Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 2.5

Delivery and Performance Committee	**Date of Meeting: 29 February 2024**
Subject:	**Agency Spend (Variable Pay) in Mental Health & Learning Disabilities**
Approved and Presented by:	Interim Executive Director of Operations, Community and Mental Health
Prepared by:	Acting Assistant Director of MH&LD
Other Committees and meetings considered at:	Executive Committee

PURPOSE:

The purpose of this paper is to provide context for the increased agency spend in mental health and learning disabilities (MH&LD) services over the past two years and assurance for the work already undertaken and continues to be progressed to reduce variable pay.

RECOMMENDATION(S):

The committee is asked to:

- **RECEIVE** and **CONSIDER** the issues set out in the paper NOTING the actions taken and further mitigations in place;
- Take **ASSURANCE** that whilst moderate financial risk continues to be realised, progress is being made to reduce the use of agency staffing (where costs do not fall within budget or are not covered by external funding) but are required to ensure the effective and safe delivery of services.

Approval/Ratification/Decision[1]	**Discussion**	**Information**
✓	✓	

[1] Equality Impact Assessment (EiA) must be undertaken to support all organisational decision making at a strategic level

THE PAPER IS ALIGNED TO THE DELIVERY OF THE FOLLOWING STRATEGIC OBJECTIVE(S) AND HEALTH AND CARE STANDARD(S):		
Strategic Objectives:	1. Focus on Wellbeing	✓
	2. Provide Early Help and Support	✓
	3. Tackle the Big Four	✓
	4. Enable Joined up Care	✓
	5. Develop Workforce Futures	✓
	6. Promote Innovative Environments	✓
	7. Put Digital First	✓
	8. Transforming in Partnership	✖
Health and Care Standards:	1. Staying Healthy	✓
	2. Safe Care	✓
	3. Effective Care	✓
	4. Dignified Care	✓
	5. Timely Care	✓
	6. Individual Care	✓
	7. Staff and Resources	✓
	8. Governance, Leadership & Accountability	✓

EXECUTIVE SUMMARY:

The paper sets out an understanding of the issues which are driving the use of agency costs with specific focus on MH&LD services, the actions that are being taken in response and where additional work is being undertaken to further reduce the financial risk associated with this issue.

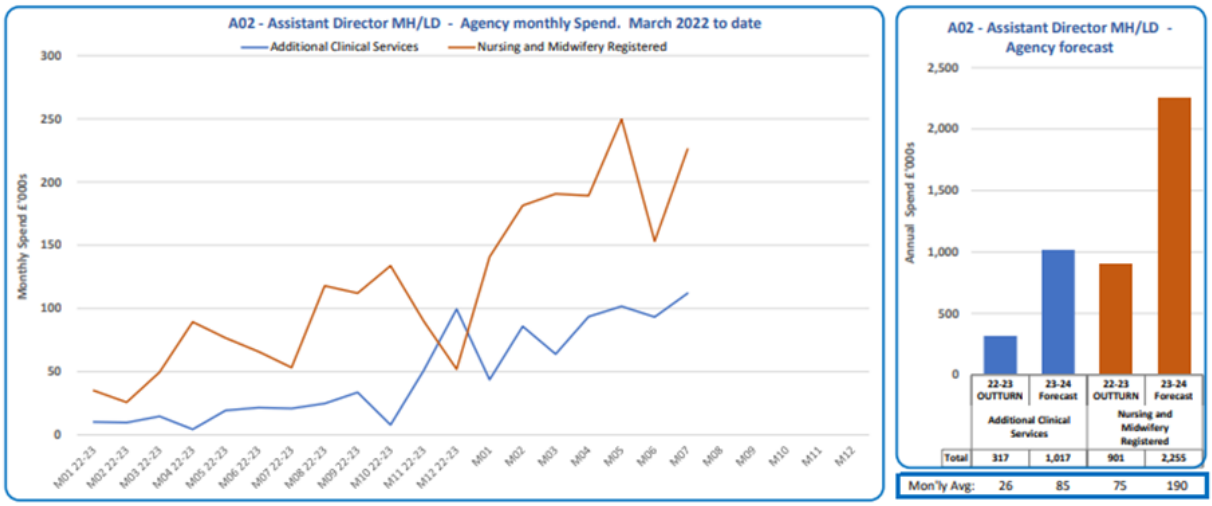
DETAILED BACKGROUND AND ASSESSMENT:

It is well recognised that for many reasons, Powys Teaching Health Board (PtHB) remains reliant on agency and locum staffing to continue the safe delivery of many clinical services. Whilst understood that this is financially detrimental and offers numerous risks (including limitations to care delivery standards) to the organisation, the provision of this workforce to ensure sufficient numbers of staffing are provided in order to maintain service delivery has been fundamental for MH&LD services during 2023/24.

Regardless, in recent years and largely as a result of the competitive market position created by the impact of the Covid-19 pandemic, it has been recognised that the costs associated with agency temporary workforce continue to escalate, and that as well as the quality benefits that a reduction on reliance to this arrangement brings, there are ongoing plans in place to improve the organisational financial impacts resulting from this approach.

However, it is important to understand that there have been specific challenges and circumstances in MH&LD Services, and new positive service developments that have impacted variable pay figures in an unprecedented (in Powys) way during 2023/24. Utilising the latest financial data to month 8 (November) of 2023 / 24, chart F1 shows the overall picture of Agency monthly spend since March 2022. MH&LD have seen an exponential increase in variable pay for both additional clinical services and registered nursing.

F1 – Overall MH&LD Agency monthly spend March 2022 to date:



Overall spend shows a forecast variable pay increase in 2023/24 of £2,054m. These figures do not include income from external funding sources.

Operational focus - general

A number of best practice operational measures were introduced in 2023, in response to growing dependency and frequency of agency usage within the Health Board.

In MH&LD, these have included:

- Professional challenge to all requests for enhanced levels of care across the Mental Health and Learning Disabilities Division (MH&LD), with requests being required in SBAR format, and assessed and signed off by either the Head of Nursing, Head of MH Operations and the Assistant Director.
- In the inpatient settings, rosters are scrutinised weekly, with monthly sign off and template checks to ensure they are as efficient as possible (within the limits of vacancies). This includes a review of annual leave utilisation and inclusion of Band 7 Nursing to pick up a number of the clinical shifts. Rosters are then released to enable ward staff to pick up additional shifts in advance, then released to the Temporary Staffing Unit (TSU) for fill.
- Rosters remain with TSU for a week, with an aim to fill vacant shifts utilising bank staffing. Following this, they are submitted for on-framework agency fill.

- 48 hours before shifts are needed, where on framework has not been able to cover, shifts are sent to TSU where not covered. HoN/AD authorises off framework (this is done by Gold on call out of hours). The only exception may be in an area where (due to high levels of vacancy), regularised off-contract agency use is relied upon.
- Head of MH Nursing spot checking of rostering performance.
- Divisional spend of agency is reviewed in Senior management Team meetings, with further discussion (including mitigation identified to contribute to planned financial savings) in 1:1 meetings with managers.
- A review of the on-call pack and arrangements to support communication out of hours is underway.
- MH&LD has also implemented its own weekly bed management meetings which supplement the weