ANEURIN BEVAN UNIVERSITY HEALTH BOARD

Minutes of Patient Quality, Safety & Outcomes Committee held on Tuesday 21st December at 9.00am via Microsoft Teams

Present:

Pippa Britton	- Chair
Shelly Bosson	- Independent Member
Louise Wright	- Independent Member
Paul Deneen	- Independent Member
Helen Sweetland	- Independent Member

In attendance:

Rani Mallison	- Board Secretary
Rhiannon Jones	- Director of Nursing
Peter Carr	- Director of Therapies & health Science
James Calvert	- Medical Director
Leanne Watkins	- Director of Operations
Gareth Hughes	- Divisional Director of Facilities
Janice Jenkins	- Interim Assistant Director of Digital Programmes
Emma Guscott	- Committee Secretariat

Observers:

Nathan Couch	- Audit Wales
Alexandra Scott	- Assistant Director Patient Safety
Katija Dew	- Independent Member
Alan Davies	- Aneurin Bevan Community Health Council
Tracey Partridge-Wilson	- Assistant Director of Nursing, Quality & Patient Safety

Apologies:

Nicola Prygodzicz	- Director of Planning, Digital & IT

1	**Preliminary Matters**
PQSO 2112/01	**Welcome and Introductions** The Chair welcomed those present to the meeting and thanked individuals for their attendance.
PQSO 2112/02	**Apologies for Absence** Apologies for absence were noted as above.
PQSO 2112/03	**Declarations of Interest** There were no Declarations of Interest raised in relation to items on the agenda.
PQSO 2112/04	**Draft Minutes of the Committee held on 19th October 2021** The minutes of the meeting held on the 19th October 2021 were agreed as a true and accurate record. Shelley Bosson requested that the following, taken from the minutes, be recorded on the Action log: **PQSOC 1910/09:** *Rhiannon Jones advised that a Senior Nurse for Safeguarding Education had been appointed and would be making direct contact with teams reporting low compliance. Rhiannon Jones would link with the Board Secretary to arrange bespoke training for Board members that did not attend the previous focussed Development session*. **Rhiannon Jones/Rani Mallison** Rhiannon Jones informed the Committee that a full review of training was being undertaken, and this would come back to the Committee at a later date. **PQSOC 1910/13:** *Peter Carr informed members that the Health Board is not meeting NICE best practice model regarding a dedicated nutritional support team to include specialist nurses. A business case for a dedicated nutritional support team is being developed and would be presented to the Executive Team for consideration, with an update to the Committee.* **Peter Carr** Peter Carr updated the Committee that the Divisions were working on the Nutrition Standards paper, and this would be presented to the Executive Team, with an update to the Committee to follow.
PQSO 2112/05	**Action Sheet of the Committee held on the 19th October 2021** The Committee reviewed those actions outstanding as recorded in the action log and noted the following:

	1910/13 Catering Review: Peter Carr informed the Committee that meetings had taken place with facilities with the view to start immediately. There was an expectation that the duration of the Health Board wide review would be 6 months with the plan to present findings to the Executive Team in Summer 2022. Rhiannon Jones updated the Committee on the following actions: **1910/06 Dementia Companions and Meaningful Occupation mode:** An update on the evaluation had been included in the Outcomes Report. Action complete. **1910/08 Putting Things Right - update against 2021/2022 priorities:** Circulated outside of the meeting. Action complete. **1910/13 Annual Assurance Report on Health & Care Standards; Nutrition and Hydration:** • Peter Carr to update and recirculate the Equality Impact Assessment. • The committee was assured that the use of different assessment tools in mental health and community settings was as a result of tools being developed for different categories of patients. Action complete. **1910/17 Highlight Reports; Urgent Care Transformation Board:** Rhiannon Jones had shared the Primary care update on Graduated Care with Shelley Bosson. Action complete.
2	**Presentations/Reports for Assurance**
PQSO 2112/06	**Urgent and Emergency Care Update** Leanne Watkins, Interim Director of Operations, provided an update on Urgent and Emergency Care, presenting the previously circulated paper. It was reported as a multi-agency issue. A review was taken across the whole system in order to understand interdependencies and create a coordinated approach. An Urgent Care structure had been put in place, overseen by the Urgent Care Transformation Board. It was noted that the work programme initially focused on Winter pressures. A 'System Reset' weekend was conducted on the 21st November to replicate seamless system conditions that were needed to improve the flow. The reset had been positive and addressed the congestion in departments and patient safety during the exercise. Leanne Watkins shared the significant areas of concern to the Committee. These were outlined as follows:

	• Over 21-day length of stay in excess of 500 patients (normal average range was noted as 200 patients). • Fragility of staffing driven by COVID and recruitment issues, to include the increased use of agency doctors and nurses. • Access to urgent care, particularly 111 services. Long wait times when accessing 111 telephone services were highlighted, along with high abandonment rates. • The impact on the Minor injuries Units and Emergency Departments (ED) as a result of the inability to access the 111 service in a timely manner was discussed. It was noted that departments were not currently equipped for the volume of self-presenters, however, the Committee was assured that plans we in place to mitigate these issues (see dedicated agenda item 2112/07) Leanne Watkins reported areas that had seen a positive impact on service delivery. An emergency reconfiguration of the respiratory model had taken place in response to fragility of staffing. Condensing the respiratory support had allowed for daily consultant support in the Emergency Department, resulting in a reduction waiting times and an improved patient experience, via Ambulatory Care. The Chair queried if Mass Vaccination redeployment had impacted on Primary Care and system pressures. It was reported that redeployment had affected all areas; whilst recognising the mass vaccination booster programme was an important step towards addressing winter pressures and the response to the emerging Omicron variant. Rhiannon Jones, Director of Nursing, flagged that staffing deficits and increased acuity were impacting on length of stay, with an average of 250 patients who were fit for discharge. Plans were being put in place to mitigate this. James Calvert, Medical Director informed the Committee that 59% of consultant posts remained vacant in Wales, which was a significant concern. Paul Deneen, Independent Member, requested assurance that patients' needs were being met when waiting for care in ED and that families were able to contact clinical staff for updates. Rhiannon Jones assured the Committee that Standard Operating Procedures were followed and that the fundamentals of care for patients with delayed handover were robust. Food and hydration were provided to patients and the HIW National report outlined the positive support ABUHB provided for delayed patients. The Committee noted that communications remained an issue. Investments had been made to address the ongoing issue by

	employing ward clerks and patient liaison officers. Further support was still required, however, and there was a current bid for a Patient Advice and Liaison Service to improve communication with patients and families, but recurring funding was required. Paul Deneen requested further information on the 'long term strategic changes for the Emergency Department' as outlined in the report. Leanne Watkins informed the Committee that work was being undertaken to support Same Day Emergency Care (SDEC). Plans for a SDEC Ambulatory Care area in the Grange University Hospital (GUH) were in development. The Health Board's Flow Centre was noted as supporting pathways, with a bespoke integrated front door model, as a fundamental model to support patients. Shelley Bosson, Independent Member, requested opinion on the more than 500 patients waiting in hospitals for more than 21 days and whether Local Authority (LA) care packages were influencing the inability to discharge. Leanne Watkins stated that delayed transfers were at approximately 250-300 in acute and community hospitals. The Health Board had been liaising with LA colleagues, commissioning additional care home beds and trying to secure adequate care packages for patients. The ability to transfer patients into the correct care setting was noted as very challenging. Some LA services were in 'business continuity', and it was noted that some care providers were handing back contracts to LA partners. Shelley Bosson queried if the weekend trial of holding additional assessment trolley space in the ED was successful, and if so, was it now implemented on a permanent basis. Leanne Watkins stated that the test of change was positive but achievement was variable if flow became compromise demand was increased the assessment space needed to be utilised. The Committee received the update and the Chair thanked the teams for the report.
PQSO 2112/07	**Minor Injuries Units (eLGHs)** Rhiannon Jones, Director of Nursing, provided the Committee with a presentation and update on the work she had been leading with James Calvert, Medical Director, in respect of Minor Injuries Units (MIU). The work was undertaken in response to the opening of GUH and unwell patients self-presenting at Minor Injury Units in both the Royal Gwent Hospital (RGH) and Nevil Hall Hospital (NHH). Rhiannon Jones presented the update on the risks and mitigated actions to the Committee. The following points were noted:

	• Some patients had been misdirected through the 111 service, highlighting the inadequate local knowledge of some call handlers. A positive tabletop exercise had taken place with WAST, amending the narrative used by the call handlers. • Site specific action cards had been produced to inform staff of correct pathways if a misdirected patient arrives at an MIU. • The Royal College of Physicians (RCP) report highlighted the concerns of medical staff in minor injury units; providing care to clinically unwell self-presenting patients. The report from Health Education and Improvement in Wales (HEIW) also indicated the use of medical SPR's to care for unwell presenters was inappropriate. The risk to patient care and staffing required action, especially with the possibly of having medical staffing trainees removed from MIU. • The moral injury to staff working in the MIU was flagged as a concern. Staff shared issues around the expectation placed upon them. Meetings had taken place to support staff and provide assurance around their roles, responsibility, accountability and protection in terms of vicarious liability. Further support through staff surveys and People First engagement events, undertaken by the Executive Team, was in place to listen and act on concerns raised by staff. • Staffing numbers had been based on Clinical Futures modelling, however, the actual attendances in the MIU in comparison to predicted data was between 20-50% higher. It was stated that the MIU' were not designed to cope with the numbers currently presenting. • Mitigation to address the MIU issues was discussed. It was flagged that stabilisation rooms had been introduced to allow for virtual contact with the Emergency Physician in Charge (EPIC) at the GUH, thus improving patient care and providing support to the nursing staff in MIU's prior to transfer. • The increase of Transfer Practitioners to a 24/7 service had been approved by the Executive Team, with on-going appointment. • Staffing levels in NHH more widely were flagged as a concern. An ongoing stabilisation group led by the Medical Director was in place. • A rapid review of nurse staffing had taken place. As a result, £800k additional investment had been approved by the Executive Team for additional nursing and health care support workers. Active recruitment was underway, noting that if recruitment was unsuccessful other options would need to be considered to mitigate risk. James Calvert informed the Committee that ongoing issues with WAST triage and patient transfers was a potential risk. Meetings had taken place with WAST and additional meetings with medical staff to pull

	together a Standard Operating Procedure for delayed ambulance transfers had been developed. Paul Deneen requested clarification as to why clear information did not identify GUH as a Critical Care Centre. It was confirmed that there had been significant communication outlining the role of GUH and eLGH's and this continued. **Action:** The Chair requested further information on patient transfers and any challenges to come back to a future meeting. **Rhiannon Jones/James Calvert**
PQSO 2112/08	**External inspections & Reviews: Healthcare Inspectorate Wales (HIW) & the Aneurin Bevan CHC- HIW National Ambulance Review, HIW GUH ED & Assessment Units, CHC 7 Days in Ed, HIW Mental Health St Cadocs and Wales Neonatal Network Peer review** Rhiannon Jones provided an update on the outlined reports, which had been previously circulated to the Committee. The Committee was informed that the HIW Welsh Ambulance Service NHS Trust (WAST) and Health Board review was conducted in April/May 2021. A full report had been received and published and a response submitted by the Health Board. It was noted that there were twelve national recommendations, relevant to ABUHB, outlined in the report. Three areas of ongoing Health Board action were noted as follows: • Patient Flow and the impact on delayed patient handover to be discussed in the Urgent and Emergency Care Update. • Appropriate representation at WAST meetings, including the Serious Clinical Incident Forum. Previously there had been representation from the nursing and Putting Things Right (PTR) teams. The Committee was assured that future meetings would include operational team representation. • Consistent approach in providing timely investigations and treatment for patients waiting for Ambulances. The Committee was informed that the Community Health Council (CHC) had spent seven days in the emergency department at GUH during August 2021. Patient surveys were undertaken, alongside staffing experience discussions and observations. As a result of the report, there had been five recommendations for the Health Board. The Health Board had produced an action plan as a result of the published findings, addressing all recommendations that had been made. The Committee was informed that the outlined report and action plans had been amalgamated to facilitate oversight and to support the operational teams. The Urgent Care Transformation Board

