Confirmed Minutes of the Strategy & Delivery Committee
Tuesday 15th September – 9:00am – 12:00pm
Nant Fawr 2 & 3, Woodland House / Via Skype

Chair:		
Michael Imperato	MI	Committee Chair
Members:		
Rhian Thomas	RT	Independent Member – Estates
Charles Janczewski	CJ	UHB Chair
Gary Baxter	GB	Independent Member – University
In attendance:		
Martin Driscoll	MD	Executive Director of Workforce & Organisational Development
Nicola Foreman	NF	Director of Corporate Governance
Fiona Kinghorn	FK	Executive Director of Public Health *(for part of the meeting)*
Steve Curry	SC	Chief Operating Officer
Caroline Bird	CB	Deputy Chief Operating Officer
Abigail Harris	AH	Executive Director of Strategic Planning
Kiethley Wilkinson	KW	Equalities Manager
Ruth Walker	RW	Executive Nurse Director
Stuart Walker	SW	Executive Medical Director
David Thomas	DT	Director of Digital Health Intelligence
Fiona Jenkins	FJ	Executive Director of Therapies and Health Sciences
Scott Mclean	SM	Director of Operations – Children & Women
Apologies:		
Sara Mosely	SM	Committee Vice Chair & Independent Member – Third Sector

S&D 15/09/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the public meeting, which was now being chaired by Michael Imperato having taken over the role as Committee Chair from Charles Janczewski UHB Chair.	**Action**
S&D 15/09/002	**Apologies for Absence** Apologies for absence were noted.	
S&D 15/09/003	**Declarations of Interest** There were no interests declared.	
S&D 15/09/004	**Minutes of the Committee Meeting held on 14th July 2020** The Committee reviewed the minutes of the meeting held on 14th July 2020.	

	Resolved – that: (a) the Committee approved the minutes of the meeting held on 14th July 2020 as a true and accurate record.	
S&D 15/09/005	**Action Log following the Meeting held on 14th July 2020** The Committee reviewed the action log and the following comment and update was made: UHB Chair pointed out for accuracy that the Tertiary Service update would be for 2021 not 2020. **Resolved – that:** Subject to the above amendment; (a) The Committee reviewed the action log following meeting held on 14th July 2020 and noted the updates provided.	**RK**
S&D 15/09/006	**Chair's Action taken following the meeting held on 14th July 2020** There had been no Chair's Actions taken following the meeting held on 14th July 2020.	
S&D 15/09/006	**Developing a Performance Framework Update** The Director of Digital & Health Intelligence (DDHI) introduced the report and the CC confirmed that the paper be taken as read. The DDHI discussed the key points around the Performance Management Framework and advised that it should be considered in principle as the relationship with Welsh Government (WG) was changing and therefore it was not yet clear what measures and performance targets we would be measured against as a result of Covid. DDHI stated that the report outlined the purpose of the Performance Management Framework, what it set out to achieve and the scope of the Framework. He referred to section 2 of the report which highlighted the need to support key frameworks which underpin the performance of the Health Board such as Shaping Our Future Well Being, Integrated Medium Term Plan (IMTP), Clinical Board/Corporate Directorate plans, Operational Plans and Strategies. The DDHI also mentioned that the document, which had been published by WG to enable reporting against the Delivery Framework Reporting Guidance 2020/21, was not currently being used in full given the situation we were in. The DDHI then discussed the principles the UHB had adopted in terms of how the Performance Framework should be managed, which had been	

