Confirmed Minutes of the Quality, Safety & Experience Committee
Held on 15 June 2022 at 09.00am
Via MS Teams

Chair:		
Susan Elsmore	SE	Independent Member – Local Authorities / Chair of the Committee
Present:		
Gary Baxter	GB	Independent Member – University
Mike Jones	MJ	Independent Member – Trade Union
Ceri Phillips	CP	Vice Chair of Cardiff and Vale University Health Board
In Attendance		
Susan Bailey	SB	Clinical Board Director CD&T
Caroline Bird	CB	Interim Chief Operation Officer
Timothy Davies	TD	Head of Corporate Business
Hayley Dixon	HD	General Manager
Marcia Donovan	MD	Head of Corporate Governance
Claire Evans	CE	Assistant Director of Primary Care
Angela Hughes	AH	Assistant Director of Patient Experience
Meriel Jenney	MJ	Executive Medical Director
Fiona Kinghorn	FK	Executive Director of Public Health
Jason Roberts	JR	Interim Executive Nurse Director
Paul Rogers	PR	Directorate Manager of the Artificial Limb and Appliance Service
Observing		
Stephen Allen	SA	Chief Officer – Community Health Council
Vanessa Davies	VD	Head of Reviews – Health Inspectorate Wales
Emily Howell	EH	Audit Wales
Secretariat		
Nathan Saunders	NS	Senior Corporate Governance Officer
Apologies		
Nicola Foreman	NF	Director of Corporate Governance
Akmal Hanuk	AH	Independent Member – Community
Rajesh Krishnan	RK	Associate Medical Director (Clinical Governance and Patient Safety)

QSE 22/06/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the meeting in English & Welsh.	**Action**
QSE 22/06/002	**Apologies for Absence** Apologies for absence were noted.	
QSE 22/06/003	**Declarations of Interest**	
QSE 22/06/004	**Minutes of the Committee meeting held on 12 April 2022** The minutes of the meeting held on 12 April 2022 were received. **The Committee resolved that:** a) The minutes of the meeting held on 12 April were approved as a true and accurate record of that meeting.	
QSE 22/06/005	**Action Log following the Meeting held on 12 April 2022** The Action Log was received, and all ongoing actions discussed.	

	The Committee resolved that: a) The Action Log from the meeting held on 12 April 2022 was noted	
QSE 22/06/006	**Clinical Diagnostics & Therapies (CD&T) Clinical Board Assurance Report** The CD&T Clinical Board Assurance Report was received. The Clinical Board Director of CD&T (CBDCDT) presented the Committee with the metrics of where the Clinical Board was at present. The work outlined within the report received by the Quality, Safety and Experience Committee reflected the key metrics that were taking place to improve quality, safety and patient experience within the CD&T Clinical Board in order to improve quality and care outcomes for patients. It also outlined the considerable development, improvement and innovation work which was underway within that Clinical Board. It was noted that the CD&T Clinical Board provided a wide range of diagnostic and therapeutic procedures on a local, regional and UK wide basis and collectively those services underpinned, and were core components of, almost every aspect of Clinical activity undertaken within the Health Board. It was noted that the Clinical Board consisted of 7 Directorates: • Laboratory Medicine • All Wales Therapeutics and Toxicology • Radiology, Medical Physics and Clinical Engineering • Medical Illustration • Outpatients/Patient administration • Therapies • Pharmacy and Medicines Management The CBDCDT advised the Committee that it had been calculated that CD&T had around one million contacts a year with patients. It was noted that during Covid-19 the Clinical Board had not stood down any Quality & Safety meetings and that the Clinical Board had remained very keen to keep "business as usual" The CBDCDT advised the Committee of the key risks held within the Clinical Board which included: • Point of Care Testing (POCT) - Risk rating 20 – It was noted that a Clinical Lead had been appointed to support the service but a lack of a POCT Governance committee had led to reduced corporate oversight. CD&T were working with the Medical Devices Group to seek support in establishing a Health Board wide governance process. • Backlog of diagnostics and therapies (as a consequence of Covid19) due to a reduction in capacity - Risk rating 16 – It was noted that weekly monitoring of waiting lists was undertaken and a significant improvement was noted. It was noted that the Directorate was currently undertaking a capacity and demand exercise to ensure the service was "right-sized" going forward. • IT/Digital - Risk rating 16 – It was noted that there had been impact from aging hardware, software and slow delivery of key IT systems and that there were some on-going stability issues. It was noted that the Clinical Board was	

	fully engaged with the National Programme to work towards standardisation and interoperability. • Estates and Facilities - Risk rating 16 – It was noted that the fabric of some estate was sub-optimal to the delivery of modern, safe and sustainable healthcare and failed to meet regulatory requirements. It was noted that CD&T continued to engage with schemes to update/replace aging infrastructure, e.g. Mortuary and Radiopharmacy, and that delivery of the schemes would be essential to satisfy the regulatory bodies. The CBDCDT advised the Committee that the Clinical Board had recognised the significant risks from Work Related Stress, and set Wellbeing, Resilience, and Mental Health as a key priority and that it was just as important than ever in the post-pandemic world. She added that the Clinical Board had recognised the significant impact the values and behaviours of staff had on each other and on the patients. It was noted that the Clinical Board adopted a "train the trainer" approach to delivering the Values in Action training and that managers across the Clinical Board were delivering the training to their teams to demonstrate leadership and commitment to the messages in the videos. The Committee was advised that the feedback from that work had been very positive and that the Clinical Board would be sharing the work with other parts of the Health Board. It was noted that the Clinical Board had recognised the ongoing impact upon managers and so a weekly Resilience session for managers was established. That was a safe space where managers could 'off load', receive support from peers and take a short time out. The CC noted that the service developments around Point of Care Testing (POCT) was impressive and asked when that would be in place. The CBDCDT responded that she hoped it would be in place as soon as possible because it was a risk that the Health Board was carrying and that the number of devices being used in remote locations meant that it was important to make sure everything worked as it should. The Interim Executive Nurse Director (IEND) advised the Committee that issues regarding POCT had been picked up by the Office of Professional Leadership and that discussion was ongoing with the Executive Medical Director (EMD) and the Executive Director of Therapies and Health Sciences (EDTHS) as to who would chair the POCT group moving forward and work with the CD&T Clinical Board. The Independent Member – Trade Unions (IMTU) asked how staff morale was within the Clinical Board. The CBDCDT responded that it was still quite low but improvements had been seen. She highlighted an email she had received that had identified a member of CD&T Clinical Board staff who had gone above and beyond to help a patient who was distressed. The Independent Member – Community (IMC) asked what measures were in place in relation to the risk rating of 16 for the backlog and waiting lists. The CBDCDT responded that there were reasonable mitigation strategies in place and that she would meet the IMC offline to go through those in detail and to provide the plans and improvement trajectories in place against each of the risks.	**SB**

	He added that the risk should start to reduce quite significantly over the coming months as the Clinical Board had made good progress. The Chief Officer for the Community Health Council (COCHC) advised the Committee that taking things "offline" meant that the public would not be sighted on those discussions. The Head of Corporate Business (HCB) responded that a summary would be provided about the risk aspects that had been discussed which would reassure any members of the public and the Committee and noted that they would also be added to the Corporate Risk Register which is received by the Board at every Board meeting. The DOCDT advised the Committee that the CBDCDT would be retiring in October 2022 and thanked her for her leadership and approach to the CD&T Clinical Board and noted that it was a much safer place for Patients and Staff because of it. The CC concurred and noted that the CBDCDT was an exemplar in terms of what she had achieved on behalf of the Clinical Board. **The QSE Committee resolved that:** a) The content of the report was discussed and noted.	**TD**
QSE 22/06/007	**Quality Indicators Report: to include Pressure Damage Update** The Pressure Damage Update was received. The Director of Nursing for Surgery Clinical Board (DNS) advised the Committee that since the last QSE meeting, the data had progressed and that, as previously discussed, the goal of the Pressure Damage Collaborative was to reduce the incidence of Healthcare acquired pressure damage with the Health Board by 25% by July 2022. It was noted that the current data available to the Pressure Damage Collaborative, which could now for the first time can be presented per 1000 beds days, showed that the pressure damage per 1000 bed days had reduced from 3.51 in May 2021 to 2.61 in March 2022 for inpatient areas. That was a reduction of 24%, which at a very high simplistic level, would indicate that the reduction goal had already been met. The DNS advised the Committee that some of the data the team hoped to collect going forward as part of the quality assurance dashboard included: a) Total number of patients with pressure damage b) A breakdown of stages (moisture lesion, 1,2,3 etc) c) Pressure damage that occurred under Health Board care (Acute) d) Pressure damage that occurred under Health Board care (Community) e) Percentage of patients whose pressure damage deteriorates. f) What pressure damage was reported g) Length of time taken for pressure damage to develop h) The number of days pressure damage was free per Clinical area. The Independent Member – University (IMU) advised the Committee that the data was welcomed but noted that clarity was required regarding duplication of reporting on the same in-hospital incidents. The DNS responded that good incident reporting would be one way to stop duplication. With the new quality dashboard and by using the relevant data, patients	

could be tracked through the system which would show the pressure damage and where it was last recorded.

She added that it would be trickier to add the data into the Community setting although she was confident that, moving forward, Patients could be tracked throughout all of their Healthcare experiences.

The COCHC asked if the delays in discharge would affect the pressure damage data on future reports.

The DNS responded that it could and that one of the things that was available to staff was a medically fit button on the Clinical workstation and that it was one of the areas that could be looked at now that data was available to see if the Health Board was causing any more harm to patients by keeping them longer in hospital.

The Quality Indicators Report was received.

The Assistant Director of Patient Experience (ADPE) presented the Committee with the QSE Framework structure and noted that the Patient Safety Team was currently setting up the Clinical Safety Group and the Organisational Learning Committee.

The National Reports Incidents (NRIs) were presented to the Committee where it was identified that in December 2021 there had been a spike of NRIs which was retrospective and hospital acquired pressure damage that had been reported.

She added that there had been a lot of work undertaken that had focussed on the NRIs management and noted that over half of the overdue NRIs on the system had been effectively managed.

It was noted that there were 46 NRIs open at present but all had a plan in place to be closed.

The Committee was advised that in terms of the number of concerns received, the number had increased to around 100/120 a week. That was a significant increase and represented a pressure for the Clinical Boards as well as the Central Team.

The ADPE advised the Committee that the Concerns response time remained at around 81% which was above the Welsh Government (WG) target.

The Committee was presented with a number of Quality Indicators which included:

i) Infection Control – It was noted that number of recorded infection control incidents was 76.

j) Mortality – Fracture Neck of Femur data, Cardiac data, Stroke data.

k) Patient Safety Notices – It was noted that there were 2 Patient Safety Notices that were non-compliant:

l) PSA012 – Deterioration due to rapid offload of pleural effusion fluid from chest drains

m) PSA008 – Nasogastric tube misplacement: continuing risk of death and severe harm. It was noted that the Delivery Unit had been kept informed of the Health Board's progress and that a robust solution would be in place. The Committee noted it was an all Wales issue.

	n) Falls **The QSE Committee resolved that:** a) The contents of the Pressure Damage Collaborate update report and the actions being taken forward to address areas for improvement were noted. b) The Quality Indicators report was noted.	
QSE 22/06/008	**Mortality Indicators** The EMD advised the Committee that the paper could be taken as read but noted the complexity of it. It was noted that there had been concerns about the Risk Adjusted Mortality Index (RAMI) being high, hence why the Medical Team wished to present a paper to the Committee. It was noted that some of the disruption in the RAMI was due to poor coding. That was partly due to Covid-19 because there had been a significant loss of staff in the coding arena. The EMD advised the Committee that not only was there a coding issue which had led to the increase in RAMI but other areas were also being investigated, such as: • Length of stay • Unscheduled care • Intensive care The EMD added that she was now chairing an internal group within Intensive Care because she was concerned about RAMI in Intensive Care and further details would be provided to the Committee in November 2022. The IMD advised the Committee that from an assurance point of view, the Medical Examiner work was now bringing in a much stronger governance structure around deaths within the Health Board, and the level one reviews were done in a much more systematic way before going back to the Medical Examiner for the second stage review. She concluded that RAMI should remain high on the QSE agenda and noted a further report could be received in November 2022. The COCHC advised the Board that it had been a complex paper to read and noted that the public could struggle to understand some of the information. The EMD responded that it was the first time the Committee had received an evidence-based paper with short, sharp data summaries and noted that it would be looked at for future meetings. The IMU agreed that the paper was quite complex and asked if there would be any value in adding a mortality review to a list for a focussed discussion/workshop. The CC responded that there were a number of items on the Action Log that required a specific Board development session and noted that mortality could be added. **The QSE Committee resolved that:** a) The contents of the paper and that henceforth, the mortality paper would be submitted in the above format with detailed narrative around the different ratios, was noted.	**MJ** **MJ** **MJ** **DCG**

QSE 22/06/009	**Maternity Services – Verbal Update** The Maternity Services – Verbal Update was received. The IEND advised the Committee that there had been a strained environment regarding national Maternity Services over the past few years with issues raised in Telford, Cwm Taf and the subsequent Ockenden Report. It was noted that the Health Board had carried out its own thematic review and that Welsh Government (WG) had put an assurance template together so that there was a standard template across Wales for all Health Boards. It was noted that the Health Board had provided assurance against that template and that it had been submitted to the Chief Nursing Officer (CNO) and WG for validation. **The QSE Committee resolved that:** a) The Maternity Services – Verbal Update was noted.	
QSE 22/06/010	**HIW Activity Overview** The HIW Activity Overview was received. The IEND advised the Committee he would take the paper as read. He added that HIW had performed 2 unannounced inspections: • Cardiothoracic services – UHL – Unannounced Visit – It was noted that the inspection was carried out by HIW in Cardiothoracic services in Llandough hospital in February 2022. Provisional feedback from the inspection was overall very positive. More detail would be shared with the QSE Committee when the report had been published. • Mental Health Services – Unannounced Visit – It was noted that the inspection took place at Hafan y Coed, Llandough Hospital in February 2022. The following areas were inspected: - Cedar Ward – Adult Crisis Admission - Oak Ward – Adult Locality treatment ward - Willow Ward – Adult Locality treatment ward The inspection was based around how services met the Health and Care Standards (2015). HIW had also considered how services complied with the Mental Capacity Act (1983), Mental Health (Wales) Measure (2010), Mental Capacity Act (2005) and Deprivation of Liberty Safeguards. It was noted that overall, HIW had found that the service provided safe and effective care to patients. HIW had found a dedicated staff team that were committed to providing a high standard of respectful care to patients, with individualised care plans that considered the patients' views reflecting the Welsh Measures domains. The IEND advised the Committee that staff had raised concerns in relation to being overstretched due to the pressures of the COVID 19 pandemic. HIW had identified that as an area in need of improvement, to ensure that the appropriate staff numbers and skill mix were available to prevent staff fatigue and to allow management to have sufficient supernumerary time to undertake their operational duties.	**JR**

	The IMU asked about the thematic review of the Stroke pathway and noted that the report suggested there would be a quality insight bulletin and asked when that would be received. The IEND responded that as soon as it was received, he would circulate to Committee members. The Head of Reviews for HIW added that HIW would be writing to all Chief Executives across Wales and noted that an update on the site visit would be provided for the Health Board with a summary letter to be sent initially to the relevant individuals. The CC noted that the report could come back to the August Committee and asked to amend the second recommendation that stated: "*Agree that the appropriate processes were in place to address and monitor the recommendations*" to state that the Committee would *"agree that the appropriate processes were in place but the monitoring outcomes would come to a future meeting".* **The QSE Committee resolved that:** a) The level of HIW activity across a broad range of services was noted. **b)** It was agreed that the appropriate processes were in place to address the recommendations but the monitoring outcomes would be presented to a future Committee	**JR** **JR**
QSE 22/06/011	**Board Assurance Framework – Patient Safety** The Board Assurance Framework – Patient Safety was received. The Head of Corporate Business (HCB) advised the Committee that he would take the report as read. It was noted that the particular risk within the report had a very direct and more obvious impact on patient safety. It was noted that risk was deemed to be at the highest risk score to the Health Board – that was 25 out of 25. **The QSE Committee resolved that:** a) The 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, was noted.	
QSE 22/06/012	**Dental Services Update** The Dental Services Update was received. The Interim Chief Operating Office (ICOO) advised the Committee that she would take the paper as read. The Committee was advised that the paper was being brought in light of concerns raised by Committee and Board Members regarding access to Dental Services. It was noted that like most services, Dental Services had been impacted by Covid-19. That had resulted in patient access difficulties and constraints, as well as an increase in the backlog of patients waiting to be seen.	

It was identified that plans had been put in place to address the position as well as the recovery and redesign around Dental Services.

It was noted that that WG had set out priorities up to 2026 and had made a commitment to reform Primary Care Dentistry and also to increase access to dentists.

The ICOO advised the Committee that WG had issued a direction to all Health Boards in Wales to restart the Dental Contract Reform from 1st April 2022 through to 2023 using an action learning approach.

She added that all General Dental Services (GDS) practices were to be given a choice, to either be part of the reform programme with a suite of delivery measures, or to return to contractual arrangements based wholly on Units of Dental Activity (UDA's).

It was noted that the position for the Health Board was:

c) 73% (46) would be operating under Dental Contract Reform
d) 17% (17) would be operating under UDA's

The Committee was advised that the Health Board was seeing an improvement trajectory.

The COCHC advised the Committee that during the pandemic the Community Health Council (CHC) had performed two reviews of Dental Services and noted three concerns which included:

- Patients had been told they could not be seen under the NHS but could be seen privately.
- The number of people on the centralised waiting lists
- The Roath estate

The Assistant Director of Primary Care (ADPC) responded that there was a large centralised waiting list for access to GDS. That centralised list had been developed by the Health Board to allow a better understanding of the issue and what would be required to move forward.

She added that the Health Board would see an additional 29,000 patients in year due to the contractual changes (ie the Dental Contract Reform) and so the waiting lists should decrease.

The Independent Member – University (IMU) asked what support would be provided to the failing estate at the Roath surgery.

The ADPC responded that the Roath site could not be used due to Infection Prevention and Control (IPC) guidance which did not allow for drilling or highspeed dentistry.

She added that due to the age of the Roath estate, relevant changes could not be made to the building to accommodate the IPC changes which had reduced capacity.

It was noted that it had been placed on the PCIC Risk Register and long-term solutions were being considered. That included moving to the Cardiff Royal Infirmary (CRI) site and the Park View development, although it was noted that those developments were a long way off and so that was why it was deemed a risk.

It was noted that it would be taken to the Capital Planning and Estates forum to see if an interim solution could be found.

	The CC advised the Committee that the CHC inspection reports would be received by the Committee in August 2022. **The QSE Committee resolved that:** a) The current position in regard to all Dental Services was noted.	**JR**
QSE 22/06/013	**Ultrasound Clinical Governance position** The Ultrasound Clinical Governance position was received. The Directorate Manager of the Artificial Limb and Appliance Service (DMALAS) advised the Committee that following an Internal Audit of Ultrasound Governance across the Health Board, several shortcomings were identified. Those had centred around a lack of assurance of appropriate governance in the correct and safe use of Ultrasound across the Health Board and insufficient communication and escalation pathways. It was noted that the Ultrasound (US) Audit Report published in August 2021 had found limited assurance for Ultrasound Governance arrangements within the Health Board and the two high priority recommendations were: • The design and implementation of Ultrasound Governance arrangements outlined within the Health Board's Ultrasound Risk Management Policy and Procedure. • Roles and responsibilities in the management of diagnostic and therapeutic ultrasound services. The Committee was advised that the following actions had been taken or were in progress to address the short fallings found in the August 2021 Ultrasound Audit: • Review of the Ultrasound Clinical Governance Group (USCGG) and new Terms of Reference (ToRs) • Membership of the USCGG was extended to include all areas of Diagnostic and Therapeutic Ultrasound across the Health Board • Suitable chair of the USCGG appointed • Clear reporting pathway for USCGG ToRs • Change of name for the Medical Ultrasound Risk Management Procedure and Policy to Ultrasound Clinical Governance Procedure and Policy • Arrange regular USCGG meetings. • Requirements to appoint Ultrasound (US) roles of Clinical Lead User, Speciality Lead User, and Educational Supervisor / Training Supervisor within relevant Clinical Boards would be actioned as part of the formation of the new USCGG • Creation and implementation of the US Safety Training would be actioned and implemented as part of the formation of the new USCGG • An annual audit template would be developed by the membership of the USCGG to include a balanced range of performance indicators on the	

