

AGENDA ITEM

2.2.8

UHB BOARD MEETING

HIGHLIGHT REPORT FROM THE QUALITY & SAFETY COMMITTEE

DATE OF MEETING	25/03/2021
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Emma Walters, Corporate Governance Manager
PRESENTED BY	Jayne Sadgrove, Independent Member
EXECUTIVE SPONSOR APPROVED	Greg Dix, Executive Director of Nursing

REPORT PURPOSE

NOTING

ACRONYMS

None Identified.

1. PURPOSE

- 1.1 This report had been prepared to provide the Board with details of the key issues considered by the Quality & Safety Committee at its meeting on 16 March 2021.
- 1.2 Key highlights from the meeting are reported in section 2.
- 1.3 The Sub Committee is requested to **NOTE** the report.



2. HIGHLIGHT REPORT

ALERT / ESCALATE	N/A
ADVISE	 The Committee received a report on Assurance on Risks assigned to the Quality & Safety Committee. Whilst the Committee expressed some concern at not being able to scrutinize a live risk register, they noted that work continued to be undertaken in strengthening the risk register and the process and noted that an updated risk register would be presented to the March Board meeting. A number of comments were made in relation to the content of the report, which would be considered further by the Director of Corporate Governance outside of the meeting. Members noted that risks related to DOLS were being discussed and monitored at the Safeguarding Executive Group which reported to the Committee on an annual basis; The Committee received the Maternity & Neonates Improvement Programme update and noted that progress had been made against a number of areas. Members welcomed the external support that was being provided to assist the team in reviewing the backlog of Serious Incidents; The Committee received the Chief Operating Officers report and noted that work was being undertaken to develop an Elective Care Recovery Plan which would address some of the issues relating to the backlog of Follow up Outpatients Not Booked. A number of questions were raised by an Independent Member regarding the report, which the Chief Operating Officer agreed to present the Unscheduled Care Improvement Plan to the next meeting of the Committee; The Committee received and noted the Integrated Locality Group Quality & Safety Reports together with the Primary Care Quality & Safety Reports together with the Arise of the committee;



ASSURE	 The Committee received a patient story which set out the experiences of a patient who had sadly lost her husband to Covid-19. The story identified the gratitude from the patient's wife for the commitment shown by staff in caring for patients during these tragic times; The Committee received an update on the Covid-19 position. The Committee noted the improving position across all three Local Authority areas and noted that there had been some recent clusters identified in the Merthyr Tydfil area which were in the process of being managed. The Committee welcomed the significant progress that had been made against the Covid-19 vaccination programme;
INFORM	 The Committee received the Handling of Persistent and Serial Complaints Policy which was approved subject to minor amendments being made; The Committee approved the Environmental Policy and the Medicines Management Vaccine Policy The following reports were noted by the Committee: Action Log; Forward Work Programme; Welsh Ambulance Services Trust Patient Experience Report December 2020; Leave No-one Behind Report; Clinical Audit Quarterly Update; Policy Improvement Plan Review update; Medical Device Alert 2020/19 Abbott Trifecta Value Prosthesis; Peer Review Systematic Anticancer Therapies (First Round) - 6 Monthly Update Report CTMUHB Response to the CHC Briefing Paper on Maternity Services in Wales Vaccination Update Quality Governance – Regulatory Review Recommendations and Progress Update; Mortality Review Progress Report; Committee Annual Self-Assessment Questionnaire Response The Committee received and noted the following two reports at the In Committee session of the meeting: CTMUHB Response to External Covid 19 HCAI Mortality



	 Neonatal Services and Update on Serious Incidents and MBBRACE Report 2018
APPENDICES	NOT APPLICABLE