	shared with the Executive team and was based on work carried out in other Health Boards to provide consistency. Section 4 referred to measuring success within the Framework. With regards to internal reviews, the Board and Committees were reviewing performance across the board from individual level up to Clinical Board level performance and with external reviews around service specifications, quality standards, monitoring arrangements and reporting requirements. There was also a role for audit in terms of internal/external audits and any clinical audit plans. DDHI advised that all staff have the responsibility to promote a culture of high performance and that the role of the Board is set out, as well as the roles of the CEO and Executive Directors. He added that there was a clear role for Clinical Boards and that the role of the HSMB could be one of reviewing how performance is managed right across the individual and collective Clinical Boards. Section 6 referred to the arrangements for Clinical Boards and Corporate Departments, recognising that it was not just the Clinical Boards that had to report on performance. Section 7 referred to the performance requirements for the Board and Committees. The DDHI pointed out that information played a key role in ensuring that performance was supported through dashboards and various data pulled through our information systems. The DDHI concluded with the Escalation and Assurance process and described how information should flow from the individual right up to the Board and that accountability comes from Board level down to the individual. The Independent Member - Estates queried how we were ensuring consistency across Clinical Board's whilst implementing this. The COO commented that there were a couple of items within the Framework that would relate to consistency however there were areas that needed refinement particularity around outcomes and measuring the right things, that matter to people. He concluded that the Tier 1 harder line measures such as waiting times, were in a state of flux due to them not being currently reported upon and also due to the fact that this would all change bearing in mind the current discussions with WG. The final point was a cultural one with regards to Covid in the context of this Framework, and how we were currently on a journey of supporting and empowering teams to take ownerships of issues and deliver rather than performance managing them, although both had a part to play. He concluded that as a Board and as Executive teams there was a need to find the high trust low bureaucracy balance to allow us to have empowered enabled teams to deliver and yet operate within the Framework. The DDHI advised that the Delivery Framework had a number of measures that would be reported on specifically such as the percentage of staff having a performance appraisal.	

	The UHB Chair thanked the DDHI for his report and wanted to know how the Committees of the Board in particular could give assurance to the Board in the delivery of performance. The Committees now had a clearer remit to manage and oversee performance on behalf of the Board, but there were only two instances of Committees engaging with the performance of Clinical Boards at present, the Finance Committee and QSE Committee and therefore we would need to look at how this information could be fed through. The UHB Chair expressed that his main concern was that if we were allocating different areas of responsibilities to different Committee's then it would have to be co-ordinated to ensure that the correct information was supporting the data coming through and that the Board gets the necessary assurance. The CC echoed the comments made by the UHB Chair and added that he would like to see a streamline dashboard, providing a quick output on progress and preview of key warning signs and issues, enabling Committees to investigate further areas of interest/concern. The CC also commented that a traffic light system could allow tracking against the IMTP. The DDHI responded that there were ongoing discussions with Committees to understand what they would find useful in terms of performance metrics. Previous work done with QSE would be expanded upon for others. The DDHI agreed to work up what mini dashboards would look like and bring an update to the next Committee meeting. The Executive Medical Director (EMD) commented that a similar piece of work was underway with the DCG, looking at how performance dashboards may look in regards to QSE, Finance, Workforce and so on but felt that a strategy one could be harder to define. It was agreed that the EMD, DDHI and DCG meet to discuss and avoid replication of work. The Executive Director of Strategic Planning (EDSP) added that a link across to the Outcomes Framework would be helpful to drive things forward via the partnership lens when thinking about progress in terms of outcomes for our population. **Resolved that:** (a) The Committee noted the report.	**DT** **NF / DT / SW**
S&D 15/09/007	**Strategic Equality Plan** The Executive Director of Workforce & Organisational Development (EDWOD) updated the Committee that since the first draft of the Plan, significant challenges around Covid-19 and the disproportionate impact on our disadvantaged communities had highlighted the work needed with risk assessments for BAME colleagues and patients. Each characteristic had an Executive lead sponsor, action plan and specific objectives to achieve. The Plan needed to be endorsed by the Equality Rights Commission by 1st October 2020.	

	At the previous Committee meeting there were comments about adding in items regarding agenda pay report which was now included, strengthening the area around equality health impact assessment, and Welsh language issues. The Executive Director of Therapies and Health Sciences (EDTHS) highlighted that there was more work to be done with health improvement for people from minority ethnic communities. The Independent Member - University queried whether the action plan table required more thought in terms of specific measures or targets and that the timeline for the action plan could apply a time point for some of the objectives which could be brought back to a future meeting. The Equalities Manager (EM) agreed to produce the next iteration of the plan for a future meeting would develop a framework around the comments made in regards to monitoring and timelines. The IM-University further queried the gender pay gap increase and whether there was any obvious cause to that. The EM confirmed that this would be investigated in the coming months. The EDWOD further commented that the main disparity was due to female staff working reduced hours but would still investigate further. It was clarified that the UHB had gone beyond the statutory requirements in producing the report. The Independent Member - Estates queried whether there were any issues that could be tackled now i.e. more women being in lesser paid roles. She also queried the intentions and actions of the new Equality Strategy Welsh Language Steering Group. The EM confirmed that in terms of gender pay, it was hoped that a third party contractor would be secured to look into this issue. The Equality Strategy Welsh Language Steering Group was holding its first meeting in October to be chaired by the EDWOD, and the Group would ensure a culture change in regards to equality and Welsh language issues. **Resolved that:** (a) The Committee noted and considered the content of this report; (b) The Committee endorsed the revised Strategic Equality Plan – Caring about Inclusion 2020-2024.	**KW**
S&D 15/09/008	**Update on CAMHS Strategy** The Director of Operations – Children & Women (DOCW) advised the Committee that the specialist CAMHS service, that was with Cwm Taf 18 months ago, was now firmly patriated. Significant work was undertaken prior to lockdown to deal with a backlog of cases and deliver performance against the Part 1 WG target, the service had met the 80% Part 1 target consistently since May 2020,	

against a backdrop of 0% compliance 12 months previously, it now sits at 80-95%.

The pandemic had impacted the services and a member of staff was lost to Covid.

The services adapted and made use of tele/video communications although there was a reduction in referrals in April and May at 80% of the pre-Covid rates. Although it was more straightforward to do an assessment via tele/video communications, providing treatment was more difficult so whilst assessment performance had increased, treatment performance had decreased.

The DOCW summarised delivery against performance targets:

1. Primary Mental Health
    - there were no longer young people waiting for long periods for assessment or intervention
2. Specialist CAMHS
    - service remained non-compliant against the referral to assessment target of 28 days
    - on transfer from Cwm Taf the waiting list was approximately 180 patients with a >12 week wait. This was reduced to 85 with an >8 week a year later, however Covid impacted on this meaning the waiting list for assessment currently stands at 130 with a >12 week wait
    - the service was currently running with a waiting list for treatment: this stands at 74 patients waiting for >24 weeks – this is significant during this time patients and families were not at school.

With regards recruitment, at the point of transfer, the service had 10.5 vacancies, there was only now a Speciality Doctor Post remaining.

There had been an increase of referrals for eating disorders, this was a specialist area that they were currently not equipped for so there would be a mixed phase of recruitment focusing on that skill set.

Next Period Actions:

- Improve performance and waiting times for Specialist CAMHS services
- Fully operational SPOA wih clinical posts in place
- Finalise School/Locality Offer and agree with partners

The Independent Member – Estates queried whether due to Covid we were likely to see an increase of referrals and what would be the plans to manage the potential bottleneck.

The DOCW replied that we were not ready to see, neither expected to see a significant spike in children's mental health, unlike adult mental health.

Similar to many services, in terms of capacity, they were confident that they could continue to assess via VC however this may not be

	sustainable as more families were waiting for face to face consultations. Finally to assure that there was no growing harm, they had implemented some hard stops, so in the case of a patient waiting 28 weeks a clinician should review the case at various time points to consider if a patient on a waiting list was at risk of harm, providing governance around the waiting list. The UHB Chair queried when the triage and consultation elements would be progressed and when progress would be seen with the digital options and website. The DOCW stated that with regards triage/consultation, posts are currently out to advert. The timescale for the website was not clear and therefore he would bring back an update to a future Committee meeting with the COO. The UHB Chair advised that the Committee should keep an eye on the neuro developmental situation which would relate to young children, it was agreed that this be included in the CAMHS update for the next Committee meeting together with concerns around waiting lists and capacity management. The CC commented that he would like to be kept up to date with regards all such key developments. **Resolved that:** • The Committee noted the status of the CAMHS service inherited by the UHB and the impact of Covid-19; • The Committee noted the improved performance for Part 1 services and continued challenges to delivery of Specialist CAMHS services; • The Committee noted the progress made to develop new service models and recruit to vacancies.	**SM/SC** **SM/SC** **SM/SC**
S&D 15/09/009	**Integrated Medium Term Plan (IMTP)** **- Avoiding waste, harm and variation** The Executive Nurse Director (END) reminded the Committee that the aim of this item was to bring together performance, money and quality and demonstrate how we were impacting all those agendas at the same time. The report was based on the Quality Patient Experience Framework, Health and Care Standards and the key deliverables in the IMTP that focused on the Quality and Safety agenda. The END confirmed with regards to Infection Prevention & Control, improvement had been made in all key areas, although not hitting targets, a reduction had been seen. The END informed the Committee that we came from a position in Wales where we were ranked: • C. difficile – Ranked First • Klebsiella spp bacteraemia – Ranked First • S. aureus bacteraemia - Ranked Second • E.coli bacteraemia - Ranked Second	

	More work was required to ensure progress in all IP&C agendas however this had been impacted considerably by Covid. In addition the END was pleased to report how there were no hospital acquired Covid cases for the following number of days in: • UHW – 72 days • Llandough – 65 days • Barry – 93 days • St David's – 125 days • Rookwood – 148 days Since completion of the report, 10 serious incidents were closed in August, closure and learning remained a priority area for the QSE teams. There was particular focus on and support of Mental Health which had the highest number of open and serious incidents. Performance against response in 30 working days in concerns was now at an all-time high of 90% whilst the quality still remained. The work done by Patient Experience around bereavement during Covid was highlighted, this included chatter lines, virtual visiting and feedback from patients around PPE. The message to loved ones had been extremely powerful along with the bereavement hotline. The EMD added that the mortality review process was changing nationally with the introduction of a medical examiner but this had been delayed by Covid, the first medical examiner service was due to open 05/10/2020. The Independent Member - Estates queried about the type of feedback received and whether it had changed being more virtual. The END replied that the systematic feedback that would normally be received had not been brought back at the moment due to difficulties and the main feedback had been direct compliments to staff and the wards, the chat line and bereavement helpline had been most impactful. **Resolved that:** (a) The Committee noted the contents of the report and progress made against the actions outlined in the UHB IMTP.	
S&D 15/09/010	**Board Assurance Framework Update – Sustainable Primary and Community Care** The DCG highlighted that she had looked into what this Committee had done in terms of Sustainable Primary and Community Care throughout the year which was supported by the report and which would impact on the mitigation and management of this risk which was also a risk on the BAF being presented to Board. The COO added that these risks were part of longer term challenges. Their approach in terms of primary care strategy was still based around	

	the framework of SOFW, National PC Strategy, Issues of Sustainability, improving access, and aligning ourselves to new ways of working i.e. Canterbury. He added how the key actions would be pursuing of multi-disciplinary teams in terms of sustainability, improving GMS access for patients, and moving services closer to home. A Primary Care Framework was being developed in terms of the approach to the pillars of the strategy and then the pathways around Mental Health, musculoskeletal, urgent care, chronic conditions and child health and frailty as being the main pillars of moving this forward. He concluded that resolving primary care resilience would require direct approaches as mentioned in the BAF as well as collateral approaches referenced in the strategy. The CC had brought to the attention the role of the pharmacy in this strategy landscape and queried if they were involved in this strategy. The COO confirmed that they were involved and that there were a number of granular level plans included in the actions and how multi-disciplinary would include pharmacies although on the BAF it would not detail every action. The DCG confirmed that not every action would be detailed just the key actions in relation to mitigating risk. **Resolved that:** a) The Committee reviewed the attached risk in relation to Sustainable Primary and Community Care to enable the Committee to provide further assurance to the Board when the BAF was reviewed in its entirety.	
S&D 15/09/011	**Other significant plans**: Infrastructure and Estates The EDSP confirmed that this was a regular update in relation to the capital programme in terms of the overarching schemes, what the risks were, and any changes to the programme. The CC was happy for the report to be taken as read and invited questions from members. The Independent Member – Estates questioned meeting the statutory obligations and mandatory obligations, what the differences were and risks faced. The EDSP responded that some are statutory and laid out in legislation i.e. being regulated by the Human Tissue Authority and statutory requirements around medical gasses. The mandatory ones did not necessarily have the same legal framework around them but were things we should still be doing. The EDSP highlighted that there were many competing priorities with the capital programme. The Executive team had close oversight over this and balanced decisions about a particular risk verses the risk of slowing down and not delivering the work programme associated with statutory compliance.	

