University Hospitals of North Midlands NHS Trust

Quality and Safety Oversight Group

The Meeting held on Monday 20th June 2022 from 2.00 p.m. was held via Microsoft Teams

MINUTES OF MEETING

Attended	Apologies/Deputy Sent	Apologies Sent	No Response

Members:			A	M	J	J	A	S
[redacted]	(AMR)	Chief Nurse						
[redacted]	(GHe)	Deputy Medical Director Quality & Safety (Vice Chair)/Patient Safety Lead						
[redacted]	(AB)	Associate Chief Nurse (Specialised)						
[redacted]	(PB)	Chief Operating Officer						
[redacted]	(AC)	Divisional Chair (Medicine)						
[redacted]	(NC)	Lead for Medicines Optimisation & Safety						
[redacted]	(ZD)	Deputy Divisional Chair for Medicine/Chief Clinical Information Officer						
[redacted]	(KE)	Associate Chief Nurse (Surgery)/Chair for Patient Experience						
[redacted]	(NH)	Deputy Associate Director of Corporate Governance						
[redacted]	(GH)	Associate Chief Nurse (Medicine)						
[redacted]	(MH)	Divisional Chair (Children's, Women's & Diagnostics)						
[redacted]	(HI)	Director of Nursing – Education and Development/Lead for Mental Health/Learning Disability and Safeguarding						
[redacted]	(AL)	Divisional Chair for the Specialised Division						
[redacted]	(VL)	Quality Assurance Manager/Lead for Clinical Effectiveness						
[redacted]	(SP)	Deputy Chief Nurse (Chair)						
[redacted]	(JMx)	Head of Quality, Safety & Compliance						
[redacted]	(DM)	Lead Nurse for Quality & Safety						
[redacted]	(SM)	Divisional Chair (Surgery)						
[redacted]	(EP)	Deputy Director/Associate Chief Nurse (Infection Prevention & Sepsis)						
[redacted]	(BR)	Associate Chief Nurse (Children's, Women's & Diagnostics)						
[redacted]	(ST)	Clinical Director of Pharmacy & Medicines Optimisation - Representing the Trust Medicines Safety Group						
[redacted]	(RT)	Divisional Chair (Children's, Women's & Diagnostics)						

In Attendance:		
[redacted]	(DB)	Quality and Risk Manager for Obstetrics and Gynaecology
[redacted]	(HB)	Lead Nurse for Infection Prevention
[redacted]	(RF)	Matron for Quality and Safety
[redacted]	(CH)	Head of Nursing, Theatres
[redacted]	(AI)	Consultant Plastic Surgeon/Divisional Lead for Governance in Surgical Division
[redacted]	(SJ)	Director of Midwifery
[redacted]	(PM)	Deputy Associate Chief Nurse for Medicine
[redacted]	(RP)	Head of Patient Experience
[redacted]	(KS)	Lead Nurse for Mental Health and Learning Disability

No.	Agenda Item	Action
	PERMISSION WAS SOUGHT TO RECORD THIS MEETING AND THE RECORDING DELETED ON COMPLETION OF THESE MINUTES.	
	PROCEDURAL ITEMS	
1.	**Chair's Welcome, Apologies and Quoracy**	
	Apologies were received as recorded above.	

2.	**Declarations of Interest**	
	There were no declarations of interest noted.	
3.	**Minutes of the Meeting held on Monday 23rd May 2022**	
	The Minutes of the above meeting were approved as a true and accurate record.	
4.	**Matters Arising via the Post Meeting Action Log**	
	Updates were recorded within the separate Action Log document.	
	SAFE	
5.	Risk Register Report	
	[redacted] presented the Risk Register Report, which had been circulated prior to the meeting and was received for information and taken as read. [redacted] highlighted the following points of interest within the Report:- • Three risks had been reduced; one of which had been reduced below a 12 and therefore was no longer within the report. • There were three new risks. • The main challenge continues to be the lack of future mitigation identified. • In terms of ensuring that the most up to date information is presented [redacted] had asked Divisions for the optimum time to review these and in general if Divisions can update the Risk Register during the first week of the month this will filter into the risk reports for the Executive Groups and Performance Reviews and hopefully mean that more up to date information will be available. **The Group was asked to request assurance from the identified leads that mitigating actions were being taken to manage the risk scores down to a 'tolerable' level and to confirm if any support is required.** [redacted] suggested that assurance around the processes within the reviews be included within the Divisional updates.	
6.	Children's, Women's & Diagnostics Division Quality Update	
	[redacted] presented the Children's, Women's & Diagnostics Division Quality Update for April, which had been circulated prior to the meeting and was received for information and taken as read. [redacted] highlighted the following points of interest within the Report:- • [redacted] had already mentioned duty of candour within the Action Log update. • Medications incidents had reduced, although the target had not been met. This would be discussed at the following days Performance Review and required focus, predominantly within Child Health. • Sepsis screening and intravenous antibiotic compliance continues to be 100%, although the sample size was small. • Risk Register reviews for each Directorate had been rearranged to improve data available for onward reporting. [redacted] fed back that there had been a presentation at the Safe Medication Group Meeting the previous week from Child Health on medication safety. Work was on-going and this is one of their driver metrics. Consideration was to be given to benchmarking to other Child Health services and also to demonstration of the impact of initiatives taken.	
7.	Medicine Division Quality Update	
	[redacted] presented the Medicine Division Quality Update for April, which had been circulated prior to the meeting and was received for information and taken as read. [redacted] highlighted the following points of interest within the Report:- • Falls had increased across the Division, particularly within the [redacted] Work is on-going with regards to Deprivation of Liberty Safeguards (DoLS) applications and visibility via doors. This is part of the A3 Performance Review Pack. • Work is on-going with regards to Sepsis compliance in the [redacted] and application of the Sepsis Nurse and group forums.	

	[redacted] fed back that there had been scrutiny from the Clinical Commissioning Groups (CCGs) with regards to sepsis within the [redacted] and they had asked if patients on ambulances were receiving appropriate sepsis screening if on an ambulance for a prolonged period. Responses to this were being sought and would be shared with this Group. [redacted] highlighted falls and asked if the removal of the doors had made any difference; [redacted] replied that there had been a reduction within the [redacted], but that there would now be a focus on [redacted] and within [redacted]. [redacted] also highlighted the Friends and Family Test recommendation score for the Accident & Emergency Department and asked if any themes had been identified; [redacted] replied that time to treatment and the communication around this was the main theme identified. [redacted] also noted themes related to a lack of pain relief and staff attitude; specifically in that patients feel an inconvenience on arrival, particularly if they have spoken to 111. [redacted] asked that actions identified to address these issues be presented at the next meeting.	[redacted]
8.	Specialised Division Quality Update	
	[redacted] presented the Specialised Division Quality Update for April, which had been circulated prior to the meeting and was received for information and taken as read. [redacted] highlighted the following points of interest within the Report:- • Falls with harm were above the target, although [redacted] noted that the Report states that this is on track, which is a typographical error. • With regards to nosocomial rates Cardiology and Trauma had outbreaks at the time of writing the Report and the Team are aware of where the rate of infection has come from and why. A reduction is expected. • With regards to the ten day duty of candour notification letter there had been three letters, two of which were not completed by the deadline. The Team are working through this with the Consultant body to understand why this was the case. • The Report notes that there had been no pressure ulcers reported; this was being queried by [redacted] • The Friends and Family Test score was at 99%. [redacted] noted that when this was drilled down the inpatient score was variable and the Team would work through this with the relevant areas. [redacted] commented that the Team are aware of issue on R2, where patients state that they do not feel informed about the level of discharge planning; work would be undertaken with the R2 Team and Rehabilitation Team to address this. [redacted] fed back that the Team would be welcoming that week's discussion at Performance Review, as negotiations around sepsis were expected. This is currently a driver metric, but is being achieved and therefore focus would be moved away from this and towards timely observations. Similarly the falls with harm driver metric had been achieved and this was now a medium to long term project in terms of sustainability and the focus would be moved to other quality issues, such as pressure ulcers for example.	
9.	Surgery Division Quality Update	
	[redacted] presented the Surgery Division Quality Update for April, which had been circulated prior to the meeting and was received for information and taken as read. [redacted] highlighted the following points of interest within the Report:- • Despite the falls rate reducing there had been one serious incident reported, which related to a [redacted] • Medication incidents had reduced, but were not on target. • There had been two serious incidents reported. • Although Venous Thromboembolism (VTE) on the Ward Information System (WIS) board is showing that the 95% target is not being achieved individual audits are showing 98% compliance. • Sepsis compliance is good with 100% compliance for intravenous antibiotics (IVAB) within the hour and screening is also good in the ward areas and emergency portal. • Friends and Family scores are above target. • With regards to risk [redacted] confirmed that the Surgical Division undertake their own Confirm and Challenge sessions and will be linking in with the timeframes mentioned by [redacted] during Item 5.	
10.	Nursing and Midwifery Staffing and Quality Report Quarter 4	
	[redacted] presented the Nursing and Midwifery Staffing and Quality Report for Quarter 4, which had been	