	effective management of US devices including training, competence and maintenance as part of the US governance framework. The CC advised the Committee that one of the Internal Audit reports for quality had supplied a limited assurance in terms of ultrasound governance due to the lack of attendance at meetings. She asked the DMALAS if assurance could be provided moving forward that attendance would improve. The DMALAS responded that the group have been very fortunate to receive support from senior managers and noted that some of the responsibility had been put back onto the Clinical Boards to ensure that their individual Directorates and teams would attend. **The QSE Committee resolved that:** a) The actions being taken to address the recommendations made by Internal Audit in the Ultrasound Governance audit report dated August 2021 were noted.	
QSE 22/06/014	**Concerns, Redress and Claims** The Concerns, Redress and Claims information was received. The Assistant Director of Patient Experience (ADPE) advised the Committee that she would take the paper as read. The IEND thanked the ADPE and her team for the sustained over 80% response rate for Patient Concerns. The CC agreed and noted that exemplary work being undertaken under the most challenging circumstances should be celebrated and to be able to maintain over 80% was very good. **The QSE Committee resolved that:** a) The contents of the assurance report were noted. b) The mitigation being taken to ensure a person-centered approach.to improve quality, safety and experience and reduce harm was noted.	
QSE 22/06/015	**Committee Effectiveness Survey Results 2021-2022** The Committee Effectiveness Survey Results 2021-2022 were received. The Head of Corporate Governance (HCG) advised the Committee that for 2021/22 the audience of who received the survey had been widened. She added that she was pleased to report that the survey results did not identify any areas of improvement for the Committee and the results would be fed into the Annual Report. The IMU advised the Committee that the way in which the Committee self-evaluated with the current tool was not the richest or most valuable way of evaluating what was being done as a Committee because he could recall writing qualitative comments which were not captured in the graphs displayed within the result. The Vice Chair of the Health Board (VCHB) agreed and noted that there were much better methods to capture Committee effectiveness which would be looked at.	

	The HCG advised the Committee that plans were in motion to replace the current methodology with a new and more appropriate one. **The QSE Committee resolved that:** a) The results of the Annual Board Effectiveness Survey 2021-2022, relating to the Quality, Safety and Experience Committee were noted.	
QSE 22/06/016	**Exception Reports (Verbal)** The Exception Reports (Verbal) were received. The EMD advised the Committee that there was nothing formal to raise but noted ongoing concerns around the "front door" which was resulting in long lengths of stay for Patients. The IEND commented that there was a lot of work ongoing and advised the Committee that the Executives had done a focussed piece of work which included an action plan and that it was an ongoing piece of work. The ICOO advised the Committee that a significant amount of work was being undertaken across the whole system and alongside colleagues at the Welsh Ambulance Service Trust (WAST). **The QSE Committee resolved that:** a) The Exception Reports were noted.	
QSE 22/06/017	**WHSSC Quality Committee – Chairs Report** The WHSSC Quality Committee – Chair's Report was received. The Vice Chair of the Health Board (VCHB) advised the Committee that it was felt that whilst the Quality and Patient Safety Committee at WHSSC reported into the WHSSC Joint Committee it was not necessarily being brought to the Health Board. He added that it gave Members an opportunity to be made aware of the processes involved. The CC thanked the VCHB for the report and noted that it connected and aligned with the Quality and Safety National Framework. **The QSE Committee resolved that:** a) The WHSSC Quality Committee – Chair's Report was noted.	
QSE 22/06/018	**Minutes from Clinical Board QSE Sub Committees:** **Exceptional Items to be raised by Assistant Director Patient Safety & Quality:** The Minutes from Clinical Board QSE Sub Committees were received. The Assistant Director of Patient Experience (ADPE) advised the Committee that action logs from each sub Committee were being looked at. The COCHC advised the Committee that it was difficult to read some of the minutes as each template was different.	

	The ADPE noted that a standard template could be provided to all sub-Committees moving forward. The Senior Corporate Governance Officer made a note to send the template out. **The Committee resolved that:** a) The Minutes from the Clinical Board QSE Sub-Committees were noted.	**NS**
QSE 22/06/019	**Corporate Risk Register** The Corporate Risk Register was received. The HCB advised the Committee he would take the report as read and noted that questions had been raised throughout the meeting in relation to risk management. He added that it was recognised that there was a considerable amount of training planned on the Risk Management System which had been suspended due to Covid-19 and Winter pressures but noted that momentum on the work would now continue. The COCHC noted that some of the risks were identified as "ongoing" or "in progress" and asked that clarity be given on future registers so that the general public would be able to read the register and understand that the risks were being dealt with. **The Committee resolved that:** a) The Corporate Risk Register risk entries linked to the Quality, Safety and Experience Committee and the Risk Management development work which was now progressing with Clinical Boards and Corporate Directorates was noted.	
QSE 22/06/020	**Items to bring to the attention of the Board / Committee**	
QSE 22/06/021	**Agenda for Private QSE Meeting** *i) Minutes of the Private Committee Meeting held on – 12.04.22* *ii) Pandemic Update & Any Urgent / Emerging Themes – Verbal* *iii) Cardiac Surgery Report Update* *iv) DNAR Orders at St David's Hospital – Update*	
QSE 22/06/022	**Any Other Business** No other business was raised.	
	Date & Time of Next Meeting: Tuesday, 30 August 2022	