediately ruled out. QSOG have asked for a paper to go next month labelling the pros and con's of the options given. The Sepsis and ED teams will have view of this document and will be able to comment.

Action - It was asked that come back to this meeting in 6 months to provide an update.

Action - It was asked by if SSoT ICB would be able to provide support by pressuring System C to complete the new vital pack ASAP.

Deteriorating Patient Reviewer Function

discussed this item in detail.

UHNM ED are not near compliance with Sepsis standards, in which the target is 90% for screening in good time and treatment to be given. Areas that could be improved are being actively reviewed. There are ongoing education packages for nursing and clinical teams.

Pre-Covid19 targets are not quite being achieved. A new role has been developed a Deteriorating Patient Reviewer (DPR) role, this is a clinician who is competent in the assessment and treatment of acutely ill patients, including sepsis. The DPR was introduced as a way of contacting staff in ED, it has helped a lot with staff being made aware of where support is needed. Patients with high needs scores should have a tier 3 clinical staff member assigned to them to check for Sepsis and other issues as quickly as possible.There are plans for encouraging response rates and enthusiasm by aiming towards making it an education opportunity.

UHNM are reviewing the most appropriate action plan that will go alongside the Sepsis guidance from NICE published in January 2024. The benefit of the new guidance is that the patients who have a high score still have a -1-hour window to be seen. Patients with lower scores are unlikely to suffer detrimental damage to their health and are given a 3-hour window. This also provides a better decision if anti-biotics are needed. [This also relates to the anti-microbial prescribing role as it should reduce CDIFF].

	███ and ██ undertook a visit to UHNM ED and the work they are putting in regarding the Sepsis programme really showed during the visit.	
7.0	**Quality Assurance Report Summary (March 2024)**	██
7.1	Quality Assurance Report ███ led this item and discussed key highlights: There are several indicator targets that are being met UHNM are consistent when it comes to Sepsis and infection prevention. Duty of Candor is at 100% for verbal but 78% for the internal target which is being addressed. The executive summary was provided for information. There was a wrong site surgery incident that was covered by the press. ███ was contacted at the time. There are █ PSII's going on. These are being pulled together and worked on using a thematic approach, so they are not isolated. ███ will share the learning and an overview of the thematic review. • Timely observations are being consistently worked on and are improving at a slow rate. There is additional work taking place as part of an improvement project. • Friends and Family – ███ asked if the pain relief statistic is a concern? Is anything happening? ███ answered that as part of CEF – timely observations and F&F tend to lower this statistic. For those clinical areas identified as bronze areas Patients are being asked to collect the feedback as part of the recovery Programme and improvements will be monitored. The deep dive into additional pressure on Your Next Patient (YNP) and Pressure Ulcers is ongoing. Complaints & PALS Report Q4 This item has been deferred to June's meeting.	
8.0	**Monthly Performance Report Summary (March 2024)**	██
	Monthly Performance Report ███ highlighted key points from this item: • ED had a better month compared to February, up from 63% to 70%. • Trolley waits are below 1000 for the month. • Ambulance handovers saw an improvement for 60-minute waits at 71%. • The main issues are to do with Endoscopy although UHNM are now getting support from NHSE. Lots of work is being done and more help is coming in for diagnostic tests. • There are 0 104-week waits. There 50-60 78-week waits but many these are due to patient choice. There has been a large spike in ENT cases, currently UHNM are unsure why. The number has increased from around 450 to 900 in the last month. This is being investigated.	

	28-day cancer diagnosis is at 75%, with combined 62-week at 61%. More work is being done around 70-day treatment targets. It was highlighted by ███ that it was positive to see the 62-week backlog is continuing to improve and now achieving pre-pandemic levels with national recognition received on this for the team. None-obstetric ultrasound performance has deteriorated, but UHNM confirmed that the issue is due to the lack of staff. To monitor the next months activity. 52+ Harm Review Report - March As discussed above.	
9.0	**Emergency Department Monthly Assurance**	███
9.1	12-hour breach/ambulance handover delay harm review proposal update There is no update to be given. SSoT ICB are involved, and ███ (UHNM) is taking a lead. The request is they attend this meeting when an update is ready.	
10.0	**PSIRF Learning (SI Update March 2024)**	███
	This item went through QSOG on Monday and was circulated post-meeting by ███ ███ highlighted key details: 6 new PSII's have been reported. ███ are related to ███, (███ ███ and ███ as mentioned in the report.) Since PSIRF was implemented on 1st December 2023, there have been 78 instances that have triggered a PSIRF response. The report shows that these cases have gone through to the risk management panel and the necessary steps have been taken. There are 40 of the old SI's which remain ongoing. As of this meeting UHNM now have 32 SI's with 6 more are under review from the ICB. The learning will be shared from the new PSII's when it is ready. ███ noted that UHNM are doing well with the transition and the system wide PSRIF Programme is progressing extremely well and is at the forefront regionally.	
11.0	**Regulation 28: Report to prevent future deaths**	███
	Trust Response Coroners Reg 28 JB The report has been shared with the GP. It has been to the coroner and a response was given although no further communication has been made. It was a joint and collaborative response. **Action – ███ will check what has happened on the GP practice side due to this Reg 28.**	
12.0	**Bi-Annual Establishment Review**	███
	This item has been deferred to June.	

13.0	**Clinical Audit Annual Plan**	■
	This item was provided and has been set up to give responses to local and national authorities. Updates will be given when ready. Audit results go through the relevant specialist forums and go to executive discussions. Escalations will be added going forward.	
14.0	**Visiting Legislation Updated April 2024**	■
	For Info – legislation around visiting arrangements.	
15.0	**Forthcoming UHNM External Reviews**	■
	None to mention.	
16.0	**Any Other Business**	All
	There is no AOB to raise.	

Next UHNM CQRM:
Thursday 20th June 2024, 12:00-14:00
Via Microsoft Teams

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