NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Our Ref: PW/KJJ/FOI/1225/1536

Stafford Education & Enterprise Park
Weston Road
Stafford
ST18 0BF

Telephone: 0300 123 1461

12 December 2025

Sent by email

Dear

FOI/1225/1536
Your request for information under the Freedom of Information Act 2000

Thank you for your request for information under the Freedom of Information Act 2000, received on the 4 December 2025.We can now 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. Please note the ICBs responses in blue text. Please find documents requested attached. Please Note the August CQRM was stood down and November's meeting minutes have not yet been approved.

Would you please forward me CQRM (Clinical Quality Review Meeting) minutes held by Staffordshire & Stoke ICB with provider UHNM NHS Trust for this year to date…ie April 2025 to date.

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

Paul Winter
Associate Director of Corporate Governance

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Meeting	UHNM CQRM
Venue	Microsoft Teams
Date/time	Thursday 18th September 2025, 12:00-14:00

Attendees:		
Cath Marsland (Chair)	Associate Director of Quality and Patient Safety, SSoT ICB	CM
Lindsey Boughey	Senior Clinical Quality Improvement Assurance Manager, SSoT ICB	LB
Pippa Caldwell	Head of Nursing, Quality Safety & Compliance, UHNM	PC
Charlotte Dunn (Part meeting)	Quality Assurance Support Manager, SSoT ICB	CD
Joe Potts	Matron, Quality, Safety and Compliance, UHNM	JP
Emyr Phillips (Part meeting)	Associate Chief Nurse/Deputy Director (Infection Prevention & Sepsis), UHNM	EP
Haidee Sim (Part meeting)	Senior Sister for Infection Prevention & Sepsis, UHNM	HS
Helen West (Part meeting)	Head of Cancer, UHNM	HW
Warren Shaw	Strategic Director, Performance & Information, UHNM	WS

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

Apologies:		
Mary Barlow	Lead Nurse for Quality & Patient Safety, SSoT ICB	MB
Steve Fawcett	Clinical Director, SSoT ICB	SF
Angela Young	Assistant Director for Nursing & Quality, NHSE	AY
Ann Marie Morris	Deputy Medical Director, UHNM	AMM
Jamie Maxwell	Head of Quality, Safety & Compliance Department	JM

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

3.0 ICB Leadership Compact

CM covered the leadership compact and all adhered.

4.0 Minutes from the previous meeting: 17th July 2025

The minutes were agreed as an accurate representation of the meeting.

5.0 Action Log from the previous meeting: 17th July 2025

Action 202 - Clinical Digital Systems Risk:

This will be presented at October's meeting. (Open)

Action 204 - Action Plan for Urethral Splits and Pressure Ulcer Deep Dive for May 2025:

This will be presented at October's meeting. (Open)

Action 206 - Endoscopy June 2025 Agenda Item:

This will be presented at October's meeting. (Open)

Action 210 - System wide audit on quality of discharge communication and medicines reconciliation:

PC will follow up with JM. (Open)

Action 215 - Sepsis Guidance:

This was presented at this meeting. (Closed)

Action 216 - EPMA Guidance:

PC will follow up with JM. (Open)

Action 217 - Plain Film X-ray Reporting Update:

Update received via email:

"We are making significant progress with this. Our backlog has reduced from over 4500 to 2600 over the past 2 weeks. Also, prior to the changes we made, our longest wait for an OP report from primary care was over 50 days. Currently, all PF are within 7 days for urgent and within 28 days for routine. We are moving to reduce this further, but I believe that we have already reduced to less than 28 days and are now working towards <7 days for all. I expect that we will have achieved tis for the majority of investigations but the end of August although I hope that GPs are already recognising an improvement in TAT for all patients.

In the process, we have also removed our entire ED/IP backlog so there will be tangible improvements for all patients as a result of this change/improvement.

Further update given during the meeting has now reduced to 20 days. (Closed)

Action 218 - AI Tool for validation lists:

WS confirmed that this tool should have been implemented around 6-weeks, but it has not been ready. UHNM have escalated this. WS will add something into the correlating report on how this will help patients and pathways. It will support, but not computer generate letters. (Open)

Action 219 - Q4 104-day Cancer Team presence at CQRM:

The Q1 report will be presented at October's meeting. (Open)

CM asked regarding the 31-day Cancer combined data which HW covered:

This is in relation to the number patients waiting longer than 31-days and the harm that may be coming to patients, and the information conveyed to GPs. HW confirmed that they are not concerned the 31-day waits as these are decreasing every month. July/August are at 93%. If skin breaches are removed then it would sit at 95%, with the overall target being 96%. The main reason for the breaches is down to staff capacity. The report will include all the details wanted by CM, and there will be a large update on Skin issues within the waiting list.

62-day Cancer combined waits – Is there a robust process around how patients are triaged/prioritised?

July is reported at 70%, and patients are prioritised in date order unless there is a specific clinical need. Patients are also not cancelled due to UEC and capacity. A clinical harm review process is in place for patients breaching 104days.

EP advised sometimes the Theatre Overruns due to IPC cleaning between patients – work is being done with theatres to improve this.

6.0	**Monthly HCAI Report (July 2025)**	**EP/JP**

EP discussed the report in detail and highlighted key points:

- There were no MRSA Bacteraemia in July, although there were 4 at the start of the financial year. 2 of which were deemed unavoidable and 2 deemed avoidable.
- C.DIFF is at 66 cases against a trajectory of 48. There is lots of work ongoing and some wards have had more than 1 case. There has been various version of CDIFF which rules out the possibility of transmission of the infection. It was identified that some patients were having their samples sent multiple times. UHNM met with MPFT, and they are having the same issue with the same patient being counted multiple times. If a patient is Cdiff + VE with 28-days, then they shouldn't be tested and counted again 1 patient was admitted through Community Services and ended up being counted 5 times.
- It was identified that some wards were sending samples outside of the 3-day target, of which some have improved, and others are being addressed.
- E-Coli cases are at 79 against a trajectory of 77, work is ongoing with SSoT ICB over the number of UTI's.

- Sepsis at Royal Stoke ED fell below where required, but the **Sepsis screening for the first time has hit 100% which is a positive.**
- The number of post-op infections has increased, and this is being worked on with the surgeons as part of the theatre cleaning plans.
- There are 13-cases of Covid-19. There are suggestions of a new variant, but this is quite common for Covid-19.
- There have been 3 cases of Flu, but none today.
- RSV – There have been 3 children with cases, but this is common in the winter months.
- There were 2 suspected cases of Measles, although 1 was negative and other is TBC. A refresher is being done with staff in relation to this.
- The UHNM vaccination campaign will be starting on 1st October, with staff only being offered the Influenza Vaccine. Patients are being offered these too through the opportunistic vaccination campaign. Some work is being done around the electronic requesting of Vaccines for Care Homes.

LB & CM were happy with the report, and all questions were answered.

CM noted an error on page-13, in relation to the number of Flu cases. This is incorrect and EP will amend.

CM asked about the Flu campaign for staff. The data is showing that the number of uptakes has been dropping every year. Is anything being done to support this? EP is working with Sam Buckingham (SSoT ICB) in relation to some Comms to try and increase this.
The data for vaccine uptake used to be available for each ward, but the data changed due to national reporting which changed the available data. Work is being carried out to analyse the data to ward level.

The local Mosque was visited to help try and clarify the concerns around the ingredients used in the vaccines.

Sepsis thematic review

The report was attached for information from JM.

CM/LB will email questions to PC/JM/EP. CM **praised that the report is very thorough and goes into a lot of extensive detail.**

7.0	**Bi-Annual Staffing Report**	JP/PC

JP discussed the report in detail and highlighted key points:

The report covers from October 2024 to February 2025, and his since been going through internal forums at UHNM. It follows national quality board expectations, and all the required reporting metrics are included, alongside the required Quality indicators.

There have been recommendations to amend the current uplift for staff leave and absence percentage from 21.5% to 27% as recommended by the RCN, alongside some recommendations around additional staffing nurse-patient ratios.

A pilot has taken place called 'stay in the bay' to reduce the need for 1 to 1's for patients' high risk of falls. More work is being carried out to increase this and embed across the Trust. CM asked regarding Business for areas where staffing increases are requested. JP advised the report had only recently been completed so would need to follow up with the Deputy Chief Nurse. **New Action- JP to follow up with the Deputy Chief nurse regarding Business cases being submitted for staffing uplifts.** JP confirmed that the future-plan is to include outpatient theatres as they are not usually included in the report. LB highlighted an error on page-2 regarding the Network Service Division as it doesn't read properly as it states that there is 1 health care for 29 patients. JP will investigate. **New Action – JP will investigate the error on Page 2 in relation to the Network Service Division section referring to 1 healthcare for 29 patients** LB asked if the Emergency care staffing review could be shared with CQRM om completion and noted ambulatory care had not had a staffing review for several years and the activity was now considerably higher. **New Action - JP to share Emergency staffing review when it has gone through internal processes in November.** LB praised the report. CM queried the £6M cost required for temporary staffing on page 3 of the report compared to 4million for staffing uplift quoted earlier in the report Is this correct? **New Action: JP to clarify the cost difference quoted on page 3 of the staffing report 4 million substantive compared to 6 million temporary staffing used** CM queried that the Women's & Children's Clinical Support Services review from last year and this year has identified that the workforce in place does not meet the demand, but no business case has been written or developed following the paper. CM would like a business case created to ensure that this is being monitored. **New Action – JP will speak to colleagues regarding why a business case was not raised in relation to the Women's and Children's Clinical Support Service and the lack of demand met by the present workforce.** **New Action – JP will follow up with the Deputy Chief Nurse regarding business cases in to the £6m staffing costs.**	

8.0	Quality Assurance Report (July 2025)	JP

Quality Assurance Report

PC took the report as read and covered key points:

- A lot of the metrics were met, but those that didn't were met within the usual variation limits.
- Duty of Candour is being audited more regularly, and more scrutiny is in place.
- Falls and the 'Stay in Bay' initiative is helping, with more work being done.
- A pilot has started using de-caffeinated drinks to help reduce falls. The results will help indicate if it is worth rolling out past the pilot stage/area in use.

