Confirmed Minutes of the Quality, Safety & Experience Committee
Held on 15th December 2020 at 09.00am
Via MS Teams

Present		
Susan Elsmore	SE	Independent Member – Local Authority
Michael Imperato	MI	Independent Member – Legal
Gary Baxter	GB	Independent Member – University
Dawn Ward	DW	Independent Member – Trade Union
In Attendance		
Stuart Walker	SW	Executive Medical Director
Carol Evans	CE	Assistant Director of Patient Safety and Quality
Christopher Lewis	CL	Interim Executive Director of Finance
Angela Hughes	AH	Assistant Director of Patient Experience
Ruth Walker	RW	Executive Nurse Director
Nicola Foreman	NF	Director of Corporate Governance
Richard Hughes	RH	
Joy Whitlock	JW	Head of Quality and Safety
Andrew Carson-Stevens	AC	Patient Safety Researcher
Clare Wade	CW	Director of Nursing Surgery
Mike Bond	MB	Director of Operations Surgery
Alun Tomkinson	AT	Clinical Board Director Surgery
Rajesh Krishnan	RK	Assistant Medical Director (Patient Safety and Clinical Governance)
Matthew McCarthy	MM	Patient Safety Facilitator
Observer		
Emily Howell	EH	Audit Wales
Maureen Edgar	ME	Research Governance Coordinator
Kerry Ashmore	KA	Information Liaison Manager
Secretariat		
Nathan Saunders	NS	Corporate Governance Officer
Apologies		
Fiona Jenkins	FJ	Executive Director of Therapies & Health Sciences
Fiona Kinghorn	FK	Executive Director of Public Health

QSE 20/12/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the final QSE Committee Meeting of 2020. The CC acknowledged that this was the last QSE meeting of the Independent Member – Trade Union.	**Action**
QSE 20/12/002	**Apologies for Absence** Apologies for absence were noted.	
QSE 20/12/003	**Declarations of Interest** The Independent Member – Legal (IML) declared an interest in agenda item 4.6 - Blood Inquiry Update.	
QSE 20/12/004	**Minutes of the Committee Meeting held on 8th September 2020** The minutes of the meeting held on 8th September 2020 were reviewed.	

	Resolved that: a) The minutes of the meeting held on 8th September be approved as a true and accurate record.	
QSE 20/12/005	**Action Log following the Meeting held on 8th September 2020** The CC noted that action QSE 19/09/011 The Gosport Review was marked as "To come to a future meeting" and asked that a date be set. The Assistant Director of Patient Safety and Quality (ADPSQ) responded that a report had been brought to the Committee previously but noted that there was an outstanding action which would be picked up via a national audit on end of life care. That was delayed due to COVID-19. The Executive Nurse Director (END) updated in respect of action QSE 20/02/009 that the entire layout of the Assessment Unit had changed and discussed in October's Board Meeting. The END recommended therefore that the action be marked as complete.	
QSE 20/12/006	**Chair's Action taken since last meeting** None taken.	
QSE 20/12/007	**Advancing Applied Analytics Health Foundation Project Presentation** The Assistant Medical Director - Patient Safety and Clinical Governance (AMD) and Patient Safety Researcher (PSR) presented to the Committee. The PSR noted that often there was a narrow and restricted view of the problem. At one end of the scale there was Incident Reporting and at the other end in-depth investigations and somewhere in between, other various data sources such as patient stories, Coroner's reports, audits of clinical care and culture surveys amongst others. The PSR advised the Committee that data sources offered a window into the healthcare system and posed how opportunities could be maximised by using the data to identify the patient safety priorities. The PSR advised the Committee that Healthcare was often criticised for collecting too much data and doing too little with it. Also the apparent lack of demonstrable progress deterred reporting, as few staff could see the rewards of their conscientiousness in trying to protect patients, and not closing the feedback loop to incident reporters had in some cases led to frustration. The PSR advised the Committee that he had been working with the World Health Organisation (WHO) and exploring what slowed down the data driven patient safety improvement agenda and culture. From observations from multiple countries it could be realised that the range and utility of the patient safety data we already had was key. The PSR commented that not all data sources could provide essential information and presented to the Committee the WHO Classification for Patient Safety model which looked at other sources. The PSR asked the Committee if the UHB knew where the gaps were in data required to understand patient safety in order to be clear on whether further data gathering was required.	

