



**AGENDA ITEM**

3.2.7 Appendix 6

**CTM BOARD**

**HIGHLIGHT REPORT FROM THE QUALITY & SAFETY COMMITTEE**

**DATE OF MEETING**

31/03/2022

**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, Vice Chair and Chair of the Quality & Safety Committee

**EXECUTIVE APPROVED**

**SPONSOR**

Greg Dix, Executive Nurse Director

**REPORT PURPOSE**

NOTING

**ACRONYMS**

**1. INTRODUCTION**

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 the 22 March 2022.

1.2 Key highlights from the meeting are reported in section 3.

**2. PURPOSE OF THE QUALITY & SAFETY COMMITTEE**

2.1 The purpose of the Quality and Safety Committee is to provide assurance to the Board on the provision of workplace health & safety and safe and

high quality care to the population we serve, including prevention through public health, primary and secondary care.

## 2.2 The Committee will:

- Put the needs of patients, carers and the public at the centre of all its business.
- Ensure appropriate arrangements are in place to support workplace health & safety.
- Provide evidence based and timely advice to the Board, based on local need, to assist in discharging its functions and meeting its responsibilities.
- Provide assurance to the Board in relation to the CTMUHB's arrangements for safeguarding the public and continuously improving the quality and safety of the services we provide.
- Ensure that care is delivered in accordance with the Health & Care Standards for Health Services in Wales.

## 3. HIGHLIGHT REPORT FROM THE LAST COMMITTEE MEETING

<b>ALERT / ESCALATE</b>	Nil
<b>ADVISE</b>	<ul style="list-style-type: none"> <li>• The Committee were presented with a <b>patient story</b> which had been shared by the Welsh Ambulance Services NHS Trust. The story related to a patient's experience whilst waiting for an ambulance whilst in extreme pain, during a time where there was unprecedented demand on the ambulance service. Members welcomed the story which they had found difficult to hear and asked for their thanks to be shared with the patient for allowing his story to be shared;</li> <li>• The <b>Organisational Risk Register</b> was reviewed and considered. A number of queries were raised which would be responded to outside the meeting;</li> <li>• The <b>Maternity Services &amp; Neonates Improvement Programme</b> report was received. Members were presented with a suite of service metrics which had been developed by the Team. Members noted that the metrics would continue to evolve over time;</li> <li>• The <b>Neonatal Services Deep Dive Report</b> was received. Members noted that investment was required to strengthen the Nursing and Allied Health Professionals workforce in order to take forward key pieces of work and noted that a Business Case would need to be developed in respect of this;</li> <li>• The <b>Quality Dashboard</b> was received. Members were advised that anomalies had been identified in relation to the data being reported in the <b>Delivery Unit Dashboard reports</b> and noted that a validation exercise would need to be undertaken prior to future reports being presented to the Committee. Members</li> </ul>

	<p>agreed to receive a spotlight report on Patient Falls at the next meeting;</p> <ul style="list-style-type: none"> <li>• A spotlight report on the <b>Community Acquired Pressure Ulcer Improvement Plan</b> was received. Members noted that Nurse Directors would be addressing the issues identified in relation to documentation and it was noted that a presentation would be shared at a future Committee in relation to the work being undertaken on the digitization of the patient record;</li> <li>• The report from the <b>Chief Operating Officer</b> was received. Members noted that a number of actions were being taken forward in relation to the 30 hour ambulance wait. Members welcomed the news that the Business Case had now been approved in relation to the Emergency Department Workforce;</li> <li>• The <b>Merthyr &amp; Cynon ILG report</b> was received. Members noted that a number of Internal/External Reviews were being undertaken at present, including a Delivery Unit Review of Patient Flow across Prince Charles Hospital and Ysbyty Cwm Cynon;</li> <li>• The <b>Rhondda Taf Ely ILG report</b> was received. Members noted that Emergency Department flow was continuing to have an impact on patients and staff;</li> <li>• The <b>Bridgend ILG report</b> was received. A discussion was held in relation to the deterioration in CAMHS performance and Members requested a further update on this at a future meeting, particularly in relation to the Care and Treatment part of the measure;</li> <li>• The <b>Primary Care Quality &amp; Safety report</b> was received. Members noted that there had been issues regarding GP Out of Hours shift fill which the team were in the process of addressing. Members noted that ongoing discussions were taking place at the Primary Care Board regarding GP practice sustainability;</li> <li>• The Committee received a report on <b>Healthcare Inspectorate Wales Mental Health Inspections</b>. Members noted that two inspections had taken place, one of which related to the Seren Ward in which positive feedback had been received. The Team agreed to consider a way in which the committee could be provided with assurance that lessons were being learnt and were being applied formally across the Health Board;</li> <li>• The <b>Internal Audit Review into Concerns</b> was received. The Committee noted that the report had been referred by the Audit &amp; Risk Committee and noted that an update on the Internal Audit Review and the Welsh Risk Pool Review would be presented to the next meeting.</li> </ul>
<p><b>ASSURE</b></p>	<ul style="list-style-type: none"> <li>• The Committee received a report on the <b>Delivery Unit Review of Open Incidents within Maternity &amp; Neonatal Services</b>. Members were pleased to hear that the review had now been completed and welcomed the hard work that had been undertaken. Members advised that they would be keen to see the learning being sustained in order to avoid recurrence of issues;</li> </ul>



	<ul style="list-style-type: none"><li>• A report on <b>Mortality Reviews and Mortality Indicators</b> was received. Members noted the positive progress that had been made in this area;</li><li>• The Committee received a report on the <b>Health Board's Preparedness for the Covid Inquiry</b>. Members noted that the Health Board was not yet aware as to whether it would be a core participant in the Inquiry;</li><li>• The <b>Development of a Listening and Learning Framework</b> report was received and welcomed by the Committee</li></ul>
<b>INFORM</b>	<ul style="list-style-type: none"><li>• The Health, Safety &amp; Fire Sub Committee was received and the Committee <b>APPROVED</b> the Health, Safety &amp; Fire Sub Committee Terms of Reference.</li></ul> <p>The following reports were received and noted</p> <ul style="list-style-type: none"><li>• Once for Wales (DATIXCYMRU) Implementation report;</li><li>• WHSSC Quality &amp; Patient Safety Committee Chairs Report;</li><li>• Covid 19 Closure Report;</li><li>• Organ Donation Annual Report;</li><li>• Quality Governance – Regulatory Review Recommendations and Progress Updates;</li><li>• National Clinical Audit Programme Update 2021/2022;</li><li>• Delivery Unit Quality &amp; Safety Dashboards;</li><li>• Infection Prevention &amp; Control Committee Highlight Report</li></ul>
<b>APPENDICES</b>	Choose an item.

#### 4. RECCOMENDATION

4.1 The Board is requested to **NOTE** the report.