The trust has created a Single Harm Action Plan which focuses on 3 areas Infection Prevention, Pressure Ulcers, and Falls. This is yet to be signed off but is proposed. This will help keep plans on track as one single harm plan.

There have been 4 Moderate harm Patient safety incidents reported– none of which have resulted in a change in patient treatment. 1 was in relation to treatment, and 3 were medication. The 3 medication were Community errors reported to UHNM.
There have been various deep dives at the Royal Stoke for theaters and infection Prevention metrics.
There are still issues with HSMR data but there are 2 new coders being trained, but they do not work independently yet.

Work is being done around the CEF process and bronze ward panel, and this is hoping to be extended to silver panels.

More work is ongoing in relation to Endoscopy and conscious sedation procedures.

The HSMR data remains high and is still thought to be due to a backlog of coding and is being worked on by UHNM coders. The statistics displayed are concerningly high, as raised by CM/LB. CM received communications from NHSE regarding this. Executives at UHNM and SSoT ICB are aware of this.

LB discussed the maternity Friends & family has dropped to 79%. LB asked for clarity about this as there wasn't much information as to why it has decreased.

CM and JM recently attended the System Mortality forum and spoke regarding HSMR as it was raised for concern at the forum. CM was able to provide assurance with support from JM regarding this and assured that the main issue is coding. CM praised that JM was very helpful.

CM raised that within the report there was a loss of codeine which appears to have been stolen. JP was part of the audit. A person of interest was identified and is being dealt with by UHNM HR as the police do not feel like they have grounds to be involved.

New Action – PC will ask UHNM colleagues about the decrease in Maternity Friends & Family feedback and get an understanding as to why it has decreased, and actions taken.

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Endoscopy incident themed review This review will come in October and will incorporate all the new policies procedures.		
9.0	**System wide audit on quality of discharge communication and medicines reconciliation update**	JP
As discussed under action 210. [redacted] will follow up with JM for an update.		
10.0	**Monthly Performance Report (July 2025)**	WS

Monthly Performance Report

WS took the report as read.

WS emailed an update to CM/LB at the start of the week in relation to the Plain film x-ray.

LB raised the NOUS (non-obstetric ultrasound) data and asked about the new triage process, as the numbers don't seem to be reducing. WS confirmed that the numbers have reduced, from 10,700 in the last report to around 8000 in the most recent data. The backlog position has improved and over 1000 patients have been discharged after the last Clinical Review.

The Gynecology pathway appears to not be getting utilised as the patients should be going to Health Harmonie before UHNM. This number has been reduced but it should happen. This has been presented to Primary Care (SSoT ICB) and is being reviewed.

NOUS is the big concern currently and the waiting list is reviewed often.

The trust has appointed more Sonographers to support NOUS. WS will update and provide a deeper trajectory in relation to NOUS by sending some slides to CM/LB.

Urgent care indicators have improved since June 2025 but are not at the desired level.

CM confirmed that the main trigger for NHSE intervention was due to NOUS numbers. CM assured NHSE that UHNM has a strong triage system.

Patients are informed that there is a longer wait than normal. LB asked what the longest wait is? WS confirmed it is around 12-14 weeks. WS confirmed that the longest waiters are reviewed/triaged very regularly.

CM asked what is being done differently to improve appraisal numbers? This had a large impact during the Covid-19 pandemic, but it has not since quite recovered. PC confirmed that long-term sick staff are included in the data, but they are looking to be removed so the actual number may be lower as it was queried at a recent forum.

New Action – JP will investigate the lower appraisal numbers to try and confirm what areas are the most affected and actions being taken.

52-week+ Harm Review Report (July) The report was taken as read. Harm reviews are at 63%, which is slowly improving, and more information is being received from specialties. Reporting systems are slowly being amended as the number of divisions has changed from 4 to 3. All the reports should have been amended by October. The trust is hoping that the harm review process will be completely online by the end of the year via the I-Portal. LB has raised that the Trauma has the biggest cohort of patients and completes the least reviews which need to be further addressed. CM raised that the Cancer rating at UHNM has been de-escalated out of tier-2 which is a positive note. AI tool for validation on waiting lists This was covered under Action 218.		
11.0	**PSII Highlight Report Q1**	PC
PC covered the report in detail and highlighted key points: There have been 48 incidents that required a PSRIF response. 2 of which were a PSII, but 1 was reported as a Never Event The Trust have carried out a PSRIF review and determined an action to develop a curriculum for patient safety training, which should be live in November. The complaints huddle has been implemented to keep staff informed of incidents/complaints that are ongoing and to ensure that they line up and that responses are timelier. A patient Liaise Framework was developed and there is a dedicated member of staff for this now. LB raised if the Never Event determined not to be one was requested to de-escalate from STEIS. LB will request the list of events open on STEIS from the ICB Patient Safety Lead, to ensure it matches what UHNM has opened. LB asked if the PSII plan/review has gone through the Quality Board before it is complete. PC confirmed it is not complete and will go through SSoT ICB sign off. LB raised that the PSII report used to include a summary table for incident learning, but it doesn't appear to have been included. It's [redacted]'s first time doing the report so it was agreed by all that it can be included going forward and not needed retrospectively. LB/CM asked that all PSII that are closed/approved are sent to the ICB data team to be closed on STEIS.		

New Action – LB will send over a list of all open PSII's on STEIS and PC will confirm which are open/closed and arrange to have learning added to STEIS to enable ICB team to close.		
12.0	**Forthcoming UHNM External Reviews**	**JP**
UHNM colleagues are not aware of any upcoming External Reviews.		
13.0	**Any Other Business**	**All**
CM raised the small improvements made to timely observations. It has only improved 5% since October 2024. The main concerns are about medicine and emergency medicine. CM asked if an improvement trajectory can be added as safe dashboards and vitals have now been rolled out. **New Action – PC to consider adding an improvement trajectory to the report for timely observations.**		

Next UHNM CQRM:
Thursday 16th October 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.

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Meeting	UHNM CQRM
Venue	Microsoft Teams
Date/time	Thursday 16th October 2025, 12:00-14:00

Attendees:		
Steve Fawcett (Chair)	Clinical Director, SSoT ICB	SF
Lindsey Boughey	Senior Clinical Quality Improvement Assurance Manager, SSoT ICB	LB
Mary Barlow	Lead Nurse for Quality & Patient Safety, SSoT ICB	MB
Fiona Bevan (Part meeting)	Clinical Director of Pharmacy, Medication and Controlled Drugs, UHNM	FB
Pippa Caldwell	Head of Nursing, Quality Safety & Compliance, UHNM	PC
Jane Holmes	Deputy Chief Nurse, UHNM	JH
Rebecca Huntley	Head of Patient Experience, UHNM	RH
Katie Leek (Part meeting)	Lead Nurse for Tissue Viability and Continence, UHNM	KL
Jamie Maxwell	Head of Quality, Safety & Compliance Department	JM
Joe Potts	Matron, Quality, Safety and Compliance, UHNM	JP
Emyr Phillips (Part meeting)	Associate Chief Nurse/Deputy Director (Infection Prevention & Sepsis), UHNM	EP
Haidee Sim (Part meeting)	Senior Sister for Infection Prevention & Sepsis, UHNM	HS
Warren Shaw	Strategic Director, Performance & Information, UHNM	WS

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

Apologies: AMM, CM,		
Cath Marsland	Associate Director of Quality and Patient Safety, SSoT ICB	CM
Angela Young	Assistant Director for Nursing & Quality, NHSE	AY
Ann Marie Morris	Deputy Medical Director, UHNM	AMM

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

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3.0	ICB Leadership Compact	
[redacted] covered the leadership compact and all adhered.		
4.0	**Minutes from the previous meeting: 18th September 2025**	
The minutes were agreed as an accurate representation of the meeting.		
5.0	**Action Log from the previous meeting: 18th September 2025**	
Action 202 - Clinical Digital Systems Risk: This was related to the EPMA Guidance under action 216. This information is now available online. (Closed) Action 204 - Action Plan for Urethral Splits and Pressure Ulcer Deep Dive for May 2025: This was covered under item 7. (Closed) Action 206 - Endoscopy June 2025 Agenda Item: The deep dive is going through internal processes and will be deferred to November CQRM. (Open) Action 210 - System wide audit on quality of discharge communication and medicines reconciliation: This was presented under agenda item 9. (Closed) Action 216 - EPMA Guidance: This information is now available online and available to staff as part of the training and use of the system. (Closed) Action 218 - AI Tool for validation lists: This was covered under item 10.1 (Closed) Action 219 – Q1 104-day Cancer Team presence at CQRM: This will be reported in November. (Open) Action 220 - Error in relation to Network Service Division: [redacted] has not had chance to investigate this yet. Actions 220-225 will be merged into 1 action as it all relates to the same subject. (Open) Action 221 - staffing review – November: [redacted] has not had chance to investigate this yet. Actions 220-225 will be merged into 1 action as it all relates to the same subject. (Closed)		

Action 222 - Cost difference in staffing report - £4m to £6m: JP has not had chance to investigate this yet. Actions 220-225 will be merged into 1 action as it all relates to the same subject. (Closed) Action 223 - Business cases relating to increasing staffing levels: JP has not had chance to investigate this yet. Actions 220-225 will be merged into 1 action as it all relates to the same subject. (Closed) Action 224 - Women and Children's Clinical Support Service lack of demand met: JP has not had chance to investigate this yet. Actions 220-225 will be merged into 1 action as they relate to the same subject. (Closed) Action 225 - Business Cases in relation to the £6m staffing costs: JP has not had chance to investigate this yet. Actions 220-225 will be merged into 1 action as it all relates to the same subject. (Closed) Action 226 - Decrease in F&F feedback: This was covered under item 8. (Closed) Action 227 - Lower appraisal numbers: An update will be brought in November. (Open) Action 228 - STEIS not matching to ICB figures regarding PSII's: LB has addressed this with JM outside of the meeting. (Closed) Action 229 - trajectory for timely observations medicine/emergency medicine: PC to look at having an improvement trajectory. (Open)		
6.0	**Monthly HCAI Report (August 2025)**	**EP/JP**
EP took the report as read and highlighted key points: • There was 1 MRSA Bacteraemia. A meeting was held, and it was determined unavoidable with no lapses in care. The patient had been in a workplace accident and came in with MRSA. • CDIFF Cases are at 85 against a target of 60, and there have been a lot of repeat patients. • E-Coli is at 96, against a target of 96. • Sepsis screening is at 100%, but anti-microbial prescribing had decreased.		

