Agenda Item Number 2.1.1

MINUTES OF THE MEETING OF CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD (CTMUHB)

HELD ON THURSDAY 28 MAY 2020 AS A VIRTUAL MEETING VIA MICROSOFT TEAMS

MEMBERS PRESENT:

Marcus Longley	– Chair
Sharon Hopkins	– Chief Executive (Interim)
Maria Thomas	– Vice Chair
Paul Griffiths	– Independent Member
Dilys Jouvenat	– Independent Member
Ian Wells	– Independent Member
James Hehir	– Independent Member
Jayne Sadgrove	– Independent Member
Mel Jehu	– Independent Member
Nicola Milligan	– Independent Member
Philip White	– Independent Member
Alan Lawrie	– Executive Director of Operations
Hywel Daniel	– Executive Director of Workforce & Organisational Development (Interim)
Greg Dix	– Executive Director of Nursing
Kelechi Nnoaham	– Executive Director of Public Health
Clare Williams	– Executive Director of Planning & Performance (Interim)
Nick Lyons	– Medical Director
Steve Webster	– Executive Director of Finance (In part)
Liz Wilkinson	– Director of Public Health (For agenda item 4.1)

IN ATTENDANCE:

Georgina Galletly	– Director of Governance / Board Secretary (Interim)
Cally Hamblyn	– Assistant Director of Governance & Risk
David Jenkins	– Independent Advisor to the Board
Cathy Moss	– Chief Officer, Cwm Taf Morgannwg Community Health Council
Olive Francis	– Vice Chair, Cwm Taf Morgannwg Community Health Council
Urvisha Perez	– Audit Wales (Observing)
Emma Walters	– Corporate Governance Officer (Secretariat)

A) PRELIMINARY MATTERS

HB/20/065 **AGENDA ITEM 1.1 WELCOME & INTRODUCTIONS**

The Chair **welcomed** everyone to the meeting and advised that it was important to recognise that the last two months had been a very difficult and challenging time for the organisation, and expressed thanks for the dedication of all staff for the care and commitment they have shown and continue to show during such unprecedented circumstances. The Chair stressed the importance of the need to gradually and safely bring services back into operation over the coming weeks and months.

The Chair advised that due to the continuing restrictions in respect of public gatherings the meeting was being held virtually using the Microsoft Teams function, and added that as a result of technical challenges it was not possible to broadcast the meeting to members of the public, however this is being explored for future meetings as a priority.

HB/20/066 **AGENDA ITEM 1.2 APOLOGIES FOR ABSENCE**

Members **NOTED** that Keiron Montague would be unable to join the meeting until 10.30am and that Steve Webster would need to leave the meeting at 11.00am.

HB/20/067 **AGENDA ITEM 1.3 DECLARATIONS OF INTEREST**

There were no declarations of interest received.

B) CONSENT AGENDA

The Chair explained the purpose of utilising the consent agenda at this time, and advised that Members had been given the opportunity to raise questions in advance of the meeting and responses had been provided by Executive leads to the questions raised. The Chair advised that if any Member felt that a report required further discussion, this would be taken out of the consent agenda and added to the main agenda. Members **NOTED** that all questions raised and responses provided would be recorded with the minutes of the meeting.

P Griffiths was pleased to note that that Independent Members had raised a number of interesting questions and observations ahead of the meeting and suggested that going forward it might also be useful to distinguish between those that need formal noting by the Board and those that are more observational or seeking minor clarity that could be dealt with outside the meeting **(added to the action log).** M Longley commented on the detailed and thorough scrutiny that had been undertaken prior to the meeting.

HB/20/068 **AGENDA ITEM 2.1 ACTION LOG**

The Board **RECEIVED** and **NOTED** the action log.

HB/20/069 **AGENDA ITEM 2.2 UNCONFIRMED MINUTES OF THE HEALTH BOARD MEETINGS HELD ON 18 MARCH 2020 AND 26 MARCH 2020**

Members **RECEIVED** the minutes of the 'In Committee' Health Board meeting held on 18 March 2020 and the 'Public' Health Board meeting held on 26 March 2020, as a true and accurate record.

In relation to the minutes of the meeting held on 26 March 2020, a question had been raised prior to the meeting by an Independent Member in relation to the final paragraph contained on page 6 and a response had been provided, as outlined below:

Question: Is there an update from the Vice Chair on whether there has been any further slippage within maternity. I understand there has been a Maternity Improvement Board sitting recently.
Answer: The improvement programme is progressing well. There are two actions which have been impacted by the pandemic:
1) In respect of the dedicated area for miscarriage, this work has not progressed as planned as the Health Board has made extensive changes to clinical services and ward areas to accommodate new models of care in response to the pandemic. We have maintained all miscarriage care throughout the Covid-19 crisis. Women are triaged and risk assessed prior to attending services. Out of hours care for women experiencing miscarriage follow process via A&E as per Covid-19 protocol. Additional welfare checks and psychological support is being given to all women accessing the services.
2) The leadership programme is currently suspended as it is not deemed to be an essential service. It will be re-instated at the earliest opportunity.

In the meeting N Milligan sought further assurance regarding the response provided in relation to the leadership programme being currently suspended. In response, H Daniel advised that a meeting was being held later that day to discuss how the Leadership Programme could now be taken forward. N. Milligan thanked H Daniel for the additional assurance provided on this matter.

The Board **RESOLVED** to:

- **APPROVE** the minutes of the 'In Committee' Health Board meeting held on 18 March 2020; and
- **APPROVE** the minutes of the 'Public' Health Board meeting held on 26 March 2020.

HB/20/070 **AGENDA ITEM 2.3 CHAIR'S REPORT AND AFFIXING OF THE COMMON SEAL**

The Board **RECEIVED** the report and **NOTED** that a question had been raised by an Independent Member prior to the meeting regarding paragraph 2.4 on page 3 of the report which related to AdminControl, as outlined below, together with the response:

Question: I understand the requirement to change system and welcome training. This will be the third board pack system introduced in my time on the Board. With each introduction, Independent Members (IMs) lose access to historic board and committee papers as the current system only includes papers published within that system's time of use. IMs do not have access to the intranet or to share point as far as I am aware. Will the project plan also consider how IMs can have access to historic board papers to enable them properly to scrutinise and assure? **Answer:** Yes. The information stored on the current system will be transferred to the Health Board in an accessible format so that historical meeting files can be accessed. This will form part of the project plan and Board Members will be kept informed.

The Board **RECEIVED** the report and **RESOLVED**:

- **NOTE** the report.
- **RATIFY** the approvals gained via Chair's Urgent Action since the last Board meeting.
- **ENDORSE** the Affixing of the Common Seal to the documents listed within the report.