	The PSR advised the Committee that this would become the premise for the Health Foundation Advancing Analytics Award that it had worked hard to progress over the last 15 months. The Health Foundation funded: 1. The exploration of how to build the capability of the administrative informatics team members to generate learning from patient safety data. 2. How to support patient safety risk managers to regularly learn from patient safety data to inform their work 3. Build will amongst the staff reporting patient safety incidents. The Patient Safety Facilitator (PSF) presented to the Committee what had been done and what had been learnt by the Patient Safety Team. The PSF advised the Committee that when the team set out on the project, they knew that UHB staff from a range of professions wanted to undertake Quality Improvement (QI) projects however the selection of topics that could be used for the projects was not targeted. The PSF advised the Committee that there were a lot of Patient Safety Incident reports within the UHB that could tell how, when and where the patients were being harmed. The PSF advised the Committee that at the beginning of the project a workshop was held with Clinicians from the Acute Child Health Directorate and the data available explored to assess how it could be used to inform quality improvement within the directorate. The PSF advised the Committee that there had been some really great discussions at the workshop and the following key messages: • It was difficult to get data • Not clear on the pros and cons of the data source • More than one data source was needed to fully understand an issue. The PSF advised the Committee that as a project team, it needed to test how clinical staff could be supported to use and analyse patient safety data to inform their QI projects. They asked staff from the Acute Child Health Directorate to join and undertake a pilot project which was named Quality Improvement using Data in Child Health (QIDICH). The PSF advised the Committee that working with the QIDICH team, they were able to extract 2 years' worth of Acute Child Health Patient Safety Incident Reports from the UHB Datix system and it was identified that there were themes within that data. The most frequent data was that of Medication and communication related incidents. The Team realised that combining data sources would give important new knowledge that would not have been identified with one source. The PSF advised the Committee that with funding from the Health Foundation they had been able to work intensively with Acute Child Health over the past 15 months.	

	Extracting and exploring data from the incident reporting system was labour intensive and time consuming so to roll that data project across the UHB, a dashboard was developed by the Business Intelligence team. They were looking at developing this dashboard further to make it more powerful by using statistical tools. The PSF advised the Committee that to improve consistency, the team removed paper forms and developed an electronic form. The PSF concluded that patient safety data could inform the UHB where areas could be improved but only if it was looked at, analysed and understood. The AMD advised the Committee that as part of the project a self-evaluation was performed to see where they were and where they could be better. Also the project would be able to give staff the skillset to look at raw data which would motivate staff to create reports. The AMD advised the Committee that they were moving into the next phase of the project which would be to roll it out across the health board and that this would be known as CAVQi and that it proposed a unifying ambition to make sure there were meaningful and bespoke QI projects being done. The AMD advised the Committee that they had won a PhD studentship with the economic and social research council to look into more of the patient safety within the UHB.	
QSE 20/12/008	**Quality Indicators Report** The END advised the Committee that she, the Director of Corporate Governance (DCG) and the Executive Medical Director (EMD) had been working on what could be reported into each Committee and that this was the first attempt at doing this. The END highlighted a number of areas within the report and advised the Committee that the number of Serious Incidents (SI) reported had reduced significantly over the last two years. The END advised the Committee that SI forms were put to WG and this was to try and prevent these types of incidents from happening again. The number of SI closure forms submitted to WG had dropped during Q1 and Q2 of 2020/2021 which was of no surprise due to the pandemic. The END advised the Committee that pressure damage had gone up in the last 2 months which was being looked at by the pressure ulcer group. The END advised the Committee that the compliance for patients admitted to the stroke ward was worrying because patients were not getting to the places where they should be and that was being looked at by the effectiveness committee. The END advised the Committee that there were some mortality indicators and 2 new groups had been set up by the EMD.	

	The CC advised the Committee that it was good to see these sub Committees that would feed in and be able to report back and the sense of the Governance framework being much tighter around QSE. The CC asked Committee if there were any questions. The IML responded that the pressure ulcer issue was always on the agenda and asked whether it would be beneficial for someone to get a better understanding of the Pressure Ulcer group. The END responded that she would be happy to bring a report about it and the functionality and aims and noted that the Director of Nursing Surgery led on that. The IMTU asked about the stroke patient figures and whether it was because the numbers presenting had gone up or because there were less staff. The END responded that the challenge was the availability of beds and getting people through the system. Testing patients in the department and the ability get them to the right place the first time was challenging. Operation teams were focused on it at the moment and this would be discussed in regards to the Lakeside Wing. **Resolved that:** a) The Quality, Safety and Experience Committee noted the contents of the Quality Indicators report and the actions being taken forward to address areas for improvement.	**CW** **RW**
QSE 20/12/009	**Exception Reports** Verbal update was provided by the END. The END advised the Committee that as of 1pm yesterday there were 14 wards that had been classified as “outbreak”, of which 46 patients had hospital acquired COVID-19 and that 73 staff were COVID positive however at that stage it was not known if it was hospital or community acquired for staff. The END advised the Committee that the number of beds available was 92 but 53 were being admitted based on risk assessment. Some patients were testing negative at the front door but when they were here for 24/48 hours they were then presenting positive. The END advised the Committee that the culmination of patients affected in their clinical environments was 122. The IMTU asked whether reporting of staff testing positive was done via DATIX and Riddor. The END responded that it was not but that recording was done if 2 or more staff members were positive as that was classed as an outbreak and would be reported via the DATIX system.	
QSE 20/12/010	**Impact of COVID-19 on Patient Safety** The END advised the Committee that this paper was more for noting however from a Governance perspective, it would be good to note the information around COVID related incident reporting and reporting in to Public Health Wales (PHW) particularly around deaths. Also how PPE has been managed, IPC and issues around handover at front door.	

	The END advised the Committee that with the issues around handover at the front door, they were working closely with WAST colleagues to ensure they could get back out to collect patients in the community. The CC noted that the paper promised a full brief on these issues at the forthcoming Committee meeting. The EMD responded that at the time of completing the paper it was not known where we would be in the course of the pandemic. He added that we were now at the most concerning point subsequent to the original peak earlier in the pandemic, and that it was well recognised that in the community instance the number of COVID positive cases were going up and up. The EMD advised the Committee that the age profile of the infected was shifting into an older cohort which was now manifesting in the number of patients coming in to the UHB. He noted that there was a significant increase in patients on critical care. The EMD advised the Committee that we were at a crucial point in the second peak and as a group of Critical Care Clinicians in Wales they had written to the Health Minister to ask him to invoke a lockdown sooner than December 28th and as a group of Executive Medical Directors they had written to the Chief Medical Officer supporting any decision he would want to make to implement an earlier lockdown. The EMD advised that a 13 day wait for the 28th December lockdown could result in 4 times as many cases. The EMD advised that the biggest constraint and concern was the workforce and the ability to deliver care; there was sufficient bed capacity but not the amount of nurses. The EMD advised that we were at the point at which a decision would need to be made about whether we discontinued certain services and surgery. The EMD advised that the signing off rotas for the Lakeside Wing had begun and that had a direct consequence on where staff were being redistributed from and staff wellbeing. The END advised that she wanted to reiterate the EMD's comments and that staffing was the biggest challenge. The END advised the Committee that had the Executive Director of Public Health Wales been in the meeting she would have reminded everybody that vaccinating had started and that a lot of staff had tested positive in the Splott vaccination centre and that they were revisiting that as an outbreak. The END advised that Track and Trace worked very well but again had an impact on the staff available to us as did the closure of schools. The Interim Executive Director of Finance (IEDF) asked the Committee to note that where we were experiencing a very difficult operational situation, finance was not a constraint and financial support was being provided but the key concern was the availability of staff.	

	The EMD advised that there was a concern regarding waiting list numbers and he considered that the commencement of level 3 or above surgery should not go ahead after Christmas. The EMD noted that a service still needed to be provided to cover urgent patients and that there was a real balance required. He advised that everything possible needed to be done to ensure the wellbeing of staff. The IMTU asked whether there would be COVID testing for all staff. The EMD responded that lateral flow tests and POC testing was being rolled out to some degree and that ultimately it would be available for all staff but there were 168,000 patient facing staff that required testing twice a week resulting in over 300,000 tests which was a large logistical task. **Resolved that:** a) The Quality, Safety and Experience Committee noted the content of the report.	
QSE 20/12/011	**Public Services Ombudsman for Wales Annual Letter** The END advised the Committee that this was a statement of fact on where we were as an organisation and that the UHB Chair had asked for the letter to be brought to the Committee. The END advised that it demonstrated that as a health board, there were no major concerns. **Resolved that:** a) The Committee noted the findings of the Ombudsman's Annual Letter 2019/2020 and the actions being taken.	
QSE 20/12/012	**Clinical Board Assurance Reports:** 1) Surgery Clinical Board The Clinical Board Director of Surgery (CBDS) presented to the Committee. He explained how the surgical board responded to the COVID-19 pandemic and what the challenges were. The CBDS advised that a number of principles, aims and objectives were used to ensure that patients were made as safe as they could be. The Clinical Board Director of Nursing Surgery (CBDNS) added that the advice from Welsh Government (WG) at the start of the pandemic was to stop all non-urgent surgical treatment. The surgical clinical board (CB) started to log the clinical risk of each of their patients and a lot of data had been collected. The UHB was one of the only health boards in Wales to have collected post-operative outcomes. The CBDNS noted to the Committee a reduction in referrals at the start of the pandemic and this impacted the whole pathway of a patient. The CBDNS advised the Committee that there had been a lot of logistics that they had had to deal with including PPE guidance changing rapidly and differing information from some professional organisations surrounding PPE and the differing advice given to Public Health Wales.	

	The CBDNS advised the Committee that communication had been important during the pandemic, not just with patients but with their teams. The CBDNS advised the Committee that they needed governance controls around the response to the pandemic and this was thought about when discussing changed to the service to fit the needs of the patients. The CBDNS advised the Committee that immediately they met as a senior team within service groups – twice daily and then once a day as the pandemic continued. This meeting was now held 3 times a week to see where they were, what needed to be done and how to plan future treatment and how the service would be shaped. The CBDNS advised the Committee that they had started a journey in December 2019/January 2020 and had started looking at how they could utilise their bed base much easier which they had named “Right Bed, First Time” and that was the ethos they would use throughout the pandemic. The CBDNS advised the Committee that Lightfoot had collected data for them in 2019 which they had been able to use to tell them what they needed to do and how they could model their services moving forward. The CBDNS advised the Committee that they had used their own frontline staff to drive the changes and to develop what the services needed to look like through the COVID-19 pandemic The CBDNS advised the Committee that the CB had linked in quickly with Infection, Prevention & Control (IP&C) colleagues and had built up good relationships and that without them the CB would not have progressed. The CBDNS advised the Committee that they had followed the evidence provided by Lightfoot and wanted to ensure that everything was patient centred. The CBDNS advised the Committee of 3 areas and how they had wanted to create safe and ring-fenced capacity: 1) Green – COVID-19 secure 2) Amber – For Patients that they are unsure of their COVID status and are tested on admission. 3) Red – COVID-19 positive patients. The CBDNS advised the Committee they wanted to create green ring-fenced capacity across the UHB to maintain their core services of urgent cases and cancer treatment. The CBDNS advised the Committee that the CB wanted the population of Cardiff and Vale to feel safe if they had to attend the green zones. The Director of Operations for Surgery (DOS) advised the Committee of the changes that had been made by the CB and expressed his amazement at how agile, responsive and creative the UHB had been as a whole.	

	The DOS advised the Committee that the UHB had moved with the CB and had helped development and that very quickly, over a weekend, they had moved all Ambulant and Frail trauma to the University Hospital Llandough (UHL) and this had proved a success. The DOS advised the Committee that had supported the cardio thoracic move to UHL and that this had gone very well. They had redesigned theatres and wards across University Hospital Wales (UHW) and UHL and had created the green zones. They had partnered with the private sector and thanked the Corporate team for the organisation of that which had created a huge amount of green capacity in Spire Hospital where over 2000 operations had been undertaken. They had increased emergency theatres which was important because when splitting services, assurance was needed that the workforce was in the right place. The DOS advised the Committee that they had revised all staffing rotas as COVID increased, supported the wider organisation and were currently running a COVID ward which was working reasonably well. The DOS presented the risks involved: • Fearful staff and patients. • Lack of understanding around what the CB had tried to do, internally and externally. • "Old habits die hard" – Working around people or try and work with them. • Anecdotes not evidence • Mental Fatigue – Staff have worked tirelessly. • Responsive, agile change in crisis wears thin. The DOS summarised what had been achieved from April 2020 until November 2020: • The CB had managed to undertake 7308 elective operations. • 5946 emergency operations. • Total redesign of surgical footprint to support the UHB and patients. • Flexible and responsive workforce. • Clinically lead models of care • One eye on the future • Clinical publication of the CB audit • "Stars are born" – Staff who have shown their true methods. The DOS advised that the CB could not return to the way it was pre pandemic and that it would be a "rocky road" going forward due to the waiting lists. He commented that the staff were the greatest asset. The CBDS advised of 2 problems faced by the CB: 1) Large backlog of undifferentiated patients 2) COVID-19 was ongoing. The CBDS advised the Committee that at this point success needed to be celebrated and the momentum needed to continue.	

	The CBDS presented its patient story. The patient had attended one of the CB green zones. She had originally presented to Cwm Taf UHB and had been diagnosed with head and neck cancer. She was pre-assessed and advised to self-isolate for 14 days and had a COVID swab 72 hours pre admission. She was admitted on the morning of her surgery and met with the anaesthetist and surgeons. She underwent the operation which took 4 hours and was cared for post operatively by ENT trained nurses on Ward A2 and discharged 4 days later. The CBDS advised that A2 was a ward that had been designed to look after a multitude of complex patients and that one of the primary concerns that Surgeons had had when creating green zones was the loss of their specific ward. The newly designed A2 was staffed with well experienced Senior Nurses and that proved a huge success with all staff. The CC noted the leadership shown by the Surgical Clinical Board had been phenomenal and that they had tackled difficult problems; their sensitivity and drive was remarkable. She enquired what staff morale was like. The CBDNS responded that the uncertainty around COVID-19 was still proving difficult but noted that Nurses and others had gone over and beyond. Staff had been very flexible and it was amazing how teams had come together during hardship. The Independent Member – University (IMU) asked about the future and how the momentum for change could be maintained. The DOS responded that traditional services needed to change and the CB were already looking at how that could look with for example virtual clinics and a complete redesign of job plans. “Right Bed, First Time” was key and the CB would think very differently and design a service fit for purpose. The DOS advised the Committee that based on Lightfoot data, issues could continue until 2027 to 2030 if the change was not maintained. The CBDS noted that every patient was guaranteed a bed during this time because of the green zone changes and that the UHB had never had a time where surgery was guaranteed. To go backwards was not an option. The Independent Member – Legal (IML) commented that if there were going to be things that looked permanently different, had the UHB considered how they would engage with stakeholders to avoid criticism. The DOS responded that they had engaged with the CHC. Richard Hughes (RH) commented that the pandemic had brought lots of challenges to Pre-op assessment and changes as a result of the pandemic would be central to the way forward. The short stay had been a godsend through the pandemic and having theatres right next to ward areas was superb. He would like to see surgical Nurses kept within surgical areas to use their expertise. The END commented that the presentation had been a very impressive example of leadership, certainly around values and behaviours and the engagement of staff.	

	The Executive Medical Director (EMD) advised that staff redistribution was a difficult problem and that some of the aspirations had to take a back seat as we delivered our COVID response. **Resolved that:** a) The Quality Safety and Experience Committee noted the progress made by the Clinical Board to date. b) The Quality Safety and Experience Committee approved the content of the report and the assurance given by the Surgery Clinical Board.	
QSE 20/12/013	**Health Care Standards Self-Assessment Plan and Progress Update** The Assistant Director of Patient Safety and Quality (ADPSQ) advised that work had been undertaken with specialist leads in the UHB to make sure their improvement plans had been implemented. The ADPSQ advised that they were currently thinking through how processes could be put in place next year without it being too onerous for Clinical Boards. The ADPSQ advised that further information would be brought back to Committee in the February meeting. The END advised that another of the red items in the paper related to the Clinical Board rolling programme of maintenance which was something looked at regularly by the Committee. The ADPSQ advised that they were looking across the small central Clinical Audit team and that there were 38 national mandated audits and the UHB were signed up to 35 of these. At the moment there was no dedicated resource to pick national audits up and they were working through with the Clinical Boards how the national audits could be delivered. The CC asked the ADPSQ for an update on this at a future meeting. The END closed that the final area reported on the 36 week elective treatment and 8 weeks diagnostics which was a report that went regularly to Board and was actively monitored. **Resolved that:** a) The Quality Safety and Experience Committee noted the progress made against the actions identified for each of the Health and Care Standards.	**CE**
QSE 20/12/014	**Board Assurance Framework – Patient Safety** The DCG advised Committee of work with the Board Assurance Framework (BAF) and how each risk was allocated to a Committee and reports had gone to the Strategy and Delivery Committee for some time. The DCG advised that this was the only risk on the BAF linked to this Committee. The covering report highlighted a number of ways patient safety could be compromised within the organisation as referred to in today's meeting. The DCG advised that this was brought to Committee to provide an extra level of assurance and to open it up for check and challenge before going	

	back to the Board. The DCG asked the Committee if it was happy with the risk net score of 15 currently based upon discussions had in the meeting. The EMD responded that 15 was the right score at the moment and the END agreed. The IMU noted that there was reference in the supporting document table to the use of capacity within the Spire hospital and asked how the UHB mitigated any risk by that private provider. The END responded that in its role as commissioner, the UHB had contracts with them which included quality indicators and they had a duty to report to the UHB any incidents or concerns. **Resolved that:** a) The Quality, Safety and Experience Committee reviewed the attached risk in relation to Patient Safety to enable the Committee to provide further assurance to the Board when the Board Assurance Framework was reviewed in its entirety.	
QSE 20/12/015	**Quality, Safety & Experience Workshop – Feedback & Action Plan** The EMD advised the Committee that it had been a great workshop and great to see some of the Independent Members had joined. Staff across the whole of the UHB had contributed and there had been a further feedback session on 13th November to ensure all of the learning had been taken from the event. The EMD advised that the plan moving forward was to convert the discussions had and create a proposal to take to Board Development in terms of next steps for some of the structural pieces. The EMD advised that they had been asked to work with the National Audit Team to undertake a Quality Governance review as an organisation. It was confirmed that there was ongoing work to ensure the right information reached the right places and at the right time as well as ensuring not to duplicate information. Meetings were also taking place to look at Learning, Education and Development and Medical Education to ensure the right approach and governance around the Learning Committee. **Resolved that:** a) The Quality, Safety and Experience Committee noted the feedback from the QSE workshop and agreed the next steps.	