- There were 50 Covid-19 cases, but this has since decreased to 32. Mask wearing in emergency portals was implemented to help prevent transmission.
- There has been a large number of Flu-A & Flu-B cases, but this is earlier than usual.
- There have been 68 cases of Influenza.
- There has been a case of RSV.
- There has been 1 norovirus case.
- There was 1 suspected case of Measles, but this was confirmed as negative.
- Vaccine uptake so far has been very good amongst staff, and a push is needed for inpatients and those going into care homes.

HCAI Quarterly CDIFF Action Plan

The document was taken as read.

LB raised that the report was missing the action for the repeat sampling of patients that already had CDIFF. It is often at the discretion of microbiologists and GPs. HS will add this into the action plan.

7.0	**Urethral Split and pressure Ulcer deep dive**	KL

The report was taken as read by KL and highlighted key points:

The deep dive was done over the last 12 months which identified that body locations were unchanged. Buttock', Sacrum and Coccyx were the most affected areas. The number of cases (with and without lapses) has risen for ECC over the past few years. No lapses were identified in Critical Care Pods 3-6 cases for 2 years until Jul-24 – issues with the new electronic system have been raised. A long list of improvement actions was presented including asking wards to now do self-audits.

KL confirmed that there are new Trezzo mattresses being used in Royal Stoke ED now. There are 11 trolleys which are still missing some, but they will soon be swapped over. This hasn't happened yet due to a supplier issue. Once this is resolved the mattresses will be rolled out to County ED.

There has been a slight downward trend in the number of incidents, which is positive.

Harm-free Educators have been in post for just over 12 months, which has shown some good improvements.
A champions program has just been introduced; this offers quarterly education teaching on tissue viability and incontinence.

An Electronic Wound Assessment has been introduced and a skin booklet and management of wounds.

The data is monitored monthly for pressure ulcers and lapses in care, and this goes into the report. This number has decreased significantly compared to previous years.

LB asked if the trust has got an over-arching action plan? There is a single Trust standardised action plan for harm free care, pressure ulcers is one of these harms. An update will be brought back in 6 months.

8.0	Quality Assurance Report (August 2025)	JM/PC

Quality Assurance Report

The report was taken as read and PC discussed key points:

There are four areas where the metrics are failing and that is the Single-Sex breaches, VTE's, HSMR and Emergency Department friends & family. Work is on-going with falls prevention initiatives such as 'stay in the bay.'

EPMA has now been implemented at the County Hospital therefore compliance with VTE risk assessments should improve in time.

LB asked about HMSR and if there were any other indicators that could be monitored for assurance.

JM advised that improvements have been made in April-May for Mortality, and it will slowly get better in time. Crude Mortality has stayed the same, but again this will improve. There has been no systematic or thematic issue identified. This further shows that main issue is coding, and JM is continuing to look at the submission of data.

JM confirmed that there is a delay between the first submission and the final submission of the SUS date. A further update will be provided to the Mortality Review Group for assurance that there are no major issues. This data/assurance will also be included as part of the next Mortality report. JM confirmed that internal Executives and non-Executives are discussing this and asking for updates. Updates also go through Quality Access, and Outcomes Committee.

LB asked if there was an update on NPSA alert for bed rails? PC advised it was presented this week at UHNM internal forums and JP is waiting for a response. There were a few queries raised, and responses were sent. It will go to Executives for sign-off once complete. There was a request to put this training back onto ESR so this will happen soon. Then the alert will be closed.
MB asked about timely observations and were there any other audits completed on effectiveness of improvement actions. PC advised the timely observation audit is done via CEF.

Endoscopy incident themed review

This has been deferred.

9.0	Clinical Digital System - EPMA	JM

SF asked how EPMA implementation is going and FB confirmed that there was a pilot on ward 15 which went live in early September. As of this week the whole County Hospital now uses Electronic medical prescribing. The prescribing and administration side has gone well and the overall feedback from staff is that it is better. Drug rounds are much clearer from an internal process perspective. A new discharge letter was created which includes clinical narrative, but

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FB confirmed that there won't be a huge improvement in the early days. FB confirmed that electronic medicinal prescribing elements have been live in over 30 hospitals across the country. The Clinical narrative element is only live in 4 hospitals including UHNM.
All medical wards and A&E have now gone live at County site. The next areas are at Royal Stoke with Maternity 27th October then the medical wards in November and Day Care Surgery, and Elective Medical.

FB also confirmed that the Emergency Department at County is also included in the electronic prescribing and has been live just over a week in ED.

Part of the delay has been getting this interface to run smoothly, but it will improve in time. It is pulling the medicinal data, but it can be confusing for GP's, so the trust is working with these to ensure clarity.

Staff have confirmed that access and training has been seamless, and the trainers are very knowledgeable.

FB also confirmed that they will be able to specifically check how many doses of a certain drug, for example A&E would have issued and be able to link this to patients. As a system the use of Opioids is under scrutiny so this would help with that.

SF asked if NS (Nutritional Supplements) will be able to be tracked also? FB is not, would need to investigate it. SF asked if the new system has electronic transfer of prescriptions to community pharmacies? BF confirmed that they do not currently, but it is planned to happen down the line. The only trust in the country (Secondary Care) that has a functioning EPS is MPFT, via the Clio system. This is on hold from the Department of Health currently.

New Action – FB will find out Nutritional Supplements will be trackable via the new electronic prescribing system.

FB assured that in March once the system is live that they can do a paper talking about the journey, what's gone well and what hasn't, and what is yet to be delivered. SF raised that the main concern is the reduction of prescribing errors. This would be valuable to include.

New Action – FB to present an update paper on EMPA implementation in March 2026.

10.0	Monthly Performance Report (August 2025)	WS

Monthly Performance Report

The report was taken as read and queries raised.

SF explained that the X-ray department has been sending duplicates randomly overnight, with some being months old. WS will check this.

New Action – WS will check with colleagues regarding the sending of duplicate X-Rays results to primary care.

LB confirmed that the main element of diagnostics is NOUS, and WS has sent lots of info which had answered this query.

WS discussed the Luna Rova AI tool which was implemented 2-weeks ago. It has identified 1442 pathways that should be able to be closed. They are not automatically closed but are reviewed by staff and a decision will be made.

A non-RTT cohort of the report will be made, alongside the regular RTT report.

52-week+ Harm Review Report (August)

The report was taken as read.

The harm review compliance is slowly increasing every month, with it now being at 72%. The system is slowly becoming electronic, but this will take time.

11.0	**Q1 Patent Experience Report**	RH

The report was taken as read, and RH discussed key points:

A new patient involvement staff member was recruited, and they are setting up the patient and carer leadership council. There was a 28% rise in formal complaints compared to Quarter 4 of the 24-25 year. There was also an increase in the escalations from PALS to formal complaints, up from 22. It's usually a 2% increase but was 4% this time. A larger piece of work is being done on this to look at the reasons why and whether any additional information is supplied when an escalation is made from PALS to formal complaint. RH will investigate this.
RH updated on a PHSO case LB had requested an update on - A complaint was made by a family member of a patient who was end of life and discharged without anticipatory medication, and the family member had to perform CPR. An apology letter was sent and compensation of £1250 was paid. A robust action plan has been completed and shared with the family.

The trust had moved to appointment only in the PALS team as there was a lot of aggression from patients who were unhappy around the waiting times from walk-ins. It seems to be working well, it started as a trail on the 1st October.

ICB colleagues asked for more information on ED FFT's. All modalities have also got text messages surveys, QR codes, post cards, paper surveys are all available which patients can use. One of the team attended the patient experience group to discuss this further and a representative is now going to attend the UHNM overarching patient experience group meetings going forward so they can work together on this. It is also on the Patient experience group action plan also.

LB praised the report and confirmed that the trust has got oversight of complaints, and that the trust is taking actions from feedback received as this is not always shown in other reports.

LB raised that on page 29 it is mentioned that the pressure ulcers are included by ward and LB asked if that is all pressure Ulcers? RH confirmed that is those that are category 2 and above and narrative is given.

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12.0	Forthcoming UHNM External Reviews	JP
There are no new reviews, and 2 were held last month. There was a BSI for hospital sterilisation and disinfection unit. There was also one minor conformity raised which will be responded to as part of the BSI inspection. The 2nd inspection was for Clinical Technology, and no non-conformities were raised.		
13.0	**Any Other Business**	**All**
There was no AOB raised.		

Next UHNM CQRM:
Thursday 20th November 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.

NHS
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Integrated Care Board

Meeting	UHNM CQRM
Venue	Microsoft Teams
Date/time	Thursday 20th November 2025, 12:00-14:00

Attendees:		
Steve Fawcett (Chair)	Clinical Director, SSoT ICB	SF
Lindsey Boughey	Senior Clinical Quality Improvement Assurance Manager, SSoT ICB	LB
Mary Barlow	Lead Nurse for Quality & Patient Safety, SSoT ICB	MB
Jane Holmes (part meeting)	Deputy Chief Nurse, SSoT ICB	JH
Pippa Caldwell	Head of Nursing, Quality Safety & Compliance, UHNM	PC
April Davies (part meeting)	Head of Cancer Services, UHNM	AD
Jamie Maxwell	Head of Quality, Safety & Compliance Department, UHNM	JM
Haidee Sim (Part meeting)	Senior Sister for Infection Prevention & Sepsis, UHNM	HS

In Attendance:		
N/A	**N/A**	**N/A**

Apologies: AMM, CM,		
Louis Finney (Minutes)	Business Support Officer, SSoT ICB	LF
Cath Marsland	Associate Director of Quality and Patient Safety, SSoT ICB	CM
Angela Young	Assistant Director for Nursing & Quality, NHSE	AY
Ann Marie Morris	Deputy Medical Director, UHNM	AMM
Rebecca Huntley	Head of Patient Experience, UHNM	RH
Emyr Phillips (Part meeting)	Associate Chief Nurse/Deputy Director (Infection Prevention & Sepsis), UHNM	EP
Joe Potts	Matron, Quality, Safety and Compliance, UHNM	JP
Warren Shaw	Strategic Director, Performance & Information, UHNM	WS

No	Item	Action Lead
1.0	**Introductions & Apologies.**	
	SF introduced all to the meeting and announced apologies as noted above.	

2.0	Declarations of Interest	
None to report.		
3.0	**ICB Leadership Compact**	
SF covered the leadership compact and all adhered.		
4.0	**Minutes from the previous meeting: 16th October 2025**	
The minutes were agreed as an accurate representation of the meeting.		
5.0	**Action Log from the previous meeting: 16th October 2025**	
Action 206 - Endoscopy June 2025 Agenda Item: This was discussed and a verbal update was given during the meeting. (Closed) Action 219 – Q1 104-day Cancer Team presence at CQRM: This was discussed. (Closed) Action 220 - Error in relation to Network Service Division: LB will chase with JP. (Open) Action 227 - Lower appraisal numbers: LB will chase with JP. (Open) Action 229 - trajectory for timely observations medicine/emergency medicine: This has been discussed in several internal forums, and a new group is being put together. PC will bring an update if needed. (Closed) Action 230 - Nutritional Supplement prescribing tracking via electronic prescribing system: PC will chase for an update. (Open) Action 231 - EPMA Implementation March 2026: This is due in March. (Open) Action 232 - Duplicate X-Rays results: This has been addressed. (Closed)		

6.0	Monthly HCAI Report (September 2025)	████/███

██ discussed the report and highlighted key points:

- There were 0 recorded MRSA Bacteraemia.
- CDIFF is at 97 cases, against a target of 72. ██ confirmed that there is an ongoing work as there are a lot of repeat samples, this is being closely monitored.
- E-Coli is at 121, against a target of 116.
- Sepsis screening is above 90% for all contracted areas, but delivery antibiotics remains difficult to achieve in ED at Royal Stoke. There are no concerns in other Emergency/Inpatient areas.
- There were 50 Covid-19 cases reported at the last meeting, this has now reduced. Mask wearing in Emergency areas remains as an advisory.
- Flu Cases are still rising and have been rising around 6-weeks early and there are 24 cases reported by today's meeting.
- There are 11 RSV cases and 0 Norovirus cases.
- Vaccination uptake remains good amongst health care workers and work is ongoing for inpatients, long term patients and those going into care homes.

██ praised that Maternity is at 100% compliance for Sepsis.

New Action - ██ raised that the charts for Flu and others don't appear to be within the report for this year, they are all last years. ██ acknowledged this and will raise it with ██ to update the report.

7.0	Quality Assurance Report (September 2025)	██

<u>Quality Assurance Report</u>

██ took the report as read and discussed key details:
EPMA has now been rolled out at Royal Stoke site, now in the second or third week of the roll out.

- VTE has not met the target but has been improving. The rollout of EMPA will support the improvement.
- Vitals have been improving, and a Working Group will be working to create a plan to meet the trajectory and develop a timeline for areas to achieve.
- Friends and Family in ED, and Single Sex breaches has not been met, but feedback has been taken on to the teams.
- HSMR and SHIMI remains of concern and above target thought to be regarding the coding issue.
- There were 10 calls for concerns, of which 1 prompted a treatment plan review which didn't result in a change. Calls for concern are being used more by staff, which is good to see.

██ asked about the bed rail alert which is now 18 months overdue. It has been improved at the MLOG (Mandatory Learning Oversight Group) and is slowly being progressed and should be closed soon.

SF asked regarding PSII process. JM explained that it is still uploaded onto STEIS. As the Trusts Incident reporting system needs a further upgrade to align to LFPSE. Once the investigation is completed it is signed off thought the Trusts internal processes. The ICB Patient safety team will be informed it can be closed, and learning is uploaded to STEIS. Learning is also added to the PSIRF report shared at CQRM.

7.2 Endoscopy Incident Themed Review

JM Advised the report required annonymising, so would provide a verbal update: A Thematic review was complete following harms identified as part of patients waiting for their Endoscopy treatment. 7 cases were investigated, of which some had no harm, some had moderate, and some were severe. The harm that has taken place may have come from waiting times according to the reviews. The PSIRF approach was used using SEIPS looking at different factors such as environment, internal, external etc. It was identified that external recovery and capacity within the organisation to meet the demand are the main focuses. A business case has been put forward to try and improve this and the proposed changes would be additional staff within the booking team, those working in the unit and the temporary staff. Funding was given by NHSE to create a unit that would work on backlog recovery. Progress is identified within the report and assurances are made within the report to ensure that the recovery is monitored. JM will provide an updated version of the report following the meeting.

LB praised the report and the use of the PSRIF system.

8.0	Deep Dive Mental Health Absconsion	

JM took the report as read and provided if for information.

LB and MB praised the report and the use of the PSRIF system to help pull this together.

JM confirmed that these reviews are monitored within the trust.

MH Thematic Review

As discussed above.

9.0	Monthly Performance Report (August 2025)	WS/HW

9.1 Monthly Performance Report

There was nobody available from the Performance Team. Queries were sent via email to WS outside of the meeting.

9.2 52-week+ Harm Review Report (August)

There was nobody available from the Performance Team.

9.3 Q1 104-day Cancer Report

AD discussed the report and highlighted key points:

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There were 76 urgently suspected cancer GP referrals treated beyond 104 days at UHNM. There were also 27 consultant upgraded/screening cancer patients treated after 104 days. Totaling 103 for Q1. This is an increase of 8 from Q4 24/25.

The main delay reasons are attributable to capacity constraints within the trust. It was patients receiving surgery as their treatment modality who had the highest volume.
Of the patients treated over 104 days and the specialty with the highest number of breaches for the quarter was urology at 35 which was the same as the previous quarter. 9% of delays for patients being treated after 104-days were those choosing to wait longer.

The report includes a further analysis of the 104-day cohort of patients, the open cancer pathways and the volume of patients waiting over 104 days on their pathway. the report also provides an update on plans to target the reporting and oversight of those patients and that will be towards patients receiving chemotherapy as their first definitive treatment over 104 days. Patients where there has been a change in pretreatment, staging and post treatment staging and patients who are receiving palliative treatment as their first definitive treatment as well.

AD discussed that the total completeness of the harm reviews is at 37%, and those reported are the ones that were completed.

LB raised that on page 7 there are charts which indicate the harm ongoing, but it does not specify the harm, so colleagues are unable to see how Clinicians determine that harm. The report doesn't clarify whether the harm is because of progression of the disease or due to treatment delays. AD assured that they are working to be more descriptive and trying to get as much data as possible for the report. Part of the learning of the next report will be supporting Clinicians to ensure that they identify the source of the harm within those reported. AD assured that the report provided to the Clinicians will include enough information for them to make a confident decision.

SF raised that Duty of Candour and asked if it had been completed. AD confirmed where appropriate it had been.

MB asked if the under-reporting is being pressed to ensure that the process is improved? AD confirmed that this is being worked on.

MB raised concern around the 8 patients who had come to harm and are the trust identifying the themes/trends that are indicating the source of the harm. AD assured that the trust does have the themes/trends and these are considered.

LB asked if Mitigating actions can be included for those who have come to harm to help reduce these incidents in the future. AD confirmed that this will be included in the next report.

New Action – AD will provide the Q2 report for the next meeting in January, including any learning actions from the harm reviews.

9.4 NOUS and Radiology Reporting Delays

An update was not ready at the time of the meeting and will be provided W/C 24th November 2025. LB confirmed that Cath Marsland (SSoT ICB) had discussed this outside of the meeting. LB is not aware if a meeting has been put into place.

An update will be obtained outside of the meeting. WS will chase.

New Action – WS will chase colleagues for an update on NOUS reporting.

9.5 SNAP Latest Performance

An update was not ready at the time of the meeting. An update will be given on 26th November 2025.

LB will chase via email for an update.

An update will be obtained outside of the meeting. WS will chase.

New Action – LB will chase WS for an update.

10.0	**Mortality Annual Report**	RH

JM provided the Annual Report for information. Various updates were given around activity and where the trust lines up to the performance indicators are in place.

The reviews of outcomes of patients who have waited 12 hours or more in ED is included and still being monitored. The SJR's completed indicate positive results and outcomes.

During 2024-25 there were 4 preventions of future deaths which were submitted with information available on the judiciary website.

Key recommendations were made around coding for key mortality indicators and improving completion rates of SJR's. Since the report came into place, the senior nursing team has started to have input into the care forums.

LB praised the report and liked the actions and actions completed.

Mortality Q1 Report

SF discussed the chart that is displayed on Page 6 (the rolling 12-month data) as it seems to be quite high. JM commented that it is mainly down to a coding/admission issue and it will continue to decrease as more data is uploaded. There are concerns within the organisation as the Executive Team are raising the same concerns.

JM discussed that the mortality data for up to July has been complete and the indicators haven't decreased a significant amount. An update is being sent through internal forums next month from clinical coding to provide an update. Additional indicators are being considered that may have an effect.

SF raised concern over the HSMR and SHIMI data as it appears to be decreasing quite slowly even with the coding being updated. JM confirmed that this is something also being picked up by the Non-Exec Team and Quality Team at the trust. A deeper understanding is being sought as there isn't complete clarification yet for these high numbers. JM discussed the report in detail and answered any additional queries. JM is currently working on the Q2 report which had additional information and will be shared at the next CQRM.		
11.0	**Forthcoming UHNM External Reviews**	JP
There are no upcoming External Reviews.		
12.0	**Any Other Business**	**All**
December's meeting has been stood down so the usual reports will be shared for information in December (Quality, Performance and Infection Prevention). JM will also provide an update on Clinical Coding and Mortality. **New Action: LF to obtain the usual reports and circulate when CQRM was planned.**		

Next UHNM CQRM:
Thursday 15th December 2026, 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.

NHS
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Integrated Care Board

Meeting	UHNM CQRM
Venue	Microsoft Teams
Date/time	Thursday 19th June 2025

Attendees:		
Mary Barlow (Chair)	Lead Nurse for Quality & Patient Safety, SSoT ICB	MB
Lindsey Boughey	Senior Clinical Quality Improvement Assurance Manager, SSoT ICB	LB
Jamie Maxwell	Head of Quality, Safety & Compliance Department	JM
Emyr Phillips (Part)	Associate Chief Nurse/Deputy Director (Infection Prevention & Sepsis), UHNM	EP
Joe Potts	Matron, Quality, Safety and Compliance, UHNM	JP
Haidee Sim (Part)	Senior Sister for Infection Prevention & Sepsis, UHNM	HS

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

Apologies:		
Cath Marsland	Associate Director of Quality and Patient Safety, SSoT ICB	CM
Angela Young	Assistant Director for Nursing & Quality, NHSE	AY
Pippa Caldwell	Head of Nursing, Quality Safety & Compliance, UHNM	PC
Steve Fawcett (Chair)	Clinical Director, SSoT ICB	SF
Ann Marie Morris	Deputy Medical Director, UHNM	AMM
Warren Shaw	Strategic Director, Performance & Information, UHNM	WS

No	Item	Action Lead
1.0	**Introductions & Apologies.**	
MB introduced all to the meeting and announced apologies as noted above.		
2.0	**Declarations of Interest**	
None to report.		
3.0	**ICB Leadership Compact**	
MB covered the leadership compact and all adhered.		

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4.0	Minutes from the previous meeting: 15th May 2025	
The minutes of the UHNM CQRM from 17th April 2025 were agreed as a true and accurate record. It was requested that page numbers be included on minutes going forward.		
5.0	Action Log from the previous meeting: 15th May 2025	
Action 193 - CQC Action Plan Review: Given that this is included as an item on the agenda it was agreed to close this action on the tracker. [Action Closed] Action 202 - Clinical Digital Systems Risk: An update on this action is not due to be reported on until October-25 and will remain open on the tracker until then. [Action Open] Action 204 - Action Plan for Urethral Splits and Pressure Ulcer Deep Dive for May 2025: JP advised that this has not yet been through assurance group however once this has been agreed it will be presented at UHNM CQRM in September-25. [Action Open] Action 205 - F&F Testing maternity: JM confirmed that the QR code has been in place since Jan-25 with only 17 QR Codes used across all touch points. [Action Closed] Action 206 - Endoscopy June 2025 Agenda Item: JP advised that work is still not completed yet and this will need to go through the Patient Safety Group for ratification. This will be presented at the Sept-25 CQRM. [Action Open] Action 207 - NOUS Wait times and recruitment paper June 2025: It was noted that the paper relating to NOUS wait times has now been received. [Action Closed] Action 210 - System wide audit on quality of discharge communication and medicines reconciliation: Papers have been included with the agenda however, representation to present is not available. JM agreed to ensure that a written update is provided, and updates given on where UHNM are against audits for September-2025. [Action Open] Action 211 - Complaints and PALs Report Q3 It was noted that this action has now been completed. [Action Closed] Action 212 - MSK Primary Care Referrals It was noted that there had been no update on this action yet, LB agreed to follow up with WS after the meeting. [Action Open]		
6.0	Monthly HCAI Report (April 2025)	
EP gave a detailed overview of information included in the HCAI Report for April-25. The following key areas were highlighted: - There were 2 MRSA Bacteraemia reported in April-25 and meetings to discuss in detail have happened for both with one being identified as avoidable due to actions not being followed		

appropriately through the maternity process. Several lessons have been learnt in Maternity and the MRSA screening policy for this area is being also being addressed.

- 12 cases of C-Diff have been reported in April-25 against a trajectory of 15.
- There are 14 COVID cases to date with an increase regionally with covid due to a new variant that is circulating throughout the summer period – there has been no changes in the acuity of covid.
- There have been 0 flu cases reported.
- 0 cases of norovirus have been reported however, NHSE are reporting that norovirus is still stubborn in the region.
- From a regional perspective, there has been significant cases of measles reported particularly around the Birmingham and Derby areas however, nothing yet in Stoke.
- There has been an increase in stomach bugs which is nothing out of normal expectations. A target threshold has been set for the coming year, and the report will be adjusted from June-25 with an emphasis on e-coli which has been raised with NHSE.
- Sepsis figures for April-25 have dipped on antibiotics within the hour at Royal ED as well as via other emergency portals, an improvement is expected following improvement work in this area.

It was noted that the HCAI Annual Report is currently with the Chief Nurse for approval and will be available at the UHNM CQRM in September-25.

7.0	System wide audit on quality of discharge communication and medicines reconciliation	

__Action__: As noted under agenda item 5.0, there is no representation to present this item so JM will obtain a written report on progress against this and report back to CQRM accordingly. — JM

JM also added that the implementation of electronic prescribing is awaited and UHNM are optimistic that this will happen this year.

8.0	Quality Assurance Report (April 2025)	

__Quality Assurance Report__

The group received the April-25 Report and it was noted that the Trust are generally doing well, there are a few areas that continue to be a challenge in terms of meeting targets i.e., DOC, Pressure Ulcers, VTE, Risk Assessments, Sepsis IV antibiotics, PSE, F&F etc. although targets are not being met, ~~this~~ these are ~~is~~ within the normal variation. JM added that PSIs with moderate harm have been looked at in more detail and there does not appear to be any significant changes in recent months, there is no area to note the increase, and this will continue to be monitored via the incident review process.

Further updates to note are as follows:

- 'Marthas Rule' is set to be trialed across Staffordshire following a roll out across other areas of the county first.
- Work is being undertaken around patients who abscond from ED, and this will filter through to PSIRF Meetings. MB added that work between trusts, i.e., NSCHT, MPFT and UHNM is being done to get a robust process in place ASAP.
- Work around sepsis management is underway and WMAS have recently undertaken a Sepsis review to assist with actions and joint learning.

- HSMR has risen to 131and UHNM is aware of the reasons for this which have been included in Mortality reporting. There is a backlog due to a recent loss of experienced coders, a paper will be submitted to the Mortality Review Group next week to look at raw data and internal monitoring – this will be shared as part of the Q4 Mortality Reporting submission in September-25.
- A completed risk assessment for child health MPSA Alerts have been completed and are due to be closed off.
- A purchase order for risks to TACO is underway and funding is being sourced. The newly revised prescription chart is also awaited.

CQC Action Plan

JM provided an update position of where UHNM are with CQC - actions identified and outstanding have all been closed. BAU processes and additional assurances have been sought and changed to green following a robust review and internal audit. The recent CQC inspections across the trust have provided no formal 'must do' or 'should do's.' This has now been closed off internally and is going through the usual processes.

9.0 Monthly Performance Report (April 2025)

Monthly Performance Report

The group received and noted the Performance Report for April-25.

52-week+ Harm Review Report

The 52-week+ Harm Review Report was received and noted by all.

NOUS Waiting Times and Recruitment Paper

The NOUS Waiting Times and Recruitment Paper was received and noted.

Action: Given that WS was not at the meeting, it was agreed that any questions relating to the performance reports should be sent via email outside of the UHNM CQRM. LB also agreed to link in with WS regarding MSK primary referrals. — ALL/LB

Q4 104-day Cancer Harm Review Report

The Q4 104-day Cancer Harm Review Report has been deferred to the July CQRM as Q3 has been submitted in error.

10.0 Fundamentals of Care Visits

ED Royal Stoke / County

Following visits to Royal Stoke and County ED in May-25, LB reported that both areas were much the same in terms of documentation not being fully accurate around fluid balance and pressure ulcer risk assessments with more gaps being identified at County. Reports from this visit will be going through Quality Governance Committees and a summary report is currently being completed by ICB with EDR reviews.

Around 50 patients were spoken to, which was beneficial in having feedback and waiting times seem to be accepted if all involved are kept up to date with care and treatment, which was one of the recommendations stated. JP advised that electronic assessments have improved in both Stoke and County areas, and monitoring continues to ensure a positive influence on documentation.

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11.0 **Forthcoming UHNM External Reviews**	
The group noted the following UHNM external reviews that have happened or are due to happen soon: - JAG accreditations visit last week. - Baby friendly accreditation/ assessments – work is being undertaken this week. - GIRFT – 19/06/25 JM agreed to include updates on external events noted above at the next UHNM CQRM.	
12.0 **Any Other Business**	
Nothing to report.	

Next UHNM CQRM:
Thursday 17th July 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.

Staffordshire and Stoke-on-Trent Integrated Care Board

Meeting	UHNM CQRM
Venue	Microsoft Teams
Date/time	Thursday 17th July 2025, 12:00-14:00

Attendees:		
Steve Fawcett (Chair)	Clinical Director, SSoT ICB	SF
Mary Barlow	Lead Nurse for Quality & Patient Safety, SSoT ICB	MB
Lindsey Boughey	Senior Clinical Quality Improvement Assurance Manager, SSoT ICB	LB
Pippa Caldwell	Head of Nursing, Quality Safety & Compliance, UHNM	PC
Jamie Maxwell	Head of Quality, Safety & Compliance Department	JM
Emyr Phillips (Part)	Associate Chief Nurse/Deputy Director (Infection Prevention & Sepsis), UHNM	EP
Haidee Sim (Part)	Senior Sister for Infection Prevention & Sepsis, UHNM	HS
Warren Shaw	Strategic Director, Performance & Information, UHNM	WS

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

Apologies:		
Cath Marsland	Associate Director of Quality and Patient Safety, SSoT ICB	CM
Angela Young	Assistant Director for Nursing & Quality, NHSE	AY
Ann Marie Morris	Deputy Medical Director, UHNM	AMM
Joe Potts	Matron, Quality, Safety and Compliance, UHNM	JP

No	Item	Action Lead
1.0	**Introductions & Apologies.**	
SF introduced all to the meeting and announced apologies as noted above. Ann Marie Morris, Joe Potts,		
2.0	**Declarations of Interest**	
None to report.		