HB/20/071 **AGENDA ITEM 2.4 CHIEF EXECUTIVES REPORT**

The Board **RECEIVED** the report and **RESOLVED** to: **NOTE** the report.

HB/20/072 **AGENDA ITEM 2.5 AUDIT & RISK COMMITTEE HIGHLIGHT REPORT FROM THE MEETING HELD ON 6 APRIL 2020**

The Board **RECEIVED** the report and **NOTED** that a comment had been raised by an Independent Member prior to the meeting in relation to a reference made in the highlight report in relation to Cochlear Implants, as outlined below together with the response:

Comment: The note on cochlear implants could usefully be strengthened by replacing "first arising last year" with first arising in August 2019". This would better communicate the Committee's level of concern. **Answer:** We will include this in the queries raised and our response will be 'this will be noted and captured in the minutes' of the Board meeting.

The Board **RECEIVED** the report and **RESOLVED** to: **NOTE** the report for assurance.

HB/20/073 **AGENDA ITEM 2.6 PRIMARY, POPULATION HEALTH AND PARTNERSHIPS COMMITTEE HIGHLIGHT REPORT FROM THE MEETING HELD ON 10 FEBRUARY 2020**

The Board **RECEIVED** the report and **NOTED** that a comment had been raised by an Independent Member prior to the meeting in relation to the reference to Quality & Risk instead of Quality & Safety within the Internal Audit Report on Primary Care Clusters, as outlined below together with the response:

Question: In the internal audit report on primary care clusters, reference to "Quality and Risk ought to read "Quality and Safety". **Answer:** We will ensure that this is recorded in the minutes.

The Board **RECEIVED** the report and **RESOLVED** to: **NOTE** the report for assurance.

HB/20/074 **AGENDA ITEM 2.7 REMUNERATION AND TERMS OF SERVICES COMMITTEE HIGHLIGHT REPORT FROM THE MEETINGS HELD ON 30 JANUARY 2020, 18 MARCH 2020 AND 26 MARCH 2020**

The Board **RECEIVED** the report and **RESOLVED** to: **NOTE** the report for assurance.

HB/20/075 **AGENDA ITEM 2.8 CORPORATE RISK REGISTER**

The Board **RECEIVED** and **NOTED** that a number of questions had been raised by Independent Members prior to the meeting that had been answered by the Executive to their satisfaction, as outlined below:

Reference: Paragraph 3.10 – Page 4
Question: It is noted that the four significant Covid19 risks on the Organisational Risk Register are also included on the Gold Command Risk Register. These four risks will remain on the Organisational Risk Register when the 'Command' arrangements are formally closed but what about the lesser risks which are presumed to be currently kept under review by the Command and Control structure. Will these be passed to appropriate

staff/departments etc. or are they already included on departmental risk registers?

Answer: The lesser risks, which are generally organisational wide risks, will be going to Management Board in June to discuss where they best fit for ongoing monitoring and to reconcile with existing departmental linked risks.

These risks were added to the Gold risk register based on the risks they posed to the Gold COVID-19 Emergency Planning strategic objectives, as oppose to the organisational objectives, and as such a discussion at Management Board will help to establish if they are now best monitored at corporate level or locally via Integrated Locality Group's (ILGs), as the risks transition from emergency planning risks, to business as usual risks.

Reference: Pages 8-11
Question: Risks 005, 047, 049 and 019 are allocated to the Finance, Performance & Workforce Committee for scrutiny. As this committee no longer exists should we correct for matter of accuracy. The same applies to page 13 of the report for the assuring committee.
Answer: Yes and Yes. In addition the Staff Wellbeing COVID-19 risk still needs to be allocated an assuring committee for oversight which will be worked through by Management Board.

Reference: Pages 6-11 Trend Column
Question: The symbol being used does not convert to anything intelligible in the published document. If this can't be fixed, I suggest using + = and - (for increases, staying same and reducing). That would make the document more meaningful.
Answer: Noted and we will look to amend for future reports.

Reference: Page 4 of 50, paragraph 3.6
Question: This states "All areas have been updated since January 2020 or more recently". Does this actually mean "in January 2020 or more recently."? Many risks have a review date of January 2020 so have not been reviewed since January.

Some of these e.g. 002 Referral to Treatment Targets (RTT) (as described later in detail in the 2.17 Integrated Performance Dashboard) or 032 safe Ophthalmology services have been substantially affected by the necessary prioritisation of COVID-19 activity but have not been updated as yet in the Risk Register. While that is understandable, from an assurance perspective we need to be able to note that formally and to have an indication of when there is likely to be an opportunity to report updated management of risks in these areas.
Answer: The risk review date will show when the risk was last reviewed

and updated. If it says last review January 2020 that's the last formal review date for that risk. As noted in the report there have been a number of risks where the risk ownership has changed, in particular the majority of those risks previously owned/managed by the Chief Operating Officer now sit with the Director of Operations, and the Director of Operations is reviewing these risks to assess current risks in the post COVID-19 re-setting environment, this will be impacted by COVID-19 and the guidance from WG on 'essential services' provision to include impact on RTT and Ophthalmology risks. This exercise has not been completed, but is in the process of being carried out, and hence a number of the risks remain as updated last: January 2020. This work will be complete and reflected in the next Corporate Risk Register that goes to Board.

Reference: Pages 4 (para 3.4) and 22, Risk 030 GP Out of Hours (OOHs)
Question: This re-rating from 20 to 12 suggests a very encouraging improvement in an area which has long been problematic for the Health Board. Can we have a little more information on how this has been achieved, and how sustainable is the improvement?
Answer: The reduction in risk score reflects a number of actions taken to aid the sustainability of the OOHs service, in terms of recruitment, retention and skill mix. The reduction in risk score was agreed following the peer review of the CTMUHB GP OOHs service where positive feedback was received on the actions taken to provide sustainable improvements in the service, some of which have been shared with neighbouring Health Boards. The Peer Review letter has been received by CTM confirming the positive verbal feedback received. Shift fill rates for the service have consistently achieved 100% over the past six months.