QSE 20/12/016	**Minutes from Clinical Board QSE Sub Committees – Exceptional Items to be raised by Assistant Director, Patient Safety & Quality** The ADPSQ advised the Committee that the main observation was that it was good to see the Clinical Boards (CB) had managed to keep their Quality and Safety meetings wholly in place throughout COVID-19. The ADPSQ noted that there were no minutes received from the Mental Health CB. The ADPSQ also highlighted that CD&T had a huge radiology backlog with over 7000 patients waiting greater than 8 weeks against their RTT. This would need regular updates. The ADPSQ advised that PCIC had been rolling out news in the prison and the Director of Nursing had a very good plan to audit this in January. The IMTU asked where we might pick up operational services and estates and facilities issues given that they were not a Clinical Board. The ADPSQ responded that we worked very closely with them especially around the environment and how it impacted on patients but acknowledged there was a gap to explore.	
QSE 20/12/017	**Self-assessment of Committee Effectiveness and Forward Action Plan** The DCG advised that she had extended the action plan after discussion with the CC. The END commented that she had been disappointed with the results, noting a deterioration to where we had been in the past, and was keen that the improvement plan delivered. She added that QSE was a challenging Committee with a lot of information brought to it and that the Independent Members needed to be assured by what was presented to them. **Resolved that:** a) The Quality, Safety and Experience Committee noted the results of the Committee's self-assessment Effectiveness Review for 2019-20. b) Approved the action plan for improvement to be completed by March 2021 in preparation for the next annual self-assessment which would feed into the 2020-21 Annual Governance Statement.	
QSE 20/12/018	**HIW Activity Overview** The ADPSQ advised that HIW did step down its normal approach to inspections during the first wave of the pandemic and that they had introduced some quality checks to do offsite virtual inspections. The ADPSQ commented that the published reports had been very positive and that the focus was on COVID preparedness. The ADPSQ advised that this would be brought back to the Committee in February. The CC commented that there were clearly improvements needed in particular Clinical Boards.	**CE**

	Resolved that: a) The Quality, Safety and Experience Committee noted the level of HIW activity across a broad range of services. b) Agreed that the appropriate processes were in place to address and monitor the recommendations.	
QSE 20/12/019	**HIW Primary Care Contractor Report** The ADPSQ advised that the amount of activity seen by HIW in Primary care had significantly reduced to what we would normally expect. HIW did an onsite inspection of Birchgrove dental surgery around COVID precautions due to an anonymous concern being raised. The ADPSQ advised that Primary Care had provided assurance that necessary mitigations were in place. The END advised that it was helpful to put everything into context against an all Wales picture and that feedback given by HIW was that we seemed to be getting positive reports to date from Primacy Care and inpatient whereas some colleagues across Wales were not. **Resolved that:** a) The Quality, Safety and Experience Committee noted the contents of this report and the inspections undertaken by HIW to GMS and GDS contractors. b) The Quality, Safety and Experience Committee were assured that appropriate remedial actions were being taken by practices in relation to immediate assurance notifications. c) The Quality, Safety and Experience Committee noted that there was a robust process in place within the Primary Care Team to manage the receipt of inspection reports and ensure review and follow up by the practice.	
QSE 20/12/020	**Blood Inquiry Update** The IML left the meeting. The DCG advised the Committee that the report was for information and to keep the Committee updated on progress. The DCG advised that outcomes would continue to be reported and any significant issues raised in the private domain when appropriate. The DCG advised that a full communications plan was in place if needed. **Resolved that:** a) The Quality, Safety and Experience Committee noted the contents of the report and links to inquiry resources.	
QSE 20/12/021	**Items to bring to the attention of the Board / Committee** The END advised that she had picked up on the point made by the IMU about data, its availability and interpretation and that this would be followed through at Board and Board Development.	
QSE 20/12/022	**Any Other Business** The CC thanked the IMTU and Vice Chair for her attendance, this being her last QSE Committee meeting. The END also noted her thanks to the IMTU for her support.	

	The IMTU thanked the Committee for their generous comments.	
QSE 20/12/023	**Review of the Meeting** The CC commented that the meeting had run well. The END added that it had been a heavy agenda but it was good to see the Committee moving forward on some of the bigger issues. The IMU commented that no matter the size of the agenda, it was important to always make space to hear the messages coming from Clinical Boards and others working within the Organisation in order to have assurance. The DCG responded that the Executive team could be smarter in using the covering report appropriately to pull out key areas for IMs to focus on which would enable more time to be spent on strategic issues.	
QSE 20/12/024	**Date & Time of Next Meeting:** Tuesday 16th February 2021 at 9am. Via MS Teams	