	circulated prior to the meeting and was received for information and taken as read. [redacted] noted that the Report would also be presented to the Quality Governance Committee. [redacted] highlighted the following points of interest within the Report:- • This quarter, taking into account the winter period, had been the worst for fill rate and the ability to staff some of the wards. This had led to some of the quality metrics of the wards going off and therefore they had been flagged for triangulation and monitoring. • [redacted] highlighted Table 2 Fill Rate and Care Hours per patient day (CHPPD) Comparisons- Maternity Only 2021/22 and noted that this appears to reflect good staffing with a 130% fill rate, but queried this as he suspected that this may be due to the rosters not being updated in terms of establishment and budget. [redacted] suggested that he meet with [redacted] to pull together local figures for this graph. [redacted] agreed that the budgeted establishment was skewing these figures. • The quarter did see one of the highest sickness levels across all Divisions, which passed 12%. • There had been an increase with regards to requests and posts filled by the Nurse Bank, with one of the busiest months with nine thousand nine hundred and five shifts filled. In comparison [redacted] noted that there was also a month with the largest number of shifts that were not filled. This would continue to be monitored and there had been recruitment within the Nurse Bank which would hopefully help moving forward. • There were twelve wards with a significantly low fill rate and this had been triangulated with patient harm by the Quality Team. Discussions had taken place between the Quality Team and these wards and plans made to mitigate were possible, with this being monitored by the Divisions. [redacted] fed back that there still appeared to be a massive underreporting of red flags for staffing and that there was work to do across all Division to ensure staffing gaps are being logged where there are potential delays in treatment or care. [redacted] noted that this Is one of the metrics used when undertaking the staffing reviews to understand the impact. [redacted] encouraged that this be promoted across the Trust.	[redacted]
11.	Improving Together A3 Update	
	There was nothing to update at this Meeting.	
12.	CQC Update For Healthcare Professionals - Safety, Equity And Engagement In Maternity Services	
	[redacted] and [redacted] presented the Care Quality Commission (CQC) Update For Healthcare Professionals - Safety, Equity And Engagement In Maternity Services, which had been circulated prior to the meeting and was received for information and taken as read. This would also be presented at the Maternity Extraordinary Quality & Safety Oversight Group Meeting. [redacted] highlighted the following points of interest within the Report:- • [redacted] noted that this was the initial benchmark against the Safety, Equity and Engagement Report in Maternity Services key themes and also focused on the four key actions from the Chief Midwifery Officer. • A further detailed Action Plan would be completed with the Maternity Voice Partnership and the Local Maternity and Neonatal Services (LMNS). • The main areas of concern related to a lack of tailored communications with BAME (black, Asian and minority ethnic) groups, the lack of representation in the Staffordshire and Stoke–On–Trent Maternity Voice Partnership and continuity of care. **The Group were asked to receive this Report as assurance of progress towards achieving compliance with the key actions from the CQC Report – Safety, Equity and Engagement.**	
13.	Serious Incident Highlight Report - April	
	[redacted] presented the Serious Incident Highlight Report for April, which had been circulated prior to the meeting and was received for information and taken as read [redacted] highlighted the following points of interest within the Report:- • There had been fourteen incidents reported during the month, with [redacted] at Royal Stoke and [redacted] at County Hospital (both falls). These were mainly falls related incidents ([redacted]), with [redacted] medication related incidents and [redacted] diagnostic related incidents. • The [redacted] diagnostic incident [redacted]) related to a patient who underwent a [redacted] following a report of a [redacted] following [redacted] samples. On examination there was no palpable or visible mass in [redacted]. It was felt that an area of tissue may have been carry over from another sample and further biopsies were undertaken and confirmed no [redacted] present. Both of	

these diagnostic incidents were under investigation.

- The second diagnostic incident ([redacted]) related to lack of follow up of an [redacted] A number of similar incidents had been identified and an Extraordinary Meeting arranged to discuss these on the 12th July 2022. There would be an overarching Action Plan.
- [redacted] noted that one of the medication incidents ([redacted]), regarding [redacted] being withheld and not being recommenced appropriately and then had a [redacted] had been deleted from the system and the Root Cause Analysis (RCA) subsequently resubmitted. The learning from this would be included within the next summary.
- The second medication incident ([redacted]) related to [redacted] being stopped prior to surgery with a plan to recommence afterwards, this did not happen and the patient [redacted]. This was under review. [redacted] noted that the medication incidents would also be reviewed by the Medicines Optimisation and Safety Meeting.
- [redacted] fed back that actions identified would also be included within the quarterly report and the Team will be looking to utilise the Actions Module on the Datix System. A meeting would be held to discuss developing a pilot.

[redacted] suggested that if the methodology could be similar to that in Maternity with regards to assurance around the actions and an audit process this would be useful; [redacted] would meet to discuss. [redacted]

14. HSIB Interim Bulletin – Harm from Handover Delays

[redacted] presented the Healthcare Safety Investigation Branch (HSIB) Interim Bulletin relating to Harm from Handover Delays, which had been circulated prior to the meeting and was received for information and taken as read

The Interim Bulletin has been published by HSIB on the 16th June 2022 and was shared for information and noting of the initial emerging findings and review to be undertaken in relation to these findings. HSIB had commenced an investigation as delay in handing over care from ambulance crews to emergency departments was causing life-threatening harm to patients. [redacted] noted that a gap analysis would be required to provide assurance of what was being done to mitigate this risk. The initial recommendations made were national recommendations for NHS England and the Department of Health.

Further updates would be provided to this Group in due course. [redacted] commented that work was on-going within the Emergency Department which would need to be formulated and bought back in a plan.

SUBGROUP REPORTS

15. Mortality Review Group Highlight Report – May

[redacted] presented the Mortality Review Group Highlight Report for May, which had been circulated prior to the meeting and was received for information and taken as read

[redacted] highlighted the following points of interest within the Report:-

- The mortality indicators, Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital Mortality Indicator (SHMI), remained pretty much unchanged and within expected limits.
- Neurology had delivered their local Mortality & Morbidity Presentation and provided positive assurance, although there had been challenges with attendance at meeting and engagement from the Nursing Team. AB agreed to pick this up outside of the meeting.
- The Nosocomial Review Panel continues, with all the 'Definite' cases reviewed and roughly halfway through the 'Probable' cases. The initial Covid-19 mortality reviews for the community acquired cases total roughly nine hundred reviews from one thousand four hundred deaths. A paper would be submitted to the Quality Governance Committee outlining a strategy for completion of the remaining nosocomial cases. In anticipation of this individual Directorates have been asked to prioritise Covid-19 related deaths.
- Neonatal mortality had been high on the Groups watch list and an Extraordinary Meeting to discuss this had been held during the previous week. The main issue with this was the lack of contemporary risk stratified data and all available is raw data which deals with small numbers and makes interpretation difficult. This paper would be presented to the Quality Governance Committee and [redacted] summarised that the view of this paper was that there probably had not been an increase in deaths at the end of the previous year that signalled a problem within the Neonatal Unit, but that this should continue to be monitored.

16.	Patient Experience Group Highlight Report – May	
	[redacted] presented the Patient Experience Group Highlight Report for May, which had been circulated prior to the meeting and was received for information and taken as read [redacted] highlighted the following points of interest within the Report:- • Visiting restrictions had been lifted, therefore the work streams planned pre-pandemic would commence. • Patient Care, Treatment and Values & Behaviours remain as top themes for complaints. • Two Patient Leaders had attended and there would be a focus on recruiting more, particularly as there would be a requirement for them to act as Patient Safety Partners as part of the Patient Safety Incident Response Framework (PSIRF). Plans would be made as to how this role would be utilised and which meetings would be attended by them. • Complaints sign off times were still delayed, but work continued on triaging less formal complaints and RP was working on developing an electronic sign off process. [redacted] noted that, in terms of strategic priorities and patient experience, [redacted] had undertaken some work to understand the top themes relating to complaints in order to do more carry out deeper analysis on areas on which to focus. [redacted] added that they had specifically looked at clinical treatment and what the breakdown of this entails and also at the upheld and partially upheld complaints to see if there are specific trends within those. This would be broken down on a monthly basis and more specific information presented. The Team are considering how best to communicate this.	
17.	Risk Management Panel Highlight Report - May	
	[redacted] presented the Risk Management Panel Highlight Report for May, which had been circulated prior to the meeting and was received for information and taken as read [redacted] highlighted the following points of interest within the Report:- • Datix incident [redacted] – This related to a [redacted] and the on-going business case to increase midwifery staffing levels to meet Birth Rate+ requirements and Ockenden recommendations had been mentioned elsewhere during the meeting. • Datix incident [redacted] – This related to an incorrect [redacted] given over three hours and not thirty minutes and actions were being undertaken to ensure prescriptions were being administered correctly. • Datix incident [redacted] – This related to staffing shortages on the Acute Medical Unit (AMU) and assurance had been given that this was included on Medicine Division Risk Register and that there were mitigations and actions in place. • As noted elsewhere there would be a thematic review of [redacted] related incidents in the Emergency Department and an Extraordinary Meeting had been scheduled for the 12th July 2022 to review progress and obtain assurance on the implementation of actions. New [redacted] were being implemented which upload straight to the iPortal system. • Datix incident [redacted] – [redacted]. Assurance had been received that all actions identified in the Action Plan had been implemented. All [redacted] had been checked by the Trust and the Manufacturer and were compliant. The doors in the Majors areas had been reviewed and a feasibility study for alternatives to provide greater visibility approved. The doors had been removed and curtains were in place. A reduction in falls had been noted. • Datix incident [redacted] – An audit of [redacted] to determine the frequency of complications was to be completed by the [redacted] and the results presented at Directorate Governance Meeting. This was to be reviewed further by the Gastroenterology Multidisciplinary Team (MDT) and an update Action Plan provided to give assurance that actions were completed. • Datix incident [redacted] – A new Fail Safe Officer Standard Operating Procedure (SOP) in [redacted] had been drafted and was ready for approval and implementation to manage the monitoring of [redacted]. [redacted] fed back that the biggest issue at present was the continued incidents within the Emergency Department regarding the electrocardiogram (ECG) and that this was a theme that needed to be addressed fully.	
18.	Medicines Optimisation & Safety Group Highlight Report	
	There was no Highlight Report submitted for the Medicines Optimisation & Safety Group, but [redacted] noted that this would be covered within Item 28.	

19.	Patient Safety Group Highlight Report - May	
	[redacted]esented the Patient Safety Group Highlight Report for May, which had been circulated prior to the meeting and was received for information and taken as read [redacted]highlighted the following points of interest within the Report:- • With regards to compliance and completion of the Nasogastric Tube checklist there had been no improvement since the previous audits and the Associate Chief Nurses (ACNs) had agreed to address compliance within Divisions and share actions undertaken at next meeting. • Staffing pressures across all Divisions and staff groups continued to be a recurrent theme and major risk to the provision of services. This also had a knock on effect to the non-urgent clinical work such as Root Cause Analyses (RCAs) and Serious Incidents. • Long waiters and how these were monitored was discussed and [redacted]had attended a meeting to in order to establish what is being done across the Trust, how this is monitored and if harm was being caused. A report was being prepared and was currently with the Medical Director and would come to this Group in due course with proposed actions. • [redacted]noted that the Venous Thromboembolism (VTE) Group had agreed trajectory to reduce the backlog of VTE RCAs and had gone some way to achieving this.	
20.	Infection Prevention & Control Committee Highlight Report - May	
	[redacted]presented the Infection Prevention & Control Committee Highlight Report for May, which had been circulated prior to the meeting and was received for information and taken as read [redacted]highlighted the following points of interest within the Report:- • A number of apologies had been received, but there was good attendance at the meeting. • All matters arising from the previous meeting had been discussed. • There was some discussion around blood culture contamination rates and five areas with blood contamination rates higher than 3% had been discussed. One of these areas was the Neonatal Intensive Care Unit (NICU), who would be presenting an Action Plan at the next meeting in July. • The surgical site surveillance for neck of femur (NOF) would commence during July and run for the quarter. • The Board Assurance Framework and Clostridium Difficile (C.Diff) rates had been discussed. The end of year figure for the last financial year had been provide as one hundred and twelve cases against a trajectory of ninety-three. Going into the current year there had been thirteen cases during April, which was above trajectory. • There had been a flurry of Covid-19 outbreaks during March and then during April across the Specialised floor. • The key Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia issues in the Surgical Division had been considered and were related to MRSA decolonisation, peripheral cannula insertion and visual infusion phlebitis (VIP) scoring, which had been seen on other Post Infection Reviews. • There had been a lot of work undertaken around the national cleaning standards and there was a paper going to the Divisional Board and Executive Team which would be taken back to the Infection Prevention & Control Committee during July. **The Group were asked to note this Report.** The Report was noted by the Group.	
21.	Mental Health, Learning Disability, Autism and Dementia Working Group Highlight Report – May	
	[redacted]presented the Mental Health, Learning Disability, Autism and Dementia Working Group Highlight Report for May, which had been circulated prior to the meeting and was received for information and taken as read [redacted]highlighted the following points of interest within the Report:- • There was poor representation from the Divisions to the Working Groups and work had been done with the Divisions to identify interested parties who may want to attend. • There had been an increasing numbers of Child and Adolescent Mental Health Services (CAMHS) attendances at the Royal Stoke Emergency Department which has been escalated to Clinical Commissioning Group (CCG) to explore alternate pathways. A separate Working Group had been setup which included key stakeholders from both local Mental Health Trusts. • Concerns had been raised around delays in the transport of patients to mental health hospitals, which had been escalated to CCGs who have agreed to commission extra training to e-Referral Service (e-RS) on	