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3.0	**ICB Leadership Compact**	
SF covered the leadership compact and all adhered.		
4.0	**Minutes from the previous meeting: 19th June 2025**	
The minutes of the UHNM CQRM from 19th June 2025 were agreed as a true and accurate record. It was requested that Amendments: Page 2 – The minutes narrative reads April and not May. There are tracked changes that need confirming on page 5.		
5.0	**Action Log from the previous meeting: 19th June 2025**	
Action 202 - Clinical Digital Systems Risk: No update needed. (Open) Action 204 - Action Plan for Urethral Splits and Pressure Ulcer Deep Dive for May 2025: No update needed. (Open) Action 206 - Endoscopy June 2025 Agenda Item: No update needed. (Open) Action 210 - System wide audit on quality of discharge communication and medicines reconciliation: This action will be brought back in September. (Open) Action 212 - MSK Primary Care Referrals WS is investigating this for an answer. It was in relation primary care referring direct for MRI scans and not stopping referrals to MSK It was querying why GPs are stopped doing direct referrals for MRI scans. LB advised the ICB did a QIA on referring to MSK and physiotherapy 1st unless clinically indicated therefore to be closed. (Closed) Action 213 – System Wide Audit Same as action 210, to be closed. (Closed) Action 214 – MSK Referrals Same as action 212, to be closed. (Closed)		

6.0	Monthly HCAI Report (May 2025)	EP
EP discussed the report in detail and highlighted key points: • There were 2 MRSA Bacteraemia in May. A meeting has been held for one and it was determined unavoidable as all policies followed. There is a meeting scheduled next week for the 2nd one. • There were 26 CDIFF cases against a target of 30. • There was 1 positive Norovirus case which is unusual for this time of year. • There was 1 suspected case of Measles which was negative. Birmingham have had a lot of cases of Measles. • Seeing quite a lot of Campylobacter cases which is expected due to warm weather and BBQs. • The trust has seen an increase in MRSA Bacteraemia cases in the community, which has been linked to dental cases in months prior. This is being investigated. • There is an IGAS meeting next week, so there is no current update. • The trust is now planning for the winter Flu-Vaccination campaign. The Trust have undertaken a Sepsis thematic review. JM has taken it through various internal forums. The trust has approached WMAS to ensure that learning is shared across emergency teams and the ED department. WMAS have advised they have completed their own review of Sepsis and have shared the report only last week, so it is still being reviewed. EP raised that there have been cases of patients in the East Midlands who have Botulism infection from what appears to be back street Botox injections. **New Action – EP to bring the Sepsis thematic review to CQRM in September and update on learning identified by WMAS.** **<u>Annual HCAI Report</u>** HS discussed the report in detail and highlighted key points: The report has been written in line with the ten criteria as outlined in the Health and Social Care Act 2008 Code of Practice in the Prevention and Control of Infection (updated 2022). • At the end of 2024-25 CDIFF Trust acquired cases were at 169 against a trajectory of 179. It has not reduced as much as EP/HS were hoping but it is still a decrease. The trust is working with internal and external colleagues and have a CDIFF action plan in place. • Bacteraemia cases are increasing nationally so this is a big focus. • The cleaning manual has been launched, and implementation is being led by the Matron for Estates/Quality. • The PLACE inspection had good ratings for Royal Stoke and County. • Anti-Microbial targets were all achieved and is being worked on further. • FFP3 Fit Mask training is in place and the trust are ensuring all staff are following health and safety requirements.		

SF praised that the report is very good, but that the index could use some improvements. Sepsis isn't mentioned at the end of the report in the conclusion, despite being one of the major challenges for the trust. HS will update the report. LB praised the report and said it demonstrates how much IPC work the team do within the trust. It is also interesting to see the large number of groups/forums IPC support. Congratulations were given to EP for winning the Chief Executive award. It was for the response to a recent infection outbreak and how it was handled. **HCAI Quarterly CDIFF Action Plans** Targets are just under trajectory, but the focus is on CDIFF and E-Coli. It is brought to IPCC every 2-months.		
7.0	**Quality Assurance Report (May 2025)**	JM
Quality Assurance Report JM spoke through the report in detail and highlighted key points: • The report has been through internal processes, BAU. • Pippa Caldwell has put together this report and has done a great job. • Performance is slightly improving alongside CQC ratings. • The dashboard highlights acceptable assurances, and less indicators are below target. • Improvements are being sustained in Maternity Triage and the induction of labour indicators. • Sepsis has improved alongside anti-biotic treatment for Inpatients, except for Royal Stoke ED where work continues to improve As of yesterday, there is a new Oversight Group for mandatory training, therefore the new bed rail training needs approval at this group before closure of the outstanding patient safety alert for bed rails. JM has managed to acquire the funding for a Prescription for Transfusions chart which will ensure compliance with the Blood Transfusion NPSA alert. JM just needs to raise the purchase order. The cost is around £600. SF highlighted that VTE screening has been decreasing but JM confirmed that it is the way it's being recorded, and once EPMA is live this should be addressed. **HAT Deep Dive Report** PC discussed the report in detail and highlighted key points: There are 21 cases where VTE risk assessments weren't completed within 12 hours, but completed afterwards, or partially. 5 Were not complete at all. These are being investigated. There were some patients who had missed doses; some were clinically indicated due to the risk of increased bleeding.		

The introduction of the Electronic Prescribing and Medicines Administration (EMPA) pilot starts in a few weeks. Once this is in place it won't be possible to progress without a complete VTE risk assessment which will improve to 100% compliance. Despite delays or omissions in the completion of the VTE risk assessment, all these patients had the appropriate thromboprophylaxis prescribed from admission. **New Action – JM will enquire for a guidance document in relation to EPMA to share with the group.**		
8.0	**Monthly Performance Report (May 2025)**	WS/JP/RW
Monthly Performance Report The report was taken as read. LB raised the question around plain film X-ray's having a 28-day time scale for results back to GP's. WS stated that this is temporary and that it will improve. **New Action – WS will enquire for an update on the Plain film X-ray reporting. An update to be sent prior to the next CQRM.** NOUS- A paper outlining actions was received at CQRM last month. The back log will take a while to clear. 52-week+ Harm Review Report The report was taken as read. LB raised that most specialties have been more engaging recently completing the harm reviews. Except for Orthopedics. WS is pushing Orthopedics more as they have the largest cohort and have completed the least harm reviews. SF highlighted that Radiology had also fallen short compared to others. WS confirmed the use of an AI (Artificial Intelligence) tool called Rova, should have started last month but there was a delay. It is being used in many trusts and should be live soon. It will be used to validate waiting lists. It should have a large impact as it will automatically filter patients based on severity of condition and prioritise patients. SF and MB requested more information about the new system. **NEW action: WS to bring a briefing paper to September CQRM regarding the AI tool for validation on waiting lists.**		

Q4 104-day Cancer Harm Review Report More harm reviews were completed than in previous quarters. There are 2 harms noted in the report, but it doesn't say what they are. **New Action: JM/WS will speak with UHNM colleagues about ensuring that someone attends to present the report. It will be brought back in September.**	
9.0 Q4 Mortality Report	
JM discussed the report in detail and highlighted key points: The MRG (Mortality Review Group) has been receiving assurance from the local M&M (Mortality & Morbidity) group that key actions and learning are being shared and identified. Mortality indices indicate that SHMI and HSMR have increased statistically higher than the expected range. On review there are issues with clinical coding and capacity. Not all patient records were fully coded, leading to a backlog. Consequently, while all hospital deaths were fully coded, the coding for other patient activities was not consistently accurate. Thus, while all patients dying from a given diagnosis were coded, all patients admitted with the same diagnosis were not necessarily coded, meaning percentage deaths from a given cause may not be accurate. There has been increases in number of patients being recorded under U-codes or R codes (diagnosis and comorbidities not fully coded) and this impact the standardisation as not reflect full mortality risks. From April all activity will be coded but this won't be seen in the HEAD system until August due to the time lag. The trust will be reviewing monthly mortality indicators to monitor improvements as the backlog of coding is completed. There have not been any changes in outcomes to SJR's or mortality reviews. The report also provides update on the SJRs being completed to assess the care and impact on patients' outcomes with 12 hours or more in the Emergency Department as part of their final admission. None of the completed reviews have identified that the long time spent in the Emergency Department contributed to the patients' outcomes but there have been some themes / learning identified. The requirement to undertake additional SJRs has now been agreed with the ICB to stop and have been used to inform the UEC Improvement programme. The trust has received two PFD reports from the HM Coroner and the trust has responded to the coroner. This information has also been uploaded to the HM Judiciary Website. Coding issues are affecting Mortality assurance, which has been downgraded to partial assurance for the time being. Outcomes on SJR's do not note any significant changes, and most are reported as good.	

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Questions were asked internally whether this is down to coding and a review was done. Death count is as expected but "expected death count" has come down by around 1000. The coding team have had a staff shortage for the last 12 months but have got several trainees. Due to being trainees, they don't have their own coding workload and won't until they are fully trained. Changes to coding should improve as time goes on as it is undergoing internal scrutiny.		
10.0	**Forthcoming UHNM External Reviews**	
There are 2 GIRFTS coming up: General Surgery and Urology.		
11.0	**Any Other Business**	
August' meeting is being stood down due to Quoracy.		

Next UHNM CQRM:
Thursday 18th September 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.