	would be overseeing the reported actions. Regular updates on actions were being provided to HIW and CHC. In September 2021 there was an unannounced inspection undertaken by HIW on wards in the Mental Health Division at St Cadoc's Hospital. As a result of the inspection, three immediate assurances were requested by HIW. The concerns were noted as follows: 1. The segregation of patients in the Psychiatric Intensive Care Unit. 2. Concerns around an individual wound care plan. 3. There was a requirement for a Divisional policy addressing long term segregation. The Committee was advised that an immediate update had been provided to HIW, since which, a full report had been received from HIW stating that they had been assured by the Health Board's actions. The Committee was assured that immediate recommendations one and two were actioned, and the third was in progress and on track to meet the December deadline. Further updates will come back to the Committee as part of the HIW actions and inspection reports. HIW undertook an unannounced visit to the Emergency Department (ED) and assessment units in GUH in November 2021. As a result of the visit, there were four immediate assurances. These were noted as; • Visibility of patients in the ED waiting room area (also flagged in the CHC report). • Infection Control measures in the Covid corridor. • Regular and systematic checking of Resuscitation trolleys (issue previously identified by HIW). • Concerns around workforce experience, based on feedback from the staff surveys and interactions conducted during the visit. The Committee was informed that a response had been provided to HIW and that HIW was assured with the actions taken. The Health Board were awaiting the final report from the HIW visit to GUH. The Neonatal Network peer review took place early 2021. The Divisions submitted a comprehensive self-assessment in response to the review. It was noted that the panel identified several areas of good practice and achievements in the GUH Neonatal Unit. Some areas were identified as areas for improvement, concerns were noted within the report. An action plan had been produced in response to concerns raised. The Committee was assured that actions were being undertaken to address recommendations within the reports. Shelley Bosson queried 'Golden Drops' as outlined in the Neonatal Network Peer Review. Rhiannon Jones agreed to provide an

	explanation outside of the meeting. **Action:** Information to be shared with committee members. **Rhiannon Jones** Louise Wright, Independent Member, requested assurance that recommendations would not be repeated in future inspections, noting that daily checking of the Resuscitation trolleys in ED inspection had been a previous HIW recommendation. Rhiannon Jones assured the Committee that policies and training were in place to ensure these issues were monitored accordingly, but could not give outright assurance they would not reoccur. Helen Sweetland, Independent Member, queried the meaning of the acronym HALO, included in the HIW National Ambulance Review. The Committee was informed that HALO stands for a Hospital Ambulance Liaison Officer. The Health Board has two HALO roles in the Emergency Department; these are ambulance personnel acting as a liaison between the department and patients waiting on ambulances with a delayed handover. The Chair noted the pressures that staff were working within and requested that associated workforce and staff well-being issues highlighted in these reports be considered by the People & Culture Committee. **Action: Secretariat** Rhiannon Jones noted concern in relation to the significant pressure and impact on staff during the external inspections at such a difficult and challenging time with system pressures and the pandemic. These concerns had been raised with the Chief Nursing Officer for Wales. The Committee acknowledged the additional pressure these reviews placed on staff. The Committee received the reports and associated updates provided. The Chair extended her thanks to Rhiannon Jones and respective teams, recognising the work undertaken.
PQSO 2112/09	**Learning From Death Report** James Calvert, Medical Director, presented the previously circulated report which provided assurance in respect of ABUHB's process to review and scrutinise inpatient mortality; and to outline the learning and improvements that are being implemented where required. The Committee noted the introduction of the Independent Medical Examiner (ME), with the aim that all deaths that occur in the ABUHB area will be scrutinised by the ME by summer 2022.

	James Calvert discussed how the Risk Adjusted Mortality Index (RAMI) enabled the Health Board to measure co-morbidity and enabled comparison with other health care settings. The ME referred a quarter of the deaths reviewed back to the Health Board; these deaths were then reviewed by the Mortality Group chaired by Steve Edwards, Deputy Medical Director. The group completes a thematic analysis which is predicted to be impactful over time at improving systems by identifying patterns. The report included patterns that had been flagged by the ME. One item of note was issues around communication. Infection control restrictions due to the pandemic had highlighted the importance of informal contact with patients' families, further supporting the need to strengthen patient advice and liaison services. The Risk Adjusted Re-Admissions Index indicated a deterioration in 2020, which was now showing improvement. The initial deterioration may be attributed to system flow issues. The Committee was assured that a Discharge Improvement Board had been established to improve system flow and standardise processes. In addition, a 'Step up-Step Down' group has been established to ensure processes were followed for inter-site transfers. **Action:** The Chair requested 6 monthly updates for the Committee. **James Calvert/secretariat** James Calvert highlighted the good progress made by Peter Carr, Director of Therapies and Health Science, and respective teams in relation to the reduction in numbers of patient falls when in hospital. The Committee received the report and noted the findings as outlined within.
PQSO 2112/10	**Cleaning Standards Report- performance against standards** Leanne Watkins, Interim Director of Operations, supported by Gareth Hughes, Divisional Director of Facilities, presented the previously circulated paper which provided an update in respect of Enhanced Cleaning Standards. Leanne Watkins informed the Committee that a paper had been presented to the Executive Team in September 2021, during which, an agreement was made to appoint additional staff to support delivery against the All-Wales Cleaning Standards. Delivery of the standards was a joint effort with Facilities, Infection Prevention and Control