The Board **RECEIVED** the report and **RESOLVED** to:

- **NOTE** the risks that have been removed over the past three months;
- **NOTE** the new risks added to the risk register over the past three months;
- **NOTE** the changes in risk scores over the past three months

HB/20/076 **AGENDA ITEM 2.9 PROGRAMME FOR CONTINUOUS IMPROVEMENT IN RESPONSE TO TARGETED INTERVENTION PROGRESS REPORT**

The Board **RECEIVED** and **NOTED** that a number of questions had been raised by Independent Members prior to the meeting that had been answered by the Executive to their satisfaction, as outlined below:

Reference: Paragraph 2.4-2.8 of the Main Document - Pages 3 & 4
Question: Will the work being carried out by Steve Webster, Executive Director of Finance and his team to demonstrate that the Health Board's

arrangements have met prescribed Covid19 governance standards be completed in time for consideration at the June Management Board meeting? This is likely to be very relevant to the Management Board's self-assessment of the governance section of the 'Targeted Intervention Maturity Matrix'.
Answer: The work undertaken between the Corporate team and the Finance team on reviewing the audit trail for decisions made in Gold and Silver Command during the Covid-19 outbreak to date can contribute to the governance section of the self-assessment evidence to go to Management Board in June 2020.

Reference: Item 2.9.4 - Appendix D - Employee Experience
Question: The Steering Group is chaired by the Independent Member Champion and the Vice Chair is an Executive Director and that it is attended and supported by Senior staff from across the Health Board - should this be added as evidence to this area?
Answer: Yes, and thank you for raising. This will be added to the evidence for the Leadership and Culture – Employee Experience category, for the revised self-assessment evidence to go to Management Board in June 2020.

Reference: Paragraph 3.1, Page 4
Question: When is the Health Board likely to receive feedback for additional Targeted Intervention (TI) investment bids from Welsh Government as this could significantly delay progress in all areas of the Maturity Matrix and improvement work? In some areas of the Maturity Matrix the Health Board has moved from basic level to early progress. Will this be reflected in the refreshed Maturity Matrix going to Management Board and then for scrutiny at Development Board?
Answer: The Health Board is still awaiting formal feedback from WG on the outcome of the additional TI investment, this continues to be followed up by the Health Board and further contact will be made in June if a response has not been received by this point.

The self-assessment scores for all TI areas and sub-categories will be reviewed by the Senior Responsible Owners (SROs) and revised scores presented to the internal TI Project Steering Group, chaired by the CEO in mid-June, these scores will then be discussed/challenged/ratified by the Project Steering Group before they go to Management Board, where they will be presented for discussion and any further challenge on the scores.
If the SROs deem the self-assessment scores to have changed from the scores that went to Management Board and WG in February 2020, this will be reflected in the scores presented to Management Board in June 2020, and incorporated into the scores that go for scrutiny at the Board Development session.

The Board **RECEIVED** the report and **RESOLVED** to: **NOTE** the report for assurance.

HB/20/077 **AGENDA ITEM 2.10 COVID-19 BOARD AND COMMITTEES**

The Board **RECEIVED** the report and **NOTED** that a question had been raised by an Independent Member prior to the meeting regarding the restarting of the Board Committee meetings that were stood down in the response to Covid-19, as outlined below together with the response:

Reference: 2.10 – Paragraph 2.3.2 – Page 3
Question: Given the recent successful virtual meeting of the Planning, Performance & Finance (PPF) Committee are the Health Board planning to make any further changes to the meeting timetable for this committee or other Committees over the next few months.
Answer: The Committee meeting schedule will be reviewed by the Interim Director of Corporate Governance in June to consider which Committees could be restarted in a virtual format in light of the Health Boards resets to the new normal. The Board will be informed of the outcome to this review in due course.

The Board **RECEIVED** the report and **RESOLVED** to:

- **APPROVE** the actions of the Chair, Vice Chair and Director of Finance outlined in this report.

HB/20/078 **AGENDA ITEM 2.11 CORPORATE GOVERNANCE ARRANGEMENTS IN RESPONSE TO COVID-19**

The Board **RECEIVED** the report and **RESOLVED** to:

- **APPROVE** the approach outlined in appendix 1 in relation to Corporate Governance Arrangements during Covid-19.

HB/20/079 **AGENDA ITEM 2.12 AMENDMENTS TO SCHEME OF DELEGATION**

The Board **RECEIVED** the report and **NOTED** that a question had been raised by an Independent Member prior to the meeting regarding the timeframe for reviewing the Scheme of Delegation, as outlined below together with the response:

Reference: General
Question: In light of the amendments made as identified in the reports – is there a timeframe for review?

Answer: No specific timeframe for review has been identified. However, in light of the changing situation around management arrangements for Covid-19 and the bedding in of the new operating structures, it is envisaged that there will be review and proposed amendments later in 2020/21.

The Board **RECEIVED** the report and **RESOLVED** to:

- **APPROVE** changes to the Scheme of Delegation relating to the amendments required to facilitate the New Operating Model (Appendix A) and the temporary approval process for both capital and revenue items relating to Covid-19 (Appendix B).

HB/20/080 **AGENDA ITEM 2.13 DISCHARGING BOARD COMMITTEE RESPONSIBILITIES DURING COVID-19 RESPONSE PHASE**

The Board **RECEIVED** the report and **NOTED** that a question had been raised by an Independent Member prior to the meeting regarding the development of the Terms of Reference for the new People & Organisational Development (POD) Committee, as outlined below together with the response:

Reference: page 7, 8. Workforce and Volunteers
Question: I note that the POD Committee is due to be established and (presumably) to start meeting circa July 2020. It would be helpful to start to work on the draft Terms of Reference (TOR) of that Committee in preparation for that. As Chair I would like to have early sight of the draft.
Answer: The Assistant Director of Governance and Risk is currently developing the ToRs for the new Committee structure and undertaking a review of existing Committees and will link in with the Committee Chairs as soon as possible.

The Board **RECEIVED** the report and **RESOLVED** to: **NOTE** the report.

HB/20/081 **AGENDA ITEM 2.14 QUALITY & SAFETY COMMITTEE HIGHLIGHT REPORT FROM THE MEETING HELD ON 12 MAY 2020**

The Board **RECEIVED** the report and **RESOLVED** to: **NOTE** the report.