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Meeting	UHNM CQRM
Venue	Microsoft Teams
Date/time	Thursday 15th May 2025

Attendees:		
Steve Fawcett (Chair)	Clinical Director, SSoT ICB	SF
Mary Barlow	Lead Nurse for Quality & Patient Safety, SSoT ICB	MB
Lindsey Boughey	Senior Clinical Quality Improvement Assurance Manager, SSoT ICB	LB
Jamie Maxwell	Head of Quality, Safety & Compliance Department	JM
Emyr Phillips (Part)	Associate Chief Nurse/Deputy Director (Infection Prevention & Sepsis), UHNM	EP
Joe Potts	Matron, Quality, Safety and Compliance, UHNM	JP
Haidee Sim (Part)	Senior Sister for Infection Prevention & Sepsis, UHNM	HS
Warren Shaw	Strategic Director, Performance & Information, UHNM	WS

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

Apologies:		
Cath Marsland	Associate Director of Quality and Patient Safety, SSoT ICB	CM
Angela Young	Assistant Director for Nursing & Quality, NHSE	AY
Pippa Caldwell	Head of Nursing, Quality Safety & Compliance, UHNM	PC
Ann Marie Morris	Deputy Medical Director, UHNM	AMM

No	Item	Action Lead
1.0	**Introductions & Apologies.**	
SF introduced all to the meeting and announced apologies as noted above.		
2.0	**Declarations of Interest**	
None to report.		
3.0	**ICB Leadership Compact**	
SF covered the leadership compact and all adhered.		
4.0	**Minutes from the previous meeting: 17th April 2025**	

The minutes of the UHNM CQRM from 17th April 2025 were agreed as a true and accurate record.

5.0 Action Log from the previous meeting: 17th April 2025

Action 182 - BI-Annual Establishment Report: It was agreed a further establishment report will now have been undertaken and superseded this action. This will come to CQRM following going through UHNM Internal processes. (Closed)

Action 193 - CQC Action Plan Review: This paper is currently being reviewed by UHNM colleagues. (Open)

Action 202 – Clinical Digital Systems Risk – This item will be brought back in October. (Open)

Action 203 – I-Gas Outbreak - This was complete. (Closed)

Action 204 - Action Plan for Urethral Splits and Pressure Ulcer Deep Dive for May 2025 – This action is in progress. JP will provide an update before the next meeting. This will go through the patient safety group so ICB colleagues will see it. This may go on July's agenda. (Open)

Action 205 - F&F Testing maternity – Details will be passed to LF for inclusion. (Open)

Action 206 - Endoscopy June 2025 Agenda Item – This item will be brought in June. (Open)

Action 207 - NOUS Wait times and recruitment paper June 2025 - This item will be brought in June. (Open)

Action 208 - 52 ww Harm Reviews update May 2025 – This will be covered under item 9.2. (Closed)

Action 209 - Reg 28 pre-meeting circulation – On agenda for discussion. (Closed)

6.0 Monthly HCAI Report (March 2025)

EP discussed the report in detail and highlighted key points:

- There was 1 MRSA Bacteraemia which was deemed avoidable. The patient was admitted with a leg wound and wasn't swabbed on admission. If the patient has had been swabbed, then it potentially could have been avoided. An alert was sent trust-wide for this.
- CDIFF cases at year end was 169 against a target of under 179.E-Coli at year end there were a total of 246, against a target of 246. The ICB is continuing to lead a piece of work across the health economy as we are quite high nationally.
- Winter infections appear to have reduced to negligible levels.
- There are currently 5 Covid-19 cases, with 1 Flu-A and 1 RSV as inpatients.
- There are currently 0 cases of Noro-Virus.
- I-Gas is ongoing.
- Measles has increased in the Birmingham area and there was 1 suspected case last week, which was negative.
- Sepsis screening and IVAB's administration compliance is improving, with lots of work ongoing.
- Work continues in ED to reduce the prescribing of Co amoxiclav.

LB raised that ED improvement on Sepsis is good to see.

MB raised that Screening is improving which is good to see.

7.0	System wide audit on quality of discharge communication and medicines reconciliation	
	This update was not received - JM will pick this up with colleagues. **ACTION: JM to request Pharmacy lead to present and update following System wide audit on quality of discharge communication and medicines reconciliation.**	JM
8.0	**Quality Assurance Report (March 2025)**	
8.1	**Quality Assurance Report** The report was taken as read and JM discussed key details: JM confirmed that there was a CQC inspection in March to the Nuclear Medicine department which went well with no concerns raised. LB advised it was good to see the Pressure ulcer assessment documentation was being reviewed in ED as it was an area picked up on the fundamental of care visits. Bed Rail Alert – JM confirmed that an update is going to Patient Safety Group next week to hopefully close this action and was escalated to QSOG. Sepsis Children – IV antibiotics within the hour graph has not updated since September 2024 this is due to Many children don't trigger requiring antibiotics within 1 hour as most are already on them. Therefore, dashboard doesn't look to be updated as NA. MB highlighted the medication incidents on page 15 – 2 incidents were linked to the community pharmacy and GP's. This learning is shared to ensure feedback is taken. JM will ensure that ICB colleagues are copied into these learning feedback emails. Will be added into the ICB soft intel emails. MB raised the deep dive for HAT's and asked when this is taking place. JM confirmed that the report is going through internal processes, and an update will be given at the next meeting.	
8.2	**Complaints and PALs Report Q3** The report was taken as read. The summary of positive assurances and improvements was good to see. LB praised that it is a very good report and queried whether 74 medication errors is high recorded for ED as there is no comparator? JM confirmed that it is not high for the throughput of patients and no trends noted. LB noted the report has triangulation with other KPI's for area's with more than 1 complaint in the quarter, just some feedback it would also be useful to include if any staffing issue as an additional indicator **New Action - JM to feedback to RH, May be useful to include an additional indicator around staffing levels when looking at other quality indicators for areas who have more than 1 complaint in the quarter.**	JM

9.0	Monthly Performance Report (March 2025)	
9.1 9.2	**<u>Monthly Performance Report</u>** The report was taken as read. MB raised a query around the closed referral routes for MSK from Primary Care. WS confirmed that communication has been drafted to Primary Care referrers that the pathways will be closed. WS will investigate further. **New Action – WS will investigate the closed MSK Primary Care Referrals.** **<u>52-week+ Harm Review Report</u>** The report was taken as read. Harm review completion rate has increased with the most ever completed in a month. There are still a few specialties that are low, however progress is being made to improve these. The report contains information regarding validation, and lots of work is ongoing for this. The trust has looked at 3700 pathways in the last week, and 1252 have been closed. RTT performance has increased by around 6% due to this. Audiological medicine has had lots of cases closed. RTT performance training is due to be signed off, which will include refresher training. 12-week validation is being carried out to ensure that all patients have had communication at least once every 12-weeks. Lots of work is being done to clear the Patient Tracking List (PTL). There have been around 23 pathways where patients have waited longer than they should have. There have been 0 cases over 104-weeks. WS confirmed that they have done a lot of Data Quality checking. This is where anomalies are picked up in the pathways where it doesn't appear correct. This is a good referral point for training for staff. The main issues currently are with work streams. Non-obstetric ultra-sounds are being brought back to the trust.	WS
10.0	**PSII Highlight Report Q4**	
	The report was taken as read. The trust are waiting for the results of the recent audit on NG tubes. The report includes updates on the PSRIF responses, and patients and their family involvement. Never Event updates are included. The new PSII template was used for a case and proved to be efficient. There are several open actions around Never Events which are being worked on.	

	There have not been any more wrong lesion Never Events since the new way of working and action implemented on action plan. One was reported but it had occurred prior to the changes. SF raised that there are lots of actions regarding the child PSII. JM believes the new process identifies more learning using the PSIRF process as looks at wider issues contributing to the incident. LB had a Never Event sent through which was a PSII from January. It was agreed it would be circulated to CQRM members by LB with the Wrong lesion action plan to approve closure. SSoT ICB colleagues praise that the report contained lots of detail.	
10.1	**<u>Wrong lesion Never Event – Action Plan</u>** The action plan was circulated to ICB colleagues for feedback.	
11.1	**Mortality Report Q3**	
	The report was taken as read. D. The Mortality indicators have increased. SF asked JM if the Trust were assured that it relates to coding not been completed. JM advised the trust has not noticed any other types of issues increasing outside of what is raised in the report. JM is working with the clinical coding team to try and make sure these issues improve, there have been additional coders recruited who will commence in June following completing training and this has been raised at UHNM internal groups. Hopefully an improvement will be seen. SF asked regarding the issues in the report if they are related to process rather than patient outcome. JM confirms it is a coding issue as discussed previously. These numbers should start to come down. Within the report that are 2 PFD notifications and the responses given to the coroner.	
11.2	**<u>Reg 28 Trust Response – J Unwin</u>** This was circulated by LB, and actions were identified with 2 being for ED.	
11.3	**<u>Reg 28 Trust Response – C Bradbury</u>** Attached for information and JM will keep ICB colleagues updated.	
12.0	**PLACE Audit**	NS
	The report was taken as read. LB and MB praised it for being a very good report.	

13.0	Forthcoming UHNM External Reviews	
	There are not any upcoming reviews.	
14.0	**Any Other Business**	
	MB asked regarding the UHNM learning event – JM will present and give the title to MB.	

Next UHNM CQRM:
Thursday 19th June 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.

Staffordshire and Stoke-on-Trent Integrated Care Board

Meeting	UHNM CQRM
Venue	Microsoft Teams
Date/time	Thursday 17th April 2025, 12:00-14:00

Attendees:		
Steve Fawcett (Chair)	Clinical Director, SSoT ICB	SF
Mary Barlow	Lead Nurse for Quality & Patient Safety, SSoT ICB	MB
Lindsey Boughey	Senior Clinical Quality Improvement Assurance Manager, SSoT ICB	LB
Pippa Caldwell	Head of Nursing, Quality, Safety and Compliance, UHNM	PC
Rebecca Ferneyhough	Professional Lead for Quality/Operations, UHNM	RF
Emyr Phillips (Part)	Associate Chief Nurse/Deputy Director (Infection Prevention & Sepsis), UHNM	EP
Joe Potts	Matron, Quality, Safety and Compliance, UHNM	JP
Warren Shaw	Strategic Director, Performance & Information, UHNM	WS

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

Apologies:		
Cath Marsland	Associate Director of Quality and Patient Safety, SSoT ICB	CM
Angela Young	Assistant Director for Nursing & Quality, NHSE	AY
Ann Marie Morris	Deputy Medical Director, UHNM	AMM
Jamie Maxwell	Head of Quality, Safety & Compliance Department, UHNM	JM
Louis Finney	Business Support Officer, SSoT ICB	LF

No	Item	Action Lead
1.0	**Introductions & Apologies.**	
SF introduced all to the meeting and announced apologies as noted above.		
2.0	**Declarations of Interest**	
None to report.		
3.0	**ICB Leadership Compact**	
SF covered the leadership compact and all adhered.		

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4.0	Minutes from the previous meeting: 20th March 2025	
The minutes of the UHNM CQRM from 20th March 2025 were agreed as a true and accurate record.		
5.0	**Action Log from the previous meeting: 20th March 2025**	
Action 182 - BI-Annual Establishment Report: It was noted that this report is not yet available and will be presented at the UHNM CQRM in May-25. [Action Open] Action 193 - CQC Action Plan Review: Actions included in the plan from the CQC visit are almost complete however, internal meetings still need to be looked at and finalised at the QSOG in June-25. [Action Open] Action196 – Commode Cleaning in ED: It was agreed that this action should now be closed at the UHNM CQRM and monitored outside of the meeting via communication between EP and LB. [Action Closed] Action 197 – Clinical Digital Systems Risk: PC advised that a request to proceed with additional modules on the system has not yet gone through. [Action Closed] Action 200 – Clinical Digital Systems Risk: The risk relating to the clinical digital system is still in place however, the severity of this has been reduced. The risk will remain in place on the register until the single system is fully implemented. [Action Closed] **Action: To fully understand what is happening with the implementation of the core system, it was agreed that actions 197 and 200 should be closed on the action tracker and a formal update be added to the UHNM CQRM Agenda in October-25 - BSO to add to agenda accordingly.** Action 201 - Clinicians completing Harm Reviews on 104-day+ Cancer Breach Patients: LB confirmed that information relating to this action has now been raised at System Quality Group for that attention of the Senior Management team at UHNM. [Action Closed]		LF
6.0	**Monthly HCAI Report (February 2025)**	
EP gave an overview of information included in the HCAI Report for February 2025: - There has been 1 MRSA reported in February-25 and a meeting to discuss further is awaited. - The target of 165 YTD for C-Diff is still being met. - COVID cases have increased however a reduction is starting to be seen. - Norovirus cases are still quite high especially the G2 strain, this is expected to reduce and was expected due to the time of year. - There is still a CPO outbreak and a meeting to discuss further is due to take place in the next week. - Sepsis screening compliance numbers dipped in February-25, however, has increased in March-25. - There are currently 9 cases of I-Gas which is an increase from 7 reported last month. Investigations have traced this back to the South Stoke District Nurse Team area. Contact has been made with the ICB Medical Director to circulate communications to GPs with information relating to prescribing the correct antibiotics.		

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	Action: To fully brief the ICB Medical Director, SF requested that an e-mail from EP with details of the I-Gas outbreak as well as what swabs need to be taken, and treatment be sent ASAP.	EP
7.0	**Clinical Digital Systems Risk update**	
As discussed under Agenda Item 5.0: Action Log.		
8.0	**Quality Assurance Report (February 2025)**	
8.1	**Quality Assurance Report** The group received and noted the Quality Assurance Report with the following areas highlighted: - MB referred to page 20 of the report, PU'S - and a plan for a deep dive and asked if this had now taken place. PC advised that this has not yet been completed however, it is on the radar of the clinical nurse specialist to complete ASAP. - In terms of urethral splits, the report shows this is within expected limits although they are increasing, MB asked what actions are being taken to address this. PC advised that the Trust are looking to identify themes and trends and complete an action plan from this in the next month, there is also a business case being developed to introduce a Continence Nurse. **Action: JP agreed to report back with information relating to the action plan for the reduction of urethral splits and the pressure ulcer deep dive at the UHNM CQRM in May-25 if work was completed.** - MB asked regarding the increase in Hospital acquired pressure ulcers in ED - The Tissue Viability Champions launch happened recently as well as a study day to discuss the role of the champions which the Trust are looking to further develop and expand so there is a link in place. A tissue-viability nurse is giving additional support to ED and there is also new equipment available to support further i.e., mattresses, chairs, etc. - In terms of the F&F Test, MB asked if the QR Codes on business cared for Maternity have now been agreed and implemented. **Action: PC agreed to liaise with JM to obtain an update on progress relating to the F&F Test and report back at May CQRM.** - MB requested additional information about VTE thrombosis and inconsistencies with doses and prophylaxis. JP advised that after 120 reviews, around 6 patients were identified as having missed one dose of prophylaxis. JP advised that actions going forward in this area are to increase training to Doctors and Nurses on the ward and to work closely with the pharmacy team to identify areas of improvement in the short term. - LB referred to page 11 of the report and noted that moderate harm has increased quite significantly this month due to endoscopy incidents. PC advised that there is a review ongoing in endoscopy which will be shared with CQRM as soon as complete. **Action: PC agreed to provide an update regarding the endoscopy incident themed review at the June-25 UHNM CQRM (LF to add to the UHNM CQRM in June-25).** - It was noted that the dashboard at the front of the report had not been updated to reflect information included in the report. JP will advise JM of discrepancy.	JP PC LF PC

9.0	**Monthly Performance Report (January 2025)**	
9.1 9.2	**Monthly Performance Report** The group received and noted the monthly UHNM Performance Report, and the following area highlighted: LB referred to non-urgent ultrasound and asked if this is continuing to be outsourced. WS advised that patients are currently being referred to Cannock due to the financial situation as well as attempting to reduce waiting lists. **Action: WS agreed to bring a paper to UHNM CQRM in June-25 to give a better understanding of wait times and recruitment.** **52-week+ Harm Review Report** WS advised that numbers of harm reviews completed are down for February breaches, which is disappointing – this is due to several pressures and finding the time to complete. The I-Portal is now a standalone system which gives more stability and will allow an electronic version of the review to give real time information. A 12-week validation for patients on the waiting list is undertaken and patients are contacted via text and/or letters to understand any changes as well as a trawl of Datix to establish any harm. For patients waiting over 104 weeks, MB asked if this was due to patient choice. WS advised that there are currently 0 patients waiting for over 104 weeks, however, there are some who have been removed due to an error and re-added as well as issues with patient choice. UHNM are currently working with NBI to undertake AI work which will run algorithms through waiting lists and then look at pathways to make improvements. Although it is hoped that there will be improvements in this area, it was noted that only a small number of reviews are being completed and there may be a need for this to be escalated. To give assurance, WS advised that the numbers reported this month appear higher and suggested the next set of reports will show improvement. **Action: It was agreed that this should be added to the UHNM CQRM Agenda in May-25 with a more detailed report regarding work being undertaken to give assurance that improvements are being made. BSO to add to the Agenda in May-25.**	WS LF
10.0	**Regulation 28 - Report to prevent Future Deaths**	
10.1 10.2	Regulation 28 – Report to prevent future deaths – J Unwin Regulation 28 – Trust Response to Coroner – J Unwin In terms of regulation 28 reports, PC advised that a response is awaiting finalisation which will then be shared with ICB colleagues. To prevent delay in receiving this information, SF requested that this be shared outside the usual cycle of CQRM. **Action: PC agreed to ensure that information related to regulation 28 is circulated to the relevant people prior to the next UHNM CQRM.**	PC
11.1	**Ambulance Handover delays – Harm Reviews Update**	
	RF advised that a review of harm due to handover delays has been completed for January-25 and a report for February-25 is due to be undertaken as a follow-up. It has been agreed that from 1st March-25, there will be no follow-up on individual patients submitted, the information is still there however and shared with NHSE, but it will not be shared externally with the organization. Any themes and trends identified will be flagged and addressed via internal pathways and attendance mitigation.	

	LB – Meetings for harm reviews still in place, RF also confirmed that meetings for harm reviews are still in place and agreed to provide a verbal update at UHNM CQRMs going forward as well as an insight report including after action reviews.	
11.2 **11.3**	**<u>Fundamentals of Care Quality Visit – Royal stoke ED report – Mar 25</u>** **<u>Fundamentals of Care Quality Visit – County ED report – Mar 25</u>** Following a quality visit to the Royal Stoke and County Hospitals in March-25, LB advised that several patients and staff gave accounts of their care especially those situated in corridors mixed reviews were given: - Patients reported that updates were not frequently provided which resulted in uncertainty about care and treatment requirements. - In terms of pressure ulcer management, the assessments seen on the day states that the patient should be moved every 3hrs and the records recorded this wasn't always completed. At County hospitals Pressure ulcer risk was being done by professional judgement. Most patients were classed as independent even though elderly as mobile prior to admission. - There were several patients who were on fluid balance which was incomplete. PC advised that hydration and nutrition are now being monitored and audited weekly, which feeds into an improvement project around staff feedback and the psychological effect this has on looking after patients in a certain environment. LB advised that another visit is planned during the first week of May-25 to both Royal Stoke and County sites, findings included in the Urgent Care insight report from all visits carried out during the winter.	
12.0	**Forthcoming UHNM External Reviews**	
Nothing to report.		
13.0	**Any Other Business**	
<u>Terms of Reference</u> It was noted that a review of the UHNM CQRM Terms of Reference is due at the end of April 25. Given the number of changes currently happening within NHS Organisations, SF suggested that this be postponed for around 2-3 months and a full review be completed once more information is known. LB added that the reporting schedule is in the process of being updated, which reflects what is included in the contract, as this ends during April 2025.		

<u>Next UHNM CQRM:</u>
Thursday 15th May 2025, 12:00-14:00
Via Microsoft Teams

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