	(IPAC) and Nursing teams. The current challenges with recruitment into facilities roles was identified. Gareth Hughes reported that since the opening of GUH and with the enhanced cleaning requirements, extra facilities posts had been required. The funding agreed at Executive Team had enabled the use of a mix of fixed term and agency staff. It was stated the agreed funding was not recurrent, foreseeing possible challenges. It was noted that recruitment was moving at pace. Flexibility of current teams allowed cover of risk-based cleaning requirements, by providing transport for staff to move around sites as required. The Committee was assured that the Division are addressing recruitment and strengthening staff retention. Gareth Hughes reported that, as a result of an audit completed by the Compliance and Health Safety Teams, collaborative work was being undertaken alongside NHS Wales Shared Services Partnership (NWSSP) Welsh Government (WG) to explore further National Cleaning Standards. The Chair requested assurance of continued training and quality. Gareth Hughes assured the Committee that an electronic system, called Simbiotic, produced live data on audit and performance, enabling robust audit and assessment of compliance. If an audit flagged a training issue, this could be rectified with staff training within 24-48 hours. Alongside this, each zone had a supervisor overseeing all facilities staff, further facilitating coordination. Gareth Hughes invited Independent members to participate in 'walk arounds' at a date deemed safe to do so. Shelley Bosson requested assurance around current cleaning compliance. Gareth Hughes reported that standards were not being met in totality, however based on risk, the Health Board was delivering in high-risk areas. Latest guidance from WG had changed cleaning standards and the teams were working on amending the audit process to reflect this. The Committee requested an update on compliance at the next meeting. **Action:** A detailed report on the organisational compliance to cleaning standards will be presented to the next committee. **Leanne Watkins** The Committee received and noted the information and update contained within the paper. The Committee was assured that the Health Board were using all avenues of recruitment to address current staffing issues and managing risk accordingly. The Committee highlighted the important role that facilities staff play in the Health

	Board and expressed appreciation to the staff in facilities for their hard work.
3	**For Consideration**
PQSO 2112/11	**Update of QPSOG** Peter Carr, Director of Therapies and Health Science presented the previously circulated paper. Paul Deneen, Independent Member, requested assurance on the mitigation of the ongoing risk of children being admitted to adult acute Mental Health Units and requested the numbers of children and young adults this affected. Peter Carr reported that this was an ongoing risk and there was no improved position at the time of the meeting. The Committee was assured that this had been escalated to the Executive Team and that part of the redesign work at GUH was looking at adequate space for young people when arriving at the hospital. Rhiannon Jones stated that, although the numbers of patients were small, it was having an adverse impact on children and young people's experience. **Action:** The Chair requested further updates to come back to the Committee. **Leanne Watkins**
PQSO 2112/12	**Quality and Safety Outcomes Report** Rhiannon Jones, Director of Nursing, presented a previously circulated report which highlighted the current position against a range of key quality indicators, identified emerging themes, areas of concern and mitigation as well as good practice. The following key issues were noted: • An improved position of falls, at the lowest level in the last two years at 5 per 1000 bed days. • Infection Prevention and Control remains at red rag rating- noting that ABUHB is performing the best in Wales in 4/6 targets. • The stroke position remained a concern. • Urgent and Emergency care remained a significant risk due to demand and capacity pressures. Associated with Infection, Prevention and Control the following was discussed: • Current low levels of Flu and RSV were noted. A revised plan for Flu immunisations had been agreed by the Executive Team, utilising the Local Options Framework. • There had been a gradual increase in COVID presentations and nosocomial transmission. Independent Members were due to be briefed on COVID outside of the meeting. The Committee was