	Resolved that: a) The Committee noted the content of the paper and supporting documentation b) The Committee was assured that the capital programme was being closely monitored to ensure the UHB meets its statutory and mandatory obligations referred to within the report.	
S&D 15/09/012	**Performance Reports:** Key Organisation Performance Indicators The COO highlighted that the waiting list position for planned care continued to age. Since the dip in unscheduled care attendances from April, it was now back up by 3000 per month and there was an increase in mental health activity from 300 to 900 referrals. There were positive outcomes in cancer with a V shaped recovery with 1500 referrals back in July, the single cancer pathway is back at 81% and the number of cancer treatments are back to 170 a month. The COO advised that we had been working under an operating model of being in a Covid ready state and that the relaxation of reporting and targets was still in place. The Deputy Chief Operating Officer (DCOO) provided a presentation and spoke about the scale of the challenge faced in terms of RTT and waiting list times. This was only of the components in terms of risk and there were higher categories in outpatient follow ups. Since June the waiting times had started to deteriorate and the waiting lists had started to grow. The DCOO then spoke about the second lens which was “Age”; analysis showed that while the waiting lists were static up to June and starting to increase, waiting times had significantly deteriorated across the board but had been impacted by Covid. The “Stage of Pathway” was then discussed i.e. what patients on a waiting list were actually waiting for: • Outpatients – represented 60% of the waiting list - biggest and growing problem • Inpatients and diagnostics – represented a 1/3 of the waiting list. The DCOO then touched on “Risk”, in terms of what was recorded on systems. The risks found were not based off prioritisation, neither were they systematic showing a crude measurement between urgent and non-urgent risks. The COO summarised that there were 280,000 patients in total, whilst our waiting lists remained largely static to June, they were starting to grow plus waiting times had deteriorated. 50,000 of patients on RTT pathway at outpatient stage plus 174,000 outpatient follow-ups. The COO discussed how strategically they could implement a framework going forward but there was significant work required to manage risk within the system as any model put in place would be a process not an event and would need managing.	

	He advised in treatment terms they were trying to safely regrow activity which faced challenges of logistics and confidence to improve the amount of activity whilst keeping things safe. The aim with outpatients wass not to re-establish what we used to do but instead re-establish something different. The DCOO gave a breakdown of the structure of the outpatient programme and the order of care model it was thought patients should sit in, in terms of Primary & Community Care and Secondary care. The COO concluded with the following considerations: • Do we default to a risk-based approach • How do we manage risk in transition • Do we think we can recover by working harder or commissioning more • How do we support clinical design and leadership but at pace • What is our 'phone first' moment for planned care. The COO then spoke about clinical design and what the first principles should be: • Designed by our Clinicians – so it is owned • Moving from time to clinical urgency • Hospital appointment as last resort. The CC asked about the Committee's role in terms of scrutiny of the process. The COO responded that the developments would be shared with the Committee every month together with progress against plans to return surgery and outpatients to pre Covid levels. The UHB Chair thanked both for the presentation and commented that it was key that the Committee be kept informed of progress. **Resolved that:** (a) The Committee noted the contents of the report (b) The Committee noted the presentation.	
S&D 15/09/013	**Performance Reports:** Key Workforce Indicators The EDWOD advised how the paper summarised the impact of Covid as headcount numbers increased due to extra recruitment and in turn increased employment costs, which also could be attributed to staff doing more overtime. Absence levels were at 10% which was lower than had been budgeted for but this had now decreased to 5% as expected even with the impact of Covid.	

	Formal training pieces had decreased due to no classroom training. Corporate inductions, were able to go ahead and training had now resumed with social distancing measures. The UHB Chair thanked the EDWOD and his team for producing the KPI table which clearly illustrated the Covid trends and was a major step forward from the previous report. **Resolved that:** a) The Committee noted and discussed the contents of the report.	
S&D 15/09/014	**Influenza Vaccination Update 2019/20 and plans for 2020/21** The Executive Director Public Health (EDPH) highlighted that influenza vaccinations was one of the more important healthcare programmes that the UHB had and along with the Flu programme, would run alongside mass Covid vaccination, so was particularly important this year. The report provided a detailed status update on flu vaccinations: • Good progress was being made with patients over 65 and amongst frontline staff • Consistently exceeded national targets in frontline staff with flu uptake 63.5% last season • Primary school aged children numbers are increasing on a yearly basis since 2017 • Uptake in clinical risk groups under 65 has been a continuing challenge on a UK wide basis with other contributing factors i.e. people with asthma downplaying their actual flu symptoms with asthma symptoms. The EDPH added that the flu programme was always important as part of the winter plans as there was a range of key priorities that the programme included: • Increasing uptake amongst all risk groups, particularly those aged 65 or over with cardiovascular, respiratory, kidney or liver disease, diabetes and adults who are morbidly obese • Significantly increasing flu vaccine uptake in 2 and 3 year olds, and older children aged 11 to 17 years in clinical risk groups (delivered through Primary Care) • Maximising uptake in primary school children • Maximising uptake in health care staff with direct patient contact • Significantly increasing uptake in care home staff and staff providing domiciliary care. The EDPH further added that we had a more mobile population and higher levels than other areas of Wales of people from BAME communities which sometimes made it more challenging to increase vaccination uptake. **Resolved that:**	