HB/20/082 **AGENDA ITEM 2.15 MATERNITY SERVICES IMPROVEMENT PROGRAMME UPDATE REPORT**

The Board **RECEIVED** and **NOTED** that a number of questions had been raised by Independent Members prior to the meeting that had been answered by the Executive to their satisfaction, as outlined below:

Reference: Paragraph 2.6, Page 4
Question: Please can clarification of the issues and further work required in relation to Neonatal Services be provided to the Board?
Answer: Neonatal Services peer review undertaken towards the end of last year is being combined with RCOG elements and will be combined within one improvement plan governed through the Maternity Improvement Board (MIB) and an update provided to the Quality & Safety Committee in July. An ongoing review of neonatal Serious Incidents is underway. Neonatal representation is now at MIB and the Independent Maternity Services Oversight Panel (IMSOP) formal panel. Perinatal mortality review process now in place. As a consequence the following actions are being progressed:

- Dedicated Neonatal Governance Management meetings have been established to develop an assurance plan and quantify specific actions relating to Royal College of Obstetricians and Gynaecologists (RCOG) recommendations and particularly PMRs, as well as demonstrate positive work to date;
- Governance processes and pathways in relation to neonatal services are being reviewed to establish clear roles and accountabilities clearly aligning with Maternity services; with the aim to integrate governance systems across the two;
- Multi-disciplinary team approach is established to formally progress Root Cause Analysis reviews, PMRT's and EBC
- A pathway for the management of PMRTs has been drafted across maternity and NNU services with consultation of the same pending

Reference: Paragraph 3.1 Page 5
Question: Following the departure of the Maternity Improvement Director and the decision that the Director of Midwifery oversees continued improvement, please can assurance be provided that there will be no impact on the delivery of the RCOG recommendations remaining and the improvement plan?
Answer: The Director of Midwifery is now overseeing the maternity improvement programme. As part of this transition the improvement team and the operational team is being adapted to ensure that there will be no impact of the delivery of the RCOG recommendations.

Reference 2.15.1 Page 3
Question: RCOG reference 7.8 status trajectory/follow up is March 2020 and examples of assurance evidence are December 2019. Is there more up to date information on the developing structure, values and behaviours work?
Answer: The evidence was noted at the maternity improvement board in May 2020. All assurance and evidence is being updated within the

highlight reports, and this will be received by the Maternity Improvement Board on 15 June 2020.

The Service specific values and behaviours work has unfortunately had to be paused due to COVID 19. However, the team are looking at ways of recommencing the programme with the new guidance.

Reference: 2.15.2
Question: Noise at night continues to be a factor in maternity, how are we addressing this as it has been a concern that was highlighted as far back as July 2019 in the "women's experience" survey.
Answer: The Directorate are monitoring the issue and promptly address any concerns that occur. There were 2 concerns raised between Jan and March which were dealt with by the ward manager. No new concerns have been highlighted since March

The Board **RECEIVED** the report and **RESOLVED** to: **NOTE** the report.

HB/20/083 **AGENDA ITEM 2.16 PLANNING, PERFORMANCE AND FINANCE COMMITTEE HIGHLIGHT REPORT FROM THE MEETING HELD ON 19 MAY 2020**

The Board **RECEIVED** the report and **RESOLVED** to **NOTE** the report for assurance.

HB/20/084 **AGENDA ITEM 2.17 INTEGRATED PERFORMANCE DASHBOARD**

The Board **RECEIVED** and **NOTED** that a number of questions had been raised by Independent Members prior to the meeting that had been answered by the Executive, as outlined below:

Reference: Paragraph 2.73, Page 24
Question: What are the likely timescales in respect of the identification of support required in each Integrated Locality Group (ILG) and the appointment of Infection Prevention Control (IPC) nurses?
Answer: There are already dedicated IP&C nursing teams within each locality, although our challenge will be sufficient resource within our community teams which have been identified through the Integrated Medium Term Plan process.

Reference: General
Question: Because of the effect of Covid-19, there is clearly a deterioration in the delivery of key performance targets. The effect could compromise patient care and safety. Is the Health Board undertaking harm reviews in some of the key services for example cancer, urology,

RTT breaches? Taking into consideration however the paper in the main agenda around Resetting/Operating Framework.
Answer: An initial review has suggested that the issue leading to the reported performance is one of data recording rather than poor clinical practice or pathways. This predates Covid-19. However, establishing the detail of what is happening has been hampered by Covid-19.

Reference: General
Question: Sepsis bundle compliance shows a drop from December 2019 to January 2020 which is particularly significant in the Emergency Department. The narrative on page 23 states it is unclear if this may be due to a real lack of compliance or capacity to undertake audits due to Covid 19. January 2020 however is pre Covid and even during Covid 6.1.1 reports that there was a 48% reduction in A&E attendances in Wales. When are the audits carried out (if there was no capacity within the outreach team) as this has been mentioned as a possible reason. More up to date information on compliance is needed along with better clarity on why there has been such a significant drop, as it stands there does not appear to be a real explanation. Whilst I appreciate Covid has affected some work these date are pre Covid-19.
Answer: The interim Assistant Medical Director (AMD) for Quality and Effectiveness is currently reviewing sepsis management and a series of actions are likely to emerge. These will be taken forward by the substantive AMD in that role, assuming a successful appointment on 2 June 2020.

Reference: pages 6-12, paras 2.1 - 2.19, Referral to Treatment times
Question: These paragraphs outline a worrying increase in waiting times as a result of Covid-19 for patients already 'in the system' with identified health needs. What measures are in place to ensure that their conditions are being monitored and escalated when necessary? How robust are those measures?
Answer: The Board will be aware that in the emerging Covid-19 challenge, which became evident by the middle of March 2020, there was a clear requirement to take down all except essential services and reconfigure hospital sites to deal with the anticipated significant volumes of activity associated with patients who had Covid-19 / Suspected Covid-19. Of note services that could be provided off a DGH site were repositioned across CTMUHB, including the use of the Vale Hospital to undertake some cancer surgery.

Along with all other Health Board's in Wales, as the Covid-19 demand has lessened , there has been a focus on restarting urgent work on District General Hospital (DGH) sites. This has involved identifying areas where the risks to patients and staff can be minimised alongside the potential

for introduction of a robust testing regime for staff in such areas and for patient prior to admission. This work is progressing on each DGH site and the governance and safety of such will be overseen through the Executive Team and the ILG Senior Teams.

Patients that are on waiting lists that could come to potential harm are being monitored by the MDT teams on each site and where an emergency procedure is required there are facilities to do such.
The board will be aware of the Essential Services review that has been undertaken and also the operating framework recently submitted to Welsh Government.

Within each ILG work has been undertaken and in under continual review to identify those patients that may come to harm and where possible actions to minimise such via telephone advice and in very urgent cases admission and treatment where the risk to the patient of not having g such outweighs the potential risks within the DGH environment. There have only been a limited number of such occurrences.
Work to have the Covid-19 Lite environments operational is a key issue for the Health Board and work is at a pace to do such.

Reference: pages 12-13, paras 2.20-2.22, Follow-ups Not Booked
Question: (a) What does 'Delayed by more than 100 per cent' mean? (b) The table showing the numbers of activities conducted virtually looks encouraging. What assessment has been made of their acceptability and efficacy, and what assessment is planned? How sustainable are these changes?
Answer: Noted and labelling will be improved in future reports. Delayed beyond 100% means delayed 100% beyond their target date. When a decision is made that a patient requires a follow-up appointment, it is good practice to provide a clinically appropriate target date by which that patient needs to be seen. The number of patients waiting for a follow-up appointment within NHS Wales is significant as can be seen below (note that the agreed date relates to a target date and not an appointment date):

The number of patients delayed more than 100% beyond their target date at the end of March 2020 for CTM was 18892 (Page 13 of the report) or 16.9%. Whilst we did reduce this figure to as low as 17757, we were not able to sustain this direction of travel once routine elective activity ceased in the middle of March and further improvement is required. For many years, NHS Wales has been slow to take advantage of new digitally enabled ways of interacting with patients. Clinicians are now able to communicate with patients through a number of mechanisms, both video and audio, which has been invaluable since the Covid-19 outbreak. Many urgent patients are reluctant to attend hospital and

these "virtual" appointments have been the only way for the clinicians to communicate with them as a consequence. I do not believe there has been a formal evaluation of the acceptability and efficacy of such appointments, though this is not new by any means. The experience of the last few weeks is convincing clinicians that these new way are essential to help cope with rising demand and meet patient expectations. They are certainly sustainable in that the software being used is tried and tested, with no issues regarding interfacing with existing systems in use.

This is an essential part of the Health Board's Outpatient Modernisation strategy for interacting with the patient in the future, with growing clinical buy-in as to how this technology can be utilised. This is part of the Outpatient Modernisation Programme, which will be regularly monitored.

Reference: pages 27 - 28, paras 2.91 - 2.93, C-Section activity
Question: Could we have an assessment of this interesting change, in the context of the analysis originally made in the Royal Colleges' review?
Answer: Maternity services have been undertaking a multi-faceted approach to reviewing all clinical care. Specifically in relation to caesarean section (CS) we have undertaken as follows:
- An on-going task and finish group for CS, who look at a wide range of issues such guidelines, patient information, patient flow etc
- We undertake a robust programme of multi-disciplinary training (included in the service training needs analysis)
- We now have a wide range of multi-disciplinary groups and incident review panels which underpin professional discourse and learning to support ongoing improvements.
- We support in-depth discussions with pregnant women in respect of birth choices so they are able to make informed decisions about the mode of delivery.

In the meeting, N Milligan sought further assurance on the response received regarding the sepsis bundle compliance In response, N Lyons advised that even though the drop in sepsis bundle compliance was concerning, it was felt that this was a data recording issue. N Lyons provided assurance that this would be addressed with immediate effect and added that the new Assistant Medical Director (AMD) will bring added leadership to support the development of these areas further. N. Milligan thanked N Lyons for the additional assurance provided on this matter.

The Board **RESOLVED** to: **NOTE** the report.

HB/20/085 **AGENDA ITEM 2.18 FINANCE REPORTS – MONTH 12 (2019/2020) AND MONTH 1 (2020/2021)**

The Board **RECEIVED** the reports and **RESOLVED** to **NOTE** the reports for assurance.

C) MAIN AGENDA

HB/20/086 **AGENDA ITEM 3.1 MATTERS ARISING**

There were no matters arising.

HB/20/087 **AGENDA ITEM 6.2 COVID -19 FINANCIAL IMPACT AND ITS MANAGEMENT**

The Board **RECEIVED** and **NOTED** that a question had been raised by an Independent Member prior to the meeting that had been answered by the Executive to their satisfaction, as outlined below:

Reference: Item 6.2.2 – Appendix 2
Question: Mitigating action is to be taken in May to explore the potential for generating further funding by the redirection of targeted WG funding including partnership funding. What are the potential sums involved and what is the likelihood of success?
Answer: There are a wide range of WG funds allocated to CTM for specific purposes, with a total value in excess of £20m. A process is underway assessing what element of these funds might be able to be used to contribute to the cost of the Covid-19 response. In the meantime a high level top down estimate of £2.6m is assumed within the net full year forecast of Covid-19 costs as at Month 1 (ie £2.6m has been netted off the estimated gross cost).

S Webster presented the report which was seeking retrospective approval for the commitment of an additional £9.9m capital expenditure and endorsement of revenue costs without guarantee of full funding from Welsh Government.

S Hopkins reminded Members that an Accountability letter had been submitted to Andrew Goodall some time ago and that following ongoing discussions with Welsh Government and Chief Executives, a further Accountability letter would be required, which would be shared with the Board in due course.

Members **NOTED** that this report was discussed and scrutinised in detail at the Planning, Performance & Finance Committee held on 19 May 2020.

P Griffiths sought clarity in relation to the utilisation of private hospital facilities which was due to come to an end on 5 July 2020. P Griffiths added that the Health Board had not seemed to have made use of these facilities and sought clarity as to how the Health Board would ensure that

these facilities were utilised over the next few weeks. In response, S Webster advised that the Health Board was utilising just over 70% of theatre capacity, and whilst the Health Board was not at the low end of utilisation, an increase in utilisation would need to be made, whilst steps were being taken to repatriate elective activity back into the Health Board. Members **NOTED** that each District General Hospital site were in the process of developing areas where elective work could be undertaken.

S Webster advised Members that in relation to Covid-19 costs, the latest cost estimate was a £51m forecast, which did not take into consideration the latest development on the community test-trace-protect initiative, which would incur significant further costs in the region of £6m, which were currently in the process of being discussed with Welsh Government.

S Hopkins advised of the importance of ensuring the Health Board remained balanced across the Quality and Financial agenda and added that there would still be some issues that would need to be handled through the Covid-19 command response route.

The Board **RESOLVED** to:

- Retrospectively **APPROVE** the commitment of an additional £9.9m capital expenditure. This is expected to be supported by additional capital resource limit from Welsh Government, but this cannot be guaranteed;
- **APPROVE** that amendments are made to the proposed cost of the Prince Charles Hospital Phase 2 scheme to reflect the costs of a delayed start. These costs are currently estimated at £3.1m, but this will be subject to the timing of re-start and also to potential additional costs resulting from social distancing measures on site.
- **ENDORSE** the Health Board continuing to incur costs without guarantee of full Welsh Government (WG) funding, at the same time as raising the formal financial risk in the risk register relating to the risk of revenue (and capital) costs being greater than WG funding provided. The total is currently uncertain but will be lower than the £51m initially forecast. Due consideration will be given to value for money.

HB/20/088 **AGENDA ITEM 4.1 COVID-19 UPDATE**

The Board **RECEIVED** and **NOTED** that a number of questions had been raised by Independent Members prior to the meeting that had been answered by the Executive to their satisfaction, as outlined below:

Reference: Paragraphs 1.3 – 1.4, Pages 2 and 3
Question: Are the Health Board and its partners doing enough to publicise the high infection rates in the Rhondda Cynon Taf and Merthyr

Tydfil Local Authority areas (and the related high 'R' numbers), the recent significant increase in the number of Covid19 admissions to Princess of Wales Hospital and the unforgivable behaviour of some members of the local community who attended A&E in recent weeks?
Answer: The Chief Executive uses her conversations with LA leaders to raise the issue. I do have to add that there are layers of complexity in that data that we need to better understand in order to target the message better. For example, the RCT figures are high but the RGH COVID-19 activity is also high. Whether it is nosocomial transmission driving community transmission or the other way round is at this point unclear but more in-depth surveillance will provide more reliable answers. This system of surveillance is being set up as part of the Test-Trace-Protect programme. At this stage, RGH is our key DGH of focus based on recent comparative COVID-19 activity and this messaging has been placed with the Site and concerted effort put in place to address the issue.

Reference: Paragraph 2.1, Page 4
Question: Does the Public Health Response Plan (PHPR) have any significant implications for Health Board's current testing priorities in relation to the six different groups of eligible people referred to in the report?
Answer: Yes - significant implications. We will need to update the CTM Testing strategy and this is ongoing. Effective contact tracing and surveillance depend on smooth access to booking, sampling, testing and test results. These four components make up the testing system and have offered varying degrees of challenge to us, not least because we're not always in control of all the steps, e.g. lab testing, which happens at Cardiff. The Test, Trace, Protect (TTP) programme will no doubt increase demand for testing. In turn, testing will impact on how effective contact tracing and surveillance end up being. This is why we're putting in a lot of effort into getting testing right and also running the TTP programme in a way that enables integrated across all the workstreams.

Reference: Paragraph 3.2, Bullet Point 5, Page 6
Question: Has the Welsh Government provided any indication that it will fund the increased costs likely to be incurred by the Health Board as a result of the introduction of the PHPR?.
Answer: I am not aware of a clear indication in relation to aspects of the programme directly resting with the HB (mainly testing) but WG has already committed to funding LAs to set up contact tracing teams under the programme.

In presenting the report, K Nnoaham drew Members attention to the following key points:

- The cumulative rate of infection in Cwm Taf Morgannwg was 553 per 100,000 population, compared to a welsh rate of 431 per 100,000 population;
- Merthyr Tydfil and Rhondda Cynon Taff have the highest rates in Wales, with Bridgend having the lowest rates in the South Wales region;
- There were 19 new infections as of yesterday (27 May 2020), which compared with a peak of 110 on 9 April 2020;
- Since the start of the outbreak, 13,136 tests had been performed, 2479 of these tests had returned as positive, giving a cumulative percentage of 18.9% against a Welsh positivity rate of 16.2%;
- The decline in positivity rates in CTM seen from the second week of April had stalled since early May and has appeared to plateau. Members **NOTED** that the higher positivity rates may be as a result of lockdown discipline, with lower levels of lockdown discipline being seen in Rhondda Cynon Taff;
- Deaths from COVID-19 in CTM reached a peak in mid-April but have reduced steadily since then;
- In relation to deaths within Care Homes, Members **NOTED** that the Health Board was picking up all administrative responsibilities regarding the introduction of a rolling programme of testing into Care Homes.

K Nnoaham advised that if lockdown measures were not undertaken in a phased way within CTM, there would potentially be an increase in the number of cases and deaths, as there is evidence in place to suggest that the lockdown did have an impact on the numbers.

Members **NOTED** that at present the population immunity was very low, which makes the Test, Trace and Protect programme absolutely essential. Members **NOTED** that the programme would go live on 1 June and CTM was one of the Health Board areas to pilot contact tracing.

Members **NOTED** that the Test, Trace and Protect programme would consist of four workstreams, which included Contact Tracing, Surveillance, Testing and Risk Communication.

In relation to risks, the following risks were **NOTED**:

- Failure of control measures to limit COVID-19 morbidity and mortality in CTM
- Financial and human resource implications of response measures
- Major policy changes in quick succession and in absence of clear national strategy presenting real challenges for local integration and coherence
- Reputational and partner confidence

- Test, Trace, Protect programme risks – resource, partnership working, digital platform, testing

M Longley extended his thanks to K Nnoaham for presenting the report and for the leadership he had shown over the last few weeks which had been tremendous and inspiring.

M K Thomas also extended her thanks to K Nnoaham and his Team for all of the work that had been undertaken and added that she understood that the Local Authority Public Health Team were also engaged and leading on the work to be undertaken in relation to the Test, Trace Protect Programme. K Nnoaham confirmed that the Contact Tracing team was entirely staffed by Local Authority colleagues, with the programme reporting into the Regional Group.

M K Thomas advised that Independent Members had been receiving helpful updates from the Chief Executive on the current position and sought clarity as to whether a communications plan was now in place moving forward. S Hopkins advised that the Communications Team were in the process of considering how messages could be cascaded moving forward and an agreement had also been reached with Chief Executives regarding the introduction of a more combined approach to the cascading of messages. K Nnoaham added that a survey had been commissioned through the Community Engagement workstream which should provide helpful information on the community's feedback to the current situation which will help target the messaging more appropriately.

M Jehu sought clarity regarding the infection rates for Merthyr Tydfil and Rhondda Cynon Taff and questioned whether work had been undertaken to analyse the age profiles of people being infected and added that the 'new normal' seemed to be creeping into communities. K Nnoaham advised that the Health Board was closely monitoring the behaviour of the virus within the population, with the highest rates of infection being seen in 20-59 year olds, which could be as a result of the amount of testing being undertaken on key workers. Members **NOTED** the age group who appeared to be most affected and admitted to hospital were 70-89 year old men.

P White welcomed the news regarding testing in Care Homes and sought clarity as to whether Care Homes would be able to undertake the tests themselves which would help lessen the demand and resource required from the Health Board. P White also sought clarity as to what impact the 14 day mandatory self-isolating procedure would have on the organisation. K Nnoaham advised that in relation to testing within Care Homes, a two week rolling programme of whole care home testing

had been put into place, with the Health Board supporting Care Homes to undertake the tests themselves. In relation to the self-isolation period, K Nnoaham advised that the 14 day isolation is for a quarantine case, with a seven day isolation period required for an index case.

The Board **RESOLVED** to: **NOTE** the report.