	mental health act paperwork. [redacted] also noted that she had a direct contact for the delays in transport. • The Team are still awaiting the Mental Health Act law e-learning to be placed on Electronic Staff Record (ESR) and have been waiting for roughly twelve months for this to be allocated to role. This work had been started. • The Surgical Division had raised concerns around Learning Disability and Dementia patients being moved during the night for capacity issues. • There had been concerns raised around the variations in Clinical Holding/Manual Handling techniques across the Trust. With regards to the latter a Task & Finish Group would be commenced to address these.	
22.	Medical Gases Group Highlight Report – May	
	There was no Highlight Report submitted for the Medical Gases Group, but [redacted] noted that this would be covered within Item 28.	
	CARING	
23.	Patient Experience Quarterly Report – Quarter 4	
	[redacted]resented the Patient Experience Quarterly Report for Quarter 4, which had been circulated prior to the meeting and was received for information and taken as read. [redacted]highlighted the following points of interest within the Report:- • The results of the 2021 Maternity Survey showed that care has predominantly remained the same since the previous survey was undertaken in 2019. The Trust did not score significantly better in any area, however did score worse or worse than expected in six questions resulting in an overall reduction specifically related to "the start of your pregnancy" and the choice in where to have their baby and being provided with enough information around the implications of Covid-19. • The Hospital User Group (HUG) remain active and although they have been restricted measures were lifting and there was an increasing number of opportunities. • The overall number of complaints had increased from one hundred and thirty-five during Quarter 3 to one hundred and fifty-two, although the Trust remains in line with its peers. • A new complaints triage process had been introduced and twenty-four complaints had been deescalated during April and thirty-one during May. • The highest reporting area was the Emergency Department, which is in line with activity. • Of the complaints reported 89% fall into six categories, relating to aspects of clinical treatment, patient care, communication, appointments (including cancellations), values & behaviours of staff and medication. This is mirrored in the Friends & Family Test comments. • The annual review of complaints by protected characteristics shows that there is work to do in terms of the complaints process and making this more accessible • The Trust is still breaching the forty day complaints target, but new structures had been implemented in order to more accurately measure where these complaints are. • Of the Parliamentary Health Service Ombudsman (PHSO) cases only [redacted] had been partly upheld, with[redacted] new referrals. • The Patient Advice and Liaison Service (PALS) remained busy, but effective with a 1.5% escalation rate and top themes were mirrored in the complaints with appointments and clinical treatment. • The Friends and Family Test had been a challenge in the Medical Division and Maternity, but work is on-going to improve. Friends and Family Test via text messaging should go ahead later in the year for maternity, Inpatient and Day Case areas, with the funding being signed off but work on-going with regards to the IT implications. • Care Excellence Framework (CEF) outcomes were shown, but RP noted that this had been suspended from the 10th to the 31st January due to Trust pressures. **The Group were asked to approve this paper and support the initiatives to improve.** There were no objections from the Group to the above request to approve the paper and support the initiatives to improve.	
24.	Mental Health Strategy	
	[redacted]presented the Mental Health Strategy, which had been circulated prior to the meeting and was received for information and taken as read. [redacted]noted that this was the second strategy and that it had been identified that the first strategy had included all that the Team wanted to achieve, therefore this was built upon in the	