	• The Committee noted the UHB's uptake of flu vaccination during 2019/20 (last season); the expansion of eligible groups for the 2020/21 flu programme • The Committee supported the implementation of actions to improve uptake in flu vaccination rates, in order to meet the expected increase in demand for flu vaccinations due to COVID-19.	
S&D 15/09/015	**Annual Update on Childhood Immunisation Uptake** The EDPH advised that during the Covid period, vaccination continued as an essential service although there was a decrease in uptake, normal levels were now returning. She highlighted uptake of most childhood vaccinations had increased in recent years with an increase in uptake of MMR for preschool children. Covid-19 had impacted on timeliness of the vaccination update. The EDPH highlighted some challenges in the available data systems, for example the Primary Care data system does not talk to the Child Health data system for vaccinations which still needed work on a national level. The Action plan priorities for 2020/21 in relation to childhood immunisations had been agreed by the Immunisation Steering Group in light of the Covid-19 pandemic and were pending approval by the Children and Women and PCIC Clinical Boards. These were: • An annual data cleansing and performance cycle for childhood immunisations (particularly at age 1, pre-school, and teenage). This will include an annual data cleansing process to ensure accuracy of data held on the Child Health Information System. • Improvements in the IT systems used by Primary Care and Child Health for documenting immunisations to improve efficiency and accuracy of data. • A regular cycle of escalation which identifies and supports Primary Care with low immunisation uptake to put in place evidence-based interventions. • Dissemination of quarterly Primary Care and cluster uptake profiles, which identify trends and compares C&V with national averages, together with follow-up discussions with localities, clusters and Community Directors to focus action. • Implementation of the Measles Elimination Action Plan for Wales to increase uptake of MMR across age groups. • Delivery of a communications package to raise awareness and provide evidence-based information. The UHB Chair commented that these were very important areas of work and voiced his support for the programme. **Resolved that:**	

	a) The Committee noted the UHB's current uptake of childhood immunisations and forthcoming changes to the immunisation programme; b) The Committee supported focused action on implementation of actions to deliver changes to the programme to improve uptake in childhood vaccination rates.	
S&D 15/09/016	**Move More, Eat Well Plan** The EDPH advised that this was launched late with the particular focus on workplaces, communities and healthy travel. They were now also looking to implement in schools where appropriate depending on the Covid-19 situation. It was highlighted that there was a question on how to support older people who did not have digital access and a guide was now available digitally and via a hard copy. It was a stay well whilst staying at home guide. This was accessible via council hubs, independent living housing scheme, Vale 50 plus forum etc. The EDPH added that it was a push to keep people healthy within the context of Covid and that good work was being done to include older people. **Resolved that:** a) The Committee noted the verbal update.	
S&D 15/09/017	**Committee Effectiveness Review** The CC had agreed the paper for noting. The UHB Chair queried that the action called for a more robust agenda setting but feels it could be a more deeper than just the agenda setting. He mentioned how the COO highlighted that we should deal with the work planning rather than the agenda setting to avoid time pressures towards the end of the period and feels that work plans should be included. The DCG agreed that out of the 18 questions asked that this area requires more work around the work plan. **Resolved that**: a) The Committee noted the results of the Committee's self-assessment Effectiveness Review for 2019-20; b) The Committee approved the action plan for improvement to be completed by March 2021 in preparation for the next annual self-assessment which will feed into the 2020-21 Annual Governance Statement.	

S&D 15/09/018	**Regional Partnership Board (RPB)** The CC stated that he would like to be more informed regarding the RPB as it fed into strategic and delivery issues. The EDSP agreed to meet with the CC. The Committee was asked to note that there was now a further year of ICF & Transformation funding and work was in process around the range of initiatives available. **Resolved that**: a) The Committee noted the update on the RPB.	
S&D 15/09/019	**Changes in Nursing and Midwifery Education** The CC asked the Committee to note the contents of the paper. The UHB thanked the END for the work involved. **Resolved that:** a) The Committee noted the contents of the report.	
S&D 15/09/020	**Review of the Meeting** The CC thanked everyone for their contribution during his first meeting. All confirmed it was a good meeting with an appropriate level of Independent Member challenge and scrutiny.	
S&D 15/09/021	**Date & Time of next Meeting** Tuesday 10th November 2020 9:00am – 12:30pm Via Skype	