	assured that all patient deaths associated with nosocomial outbreaks received a full root cause analysis. The COVID Implementation Plan had been updated to include further changes to national IPAC guidance. The Omicron variant and current isolation guidelines were noted as a risk and possibly detrimental in terms of staffing. • Clostridium Difficile was improving but remained a concern. • HPV cleaning had been maintained but proved challenging due to demand and capacity pressures. IPAC teams had met with Divisions to address issues and develop improvement plans. The Committee noted that Deb Jackson would be replacing Liz Walters as Infection Control Lead. A Meaningful Activities pilot had been undertaken in Ysbyty Aneurin Bevan. A full report would be rolled out throughout the Health Board. It was noted as a positive pilot with a good outcome for patients. Rhiannon Jones noted significant pressures within the Putting Things Right Corporate team due to staff sickness, which was in turn impacting performance. Actions were being undertaken to address departmental issues. The new Datix system had been implemented across Wales. Comparative data indicated an increase of complaints, with two main themes noted as communication and waiting times for treatment. A 'Test of Change' had been approved by the Executive Team around the management of complaints. Investigating Officers would be employed to process low level complaints. There had been two Never Events during October and November 2021. Actions were being taken to address these. An anonymous concern had been made to HIW in relation to theatre safety. A response had been sent to HIW and a response from HIW was awaited. Peter Car provided an update on the Stroke pathway and mitigations. An updated action plan addressing challenges had been reported to the Executive Team. A new effective Triage Criteria had been implemented in the ED. Since the opening of GUH and the implementation of the ideal model, the Health Board had a dedicated Stroke facility. An updated escalation plan for Stroke capacity had been completed providing a framework for staff around demand and capacity for the Hyper Acute Stroke facility. It was stated that the under performance around stroke therapies was as a direct impact of the loss of the Therapies Assessment room. The Health Board did intend to reinstate the Therapies Assessment room. Demand and capacity work had been undertaken, with support of the corporate planning team, to determine if current capacity matched demand. Peter Carr stated that an external review had been commissioned across all therapy services, resulting in recommendations. The findings

	would be aligned with work undertaken in 2022 with 'Getting Things Right First Time' to produce a strategic plan for Stroke services. It was noted that HIW were completing a review of Stroke services and pathways across Wales and the recommendations would feed into the Health Boards action plan. The Committee was assured that a Stroke Delivery Group, reporting to the Executive Team, was providing oversight of the actions outlined. Shelley Bosson requested that the outcomes report be mapped to the priorities in the Annual Plan. **Action:** Future reports to cross reference the Annual Plan and IMTP. **Rhiannon Jones** The Committee received and noted the report and thanked teams for the work underway.
PQSO 2112/13	**WCCIS Implementation** Janice Jenkins, Interim Assistant Director of Digital Programmes, presented a previously circulated paper which provided an update on the risk exposure for the Health Board due to the postponement of the implementation of WCCIS for MH&LD services. The Committee was assured that the Health Board was pursuing urgent discussions with EMIS to establish extended support arrangements post March 2022. WCCIS performance had stabilised and there was a possibility of a rescheduled WCCIS 'go live' date of March 2022. Further discussions would take place at the Strategy, Planning, Partnerships and Well-being Group (SPPWBG). **Action:** The Chair requested an update be provided to the SPPWBG. **Nicola Prygodzicz/secretariat** A strategic review was underway by WG of WCCIS national programme. The results of the report will influence how the Health Board utilises the system. A draft report would be completed by WG in January 2022. **Action:** Draft report to be shared with Independent Members once published. **Rani Mallison**
4	**Items for Quality Assurance- for information**
PQSO 2112/14	**Highlight Reports:** The Committee noted the following reports: • **Safeguarding Committee** A Child practice review was reported, highlighting lessons learned for multiple agencies. The Outcomes Report flagged low compliance with level 2 training, a particular concern of note was Children's Safeguarding training. Divisions were looking at ways to improve this shortfall in safeguarding compliance. Children's

	services remained a protected service in terms of redeployment. The Chair requested assurance that this was flagged as a risk. The Committee were assured that low training compliance is on the Corporate Risk Register, and that direct engagement from the Divisions had seen positive improvements in compliance from some teams. • **Urgent Care Transformation Board** The Committee received the report for information.
5	**Items for Board Consideration**
PQSO 2112/15	**Strategic Risk Report (Key Risks)** Rani Mallison noted that further work was underway on presentation of risks and how these risks should influence the Board and Committee agendas. **Action:** Update on risk management approach to be provided at the next meeting. **Rani Mallison** **Confirm Key Risks and items for Board Consideration** None Noted.
6	**Date of Next Meeting is Tuesday 8th February 2021 at 09:30 via Microsoft Teams**