HB/20/089 **AGENDA ITEM 5.1 SOUTH WALES PROGRAMME – PROGRESSING OUTSTANDING RECOMMENDATIONS**

The Board **RECEIVED** and **NOTED** that a number of questions had been raised by Independent Members prior to the meeting that had been answered by the Executive to their satisfaction, as outlined below:

Reference: General
Questions: How will the work be impacted by the reduced attendances during the Covid-19 outbreak?
Answer: The reduced number of attendances has released some pressure on the department, however in the short term the increased pressure due to running "Covid-19" and "non-Covid-19" pathways has not released any significant staffing capacity.

Question: Does the recruitment already taken place assist in looking at how a 24/7 service can be continued?
Answer: The recruitment has led to increased stability and consistency in the medical rotas but there remains a significant shortfall in senior staffing levels.

Question: Has the Covid-19 experience identified alternative ways of working that can support a sustainable service?
Answer: There is significant learning from Covid-19 in terms of how the department can work as part of the wider hospital.

Question: What progress has been made in respect of changes to Ysbyty Cwm Rhondda minor injury unit to support the sustainability of the A&E at Royal Glamorgan Hospital?
Answers: The focus on Covid-19 and, more recently the model for delivering Essential Services (which led to the pausing of work on the model for delivering Emergency Department services) means no progress has been made since the last Board meeting in March 2020.

N Lyons presented the report which was seeking approval from Board Members to recommence the work that had been paused as a result of Covid-19.

Members **NOTED** that there were encouraging signs within the report, which identified that small but relatively important recruitment successes had been made, with more leadership now in place.

Members **NOTED** that a number of discussions had been held over the last week with key stakeholder groups and staff, a meeting had also been held with the Campaign Group Chair and Secretary. S Hopkins advised that all stakeholders understood the situation fully and were content that recruitment had continued to be undertaken during the pandemic and that this would continue at pace. Members **NOTED** that the unit has welcomed the leadership measures that have been put into place, with staff now knowing who they would be working with which was is a positive step.

S Hopkins advised that discussions had been held with stakeholders regarding behavioural aspects within the community moving forward, with further work to be undertaken on the significant amount of minor injuries being treated within the department. N Lyons added that the meetings held recently had been positive, with staff feeling that they can now work much more productively and start to build a more appropriate model moving forward.

D Jouvenat sought clarity as to whether it was known what numbers of patients were presenting at the Minor Injuries Unit at Ysbyty Cwm Rhondda. Members **NOTED** that it appeared that attendances had not taken place during recent weeks. S Hopkins advised that it appears that the fear of attending places in closed settings in the current circumstances had driven changed behaviours and further discussions, engagement and support with the community will be undertaken moving forward as the Health Board resets to a new normal.

Members **NOTED** that as of Monday the programme team would be reconstituted and it was expected that by the June Board meeting there would be greater clarity on the long term model for the department, alongside a clearer sense of direction.

The Board **RESOLVED** to:

- **NOTE** the content of the report:
- **APPROVE** the recommencement of the project, including the ongoing focus on recruitment to the Emergency Department at the Royal Glamorgan Hospital.

HB/20/090 **AGENDA ITEM 5.2 COVID-19: DISRUPTION TO NURSE STAFFING LEVELS (WALES) ACT 2016**

The Board **RECEIVED** and **NOTED** that a number of questions had been raised by Independent Members prior to the meeting that had been answered by the Executive to their satisfaction, as outlined below:

Reference: 5.2 – Appendix 1, Pages 9-12
Question: Wards highlighted with an asterisk indicate acute, medical and surgical wards under Section 25B of the Act. The table shows that no ward in Prince Charles Hospital (PCH) falls under that section of the Act – is this correct?
Answer: All of our S25B wards are highlighted across the three acute sites – the * makes reference to 'note'.

Reference: General
Question: Ward 20 RGH closed on 25.3.20 due to staff testing positive for Coronavirus. What is the situation with the staff now as we are over 8 weeks on from this date. What are the plans to re-open the four wards closed between RGH and POW given that we are seeing an increase in unscheduled care and we are planning new ways to enable planned admissions, what impact are we expecting to see on our staff establishments and ultimately our staff and patients.
Answer: The site leads will take responsibility for reopening their current closed capacity based on operational demand and current plans in relation to non-covid elective activity. Balancing re-opening capacity and safe staffing levels is key and the decision will be taken collectively by the ILG directors with professional advice provided by the ILG Nurse Directors. Derogation away from the Nurse Staffing Act in 'extreme' circumstances will need to be agreed by the executive nurse director.

Reference: General
Question: It is understood that the 7 Health Visiting staff accounted for in POW to support have been recalled to their substantive posts. What if any impact has this had on the establishments shown especially as two were due to join ward 11 whose establishment had already dropped from its pre Covid level.
Answer: 11 Health Visiting staff were allocated to the PoW site and worked for 2 weeks prior to being redeployed back to their substantive roles. For these two weeks, the HV's were not part of the rosta numbers (in addition) and therefore there was no direct impact on the establishment.

Reference: General
Question: In May 2019 our sickness levels were 6.31% and in November 2019 the 12 month rolling average showed sickness at 6.02%. It would be interesting to know what our sickness levels are now and also how many staff we have managed to recruit to support with the current Covid

situation. Are there plans to try and retain some of these staff groups past our current position.
Answer: April's sickness for Registered Nurses/Midwives 8.64% and Healthcare Support Workers 13.17%.

In presenting the report, G Dix advised that the Annual Report, which would normally be presented to the Board at this time of year, would now be presented to the September Board meeting. Members **NOTED** that no changes to establishments would be required at present and **NOTED** that the June Acuity Audit had been postponed in light of the current position. G Dix advised that data for July would now be presented to the September Board.

G Dix advised that he was incredibly proud of all nursing staff and their teams who had worked really hard over the past few weeks and months. M Longley echoed the thanks expressed and added the response from colleagues throughout the Health Board, and from partners, had been incredible and humbling.

M K Thomas advised that she would be happy to endorse the following recommendations and also extended her thanks to G Dix for his leadership and her thanks to the senior nursing team for their hard work.