	second. This had also been presented to the Mental Health Working Group and Trust Learning Disability and Mental Health Group. [redacted] asked that formatting be reviewed and steps taken to ensure that this aligns to the Quality Strategy. [redacted] suggested that the Dementia Strategy could be re-launched via the Communications Team; [redacted] agreed that this should be done for all three of these papers.	
25.	Learning disability Strategy	
	[redacted] presented the Learning disability Strategy, which had been circulated prior to the meeting and was received for information and taken as read. [redacted] noted that this was the first strategy and that this had also been presented to the Learning Disability Working Group and Trust Learning Disability and Mental Health Group. [redacted] asked that formatting be reviewed and steps taken to ensure that this aligns to the Quality Strategy. [redacted] suggested that the Dementia Strategy could be re-launched via the Communications Team; [redacted] agreed that this should be done for all three of these papers.	
26.	Dementia Strategy	
	[redacted] presented the Learning disability Strategy, which had been circulated prior to the meeting and was received for information and taken as read. [redacted] noted that this was being bought to the meeting as this was written in 2020, but a lot of staff seemed to be unaware of this, therefore a plea was made to take this through Divisional Governance Meetings for dissemination. [redacted] suggested that this could be re-launched via the Communications Team; [redacted] agreed that this should be done for all three of these papers.	
	WELL LED	
27.	CQC Action Plan Update	
	[redacted] presented the Care Quality Commission (CQC) Action Plan Update, which had been circulated prior to the meeting and was received for information and taken as read. [redacted] highlighted the following points of interest within the Report:- • This was in the process of being updated for the Quality Governance Meeting following receipt of additional information after circulation for this meeting. • The Action Plan addresses both the nine overarching actions that the Trust must take and the nineteen overarching actions that the Trust should take. From this thirty-five individual actions had been developed for the must do actions and thirty-one for the should do actions. • For the must do actions seventeen (48.5%) are complete, seventeen (48.5%) are on track and one (3%) is problematic. The problematic action related to compliance with the fifteen minute assessment times in the Royal Stoke Emergency Department. [redacted] noted that since the paper had been released the Medical Director, as Executive Lead, felt that three actions within A9 were also problematic with regards to resources for the Clinical Effectiveness work stream, therefore this would be amended. • For the should do action six (19.3%) are complete, twenty-four (77.5%) are on track and one (3.2%) is problematic. The problematic action related to the recommendation that the Trust SHOULD consider making the Speech And Language Therapy (SALT) service provision equitable across County Hospital. Of the twenty-four actions deemed to be on track, a large number of these actions are still under development/not yet commenced so a more accurate view of progress should be clearer by Quarter 2. [redacted] fed back that a monthly assurance meeting is now being held. [redacted] added that the CQC Working Group had been held during the previous week and one action had been for the addition of a column for the Executive Lead and to make the Operational Lead clearer. **The Group was asked to note the contents of the CQC Action Plan. The Group was asked to consider and approve the proposed monthly review process to monitor progress against the actions and to enable escalation of problematic actions.** The contents were noted and there were no objections from the Group to the above request.	
	EFFECTIVE	
28.	Medicines Optimisation Report Quarter 4 2021-22 and Quarter 1 2022-23	
	[redacted] presented the Medicines Optimisation Report for Quarter 4 2021-22 and Quarter 1 2022-23, which had been circulated prior to the meeting and was received for information and taken as read. [redacted] highlighted the following points of interest within the Report:-	

- Medicines expenditure at Month 12 2021-22 was £102.8M against a budget of £98.92M. This represents an increase in expenditure of over £13M compared with the previous financial year. At Month 2 2022-23 expenditure (when extrapolated) would equate to £104.97M. [redacted]noted that expenditure had increased from £27M during 2012-12 and the infrastructure is required to support this and the paper outlines some of the capital and resource investments which have gone in to support medicines optimisation.
- The external Radiopharmacy audit was undertaken during June 2022 and positive assurance provided.
- There had been successful uploading of three thousand contract line changes in line with interoperability standards, although supply chain post contract start dates has been a challenge and [redacted]praised the Procurement Team for their work on this. Roughly £200,000 saving had been initiated.
- Digital medicines optimisation work continues and there had been good progress with electronic prescribing and administration of medicines (ePMA), which is now in the test environment.
- The work of the Covid-19 Medicines Delivery Unit continues.
- A number of extreme and high risks (corporate and pharmacy directorate) are being actively managed and addressed. [redacted]had identified trends within the Report.
- In terms of supply chains there had been challenges regarding the deterioration in the turnaround times of chemotherapy products from third party providers with regards to iodine contrast media shortages for computerised tomography (CT) imaging during the last few weeks. This had resulted in daily stock counts, liaison with the Imaging Team and escalation to a national level through region. Also a septic stock chemotherapy supplier's third party are now delivering at least twenty-seven days turnaround, against a contracted five days. This is a challenge and needs to be managed so that patients received the chemotherapy they need.
- Further assurance on the clinical pharmacy workforce is required especially into Emergency Portals, Gastroenterology and Frailty and discussions are on-going with Directorates and Divisions.
- There are now a number of Regional and Integrated care systems (ICS) Health Education England (HEE) initiatives been undertaken to support the development of robust workforce plan which is a positive development. Enhanced clinical placements for pharmacy undergraduates have taken place since February 2022. Feedback awaited and national adoption of a tariff in September 2022 will come into place.
- The Controlled Drug (CD) quarterly report to the Local Intelligence Network (LIN) is to be noted as required under the Controlled Drugs legislation. A risk rating of incidents during Quarter 4 was low, with two rated as medium harm. Following feedback from the CD LIN ST as the Accountable Officer would be ensuring that processes are in place for reporting diversion incidents as outlined in UHNM Policy MM04.
- The sustainability agenda within the Trust and ICS have been launched which includes medicines, nitrous oxide and anaesthetic agents.

The Group were asked to note this Report.

The Report was noted by the Group.

ITEMS FOR INFORMATION – These were not to be discussed, but there was opportunity for members to raise any questions

29. Trust Quality & Safety Report – April

[redacted]presented the Trust Quality & Safety Report for April, which had been circulated prior to the meeting and was received for information and taken as read.

[redacted]ghlighted the following points of interest within the Report:-

- A number of the issues outlines within the Report had already been discussed from a Divisional and Corporate perspective.
- [redacted]s working with Commissioning Support Units (CSU) around providing support and linking to power BI and data warehouse to get this information out quicker and more effectively.

The Group were asked to receive the report for assurance and identify any further areas that require more detailed information/assurance.

[redacted]asked if there was assurance that the suite of data is being reviewed robustly and any requirement for further review identified; [redacted]replied that the steps taken above should allow data to be received in a timelier manner and reviewed. [redacted]highlighted that the Quality Systems Team had been asked to look at staffing and discharge related incidents. [redacted]noted previous comments around the underreporting of red flags and pointed out that it would be useful to triangulate this information and this would be shared with [redacted]d the Divisions.

30.	Mortality Summary Report – May	
	[redacted] presented the Mortality Summary Report for May, which had been circulated prior to the meeting and was received for information and taken as read. [redacted] highlighted the following points of interest within the Report:- • A general overview had been given during Item 15. • [redacted] and [redacted] would be meeting to discuss the Report and the requirements of the Report for assurance purposes and would also be meeting with the Non-Executive Director. • There had been no mortality alerts. [redacted] highlighted the increasing hospital standardised mortality ratio (HSMR) within CWD and the Specialised Division during their updates in Items 6 and 8; [redacted] replied that that there were plans to change how data was presented, as this was a Statistical Process Control (SPC) chart, rather than a Healthcare Evaluation Data (HED) chart. Although [redacted] noted that this is above the 100 benchmark for both Divisions this was still within expected ranges and no specific concerns had been identified. With regards to CWD an extraordinary Mortality Review Group Meeting was to be held for Neonatal mortality following concerns, but for CWD as a whole mortality rates had reduced during the Covid-19 pandemic, but were now similar to the pre-pandemic level. With regards to the Specialised Division AB commented that the mortality rates had been raised previously and assurance given that this would be reviewed by the Mortality Review Group and no concerns had been raised. [redacted] also highlighted that they had noticed that figures had been affected by the Specialised wards being used for different purposes during the Covid-19 pandemic. [redacted] asked if there were any specialities within these Divisions with a mortality rate higher than it should be; [redacted] replied that this would be monitored by diagnostic groups and that this would continue to be reviewed via the Mortality Review Group and reported up to this Group and potentially the Clinical Effectiveness Group and Quality Governance Committee.	
31.	Approval of Revised Trust Policies	
	There were no revised Trust Policies submitted for approval.	
	CLOSING MATTERS	
32.	Any Other Business	
	The Care Excellence Framework (CEF) Summary had been circulated prior to the meeting and was received for information and taken as read. This would be submitted to the CCG and details thirty- five visits. Of those visits there were two rated as Platinum, twenty-one Gold and twelve Silver. There were a few bronze domains, but none rated as bronze overall. Corporate actions were detailed within the Report to address common themes identified and recommendations made.	
33.	Agreement of Items for Highlight Report including Items for Escalation to Committee	
	The Highlight Report would be prepared outside of the meeting and circulated accordingly.	
34.	Review of Business Cycle	
	The Business Cycle had been updated and circulated.	
35.	Review of Meeting Effectiveness	
	There were no comments made during the Meeting regarding Meeting Effectiveness.	

Date and Time of Next Meeting
Monday 18th July 2022 from 2.00 p.m. via Microsoft Teams