The Board **RESOLVED** to:

- **NOTE** the Welsh Government position associated with the NSA Act under these exceptional circumstances; and
- **APPROVE** the Health Board's proposed stance to:
  • Support the Nurse Staffing Levels (Wales) Act for COVID 19 Wards based on a revised multidisciplinary workforce approach.
  • Sign off the establishments for all acute medical and surgical wards following January 2020 acuity audit
  • Acknowledge the planned April 2021 coming into force date for paediatric in patient wards will be postponed.
  • Agree the step down of the bi-annual acuity audit in due to take place in June 2020
  • Agree clear and transparent audit trail in decision if wards are repurposed to enable exceptions under the definition of the Act

HB/20/091 **AGENDA ITEM 6.1 RESETTING CWM TAF MORGANNWG (CTM) OPERATIONAL FRAMEWORK**

The Board **RECEIVED** and **NOTED** that a number of questions had been raised by Independent Members prior to the meeting that had been answered by the Executive to their satisfaction, as outlined below:

Reference: General
Question: Is it proposed that the Board will have a Board Development on Resetting CTM Operational Framework?
Answer: Yes, this is in the process of being scheduled

Reference: Paragraph 2.8, Page 5
Question: Is the Health Board intending to 'look back' to assess the level of harm that has already been suffered by patients as a consequence of the interruption to 'essential' services. If that is the case, what is the timetable for completion of the work including Committee/Board reporting?
Answer: The Health Board harm review standard operating procedure remains in place, routinely reviewing patients waiting over 104 days. The likely biggest area of harm is in those patients who as a consequence of Covid-19 have not presented to the Health system and there is currently no way of undertaking a review on this group.

Reference: Appendix 1 – Page 6
Question: Field hospital capacity in non-NHS settings has generally been based on a provisional timetable covering Quarter 1. The Welsh Government is now expecting plans for future field hospital use to be prepared with greater emphasis given to Regional solutions. How are plans progressing?
Answer: Use of field hospitals is under constant review and currently forms part of Covid-19 surge capacity plans. Their use as a possible regional solution is currently being explored via wider Executive discussion.

Reference: Appendix 1 – Page 11
Question: What are the internal arrangements (particularly Committee/Board reporting) for monitoring and overseeing the development and delivery of local operational plans that include the 8 specific areas referred to in the 'NHS Wales Covid-19 Operating Framework – Quarter 1' publication?
Answer: The operational management and subsequent governance and assurance requirements are currently being work through via weekly a senior leadership meeting. The process will result in a robust but agile approach.

C Williams presented the report and advised that whilst Welsh Government had shared a Quarter 1 Framework, the Health Board had submitted back a realistic framing approach until the end of the financial year at least, in addition to a Quarter 1 submission. Members **NOTED** that a review of the Integrated Medium Term Plan had been undertaken, together with what had been learnt from Covid-19 and what the Covid-19 requirements could be moving forward.

Members **NOTED** that nine workstreams had been outlined within the report, each of which had an Executive Lead, and Members **NOTED** that the programme would be undertaken in six week cycles to ensure the assumptions made were still fit for purpose.

Members **NOTED** that initial feedback had been received from Welsh Government regarding the framework, with specific feedback expected by the end of the week. A meeting would be held with Executive Directors on 8 June to further discuss the approach. Members **NOTED** that no date had yet been set for the issuing of the Quarter two framework from Welsh Government, although initial feedback indicated that there will be a focus placed on winter planning.

In response to a question raised by I Wells regarding the acceleration by Welsh Government of the Digital investment fund, S Hopkins advised that this related to Critical Care Information Systems which was being taken forward by the NHS Collaborative and was part of a whole series of investments being made by Welsh Government.

In response to a question raised by C Moss as to whether a more public facing summary version of this document would be produced, C Williams advised that a discussion had been held with the Communications Team as to whether an easy read document should be produced or whether a more simpler plan on a page format should be developed which contained key messages.

A discussion was held in relation to the number of key services which needed to be brought back into operation, for example, Cancer Services. Members **NOTED** that Cancer was being clinically led through the Integrated Locality Groups. Consideration was being given to strengthening the Operational Support into Cancer Services and discussions were taking place regarding the low numbers of referrals being received at present. N Lyons advised that although referrals were down, this would be expected given the current situation and referral decisions would be being made entirely on a clinical risk based decision. S Hopkins advised that consideration would need to be given as to what risks there would be to not introducing services now compared to what the likely harm this would pose to patients in a year's time.

M K Thomas sought clarity as to how this piece of work could be taken forward under the partnerships agenda and whether any request had been made to re-establish the Regional Partnerships Board governance arrangements. C Williams advised that winter pressures had already been discussed with Local Authority colleagues and agreed that there would be a need to ensure governance arrangements were aligned.

In response to a request made by M K Thomas for any risk based decisions regarding Harm Reviews to be presented to the Quality & Safety Committee, S Hopkins advised that this would require further discussion outside of the meeting before a commitment was made and added that if there were any ethical dilemmas, these could be discussed in smaller groups outside of the Quality & Safety Committee.

Members **NOTED** that further discussion was required regarding the governance structure surrounding this piece of work and **NOTED** that a further discussion on this would be held at a future Board Development Session.

The Board **RESOLVED** to:

- **NOTE** the 'NHS Wales Covid-19 Operating Framework, Quarter 1' (Appendix 1) & the 'NHS Wales Essential Services Framework' (Appendix 2)
- **APPROVE** 'Resetting Cwm Taf Morgannwg' Operating Framework 2020/21 (Appendix 3).

HB/20/092 **AGENDA ITEMS 6.3 PRINCE CHARLES HOSPITAL CAPITAL PROGRAMME**

A Lawrie presented the report which provided an update to the Board on the status of the Rhymney Block, Prince Charles Hospital (PCH) in terms of Covid-19 plans and references the impact of Covid-19 in the PCH Fire Enforcement Notice on this scheme.

The Board **RESOLVED** to:

- **NOTE** the report;
- **APPROVE** the recommendation that Rhymney Block (including Ward 19) is handed back to Major Projects to progress the capital works and is no longer available for Covid-19 planning and to confirm Marsh House will continue to be available for the remainder of 2020/2021.

HB/20/093 **AGENDA ITEMS 7.1A – 7.2B ITEMS FOR INFORMATION**

The Board **RECEIVED** the following items for information only:

- Welsh Health Specialised Services Joint Committee Briefings from the meetings held on 10 March 2020 and 12 May 2020
- Emergency Ambulance Services Committee Chairs Report from the meeting held on 12 May 2020;
- Emergency Ambulance Services Committee Minutes from the meetings held on 28 January 2020 and 10 March 2020;

HB/20/094 **AGENDA ITEM 8.1 ANY OTHER BUSINESS**

There was no other business to report.

HB/20/095 **AGENDA ITEM 8.2 DATE OF NEXT MEETING**

The next scheduled meeting would take place on Monday 29 June 2020.

SIGNED:.....
M Longley, Chair

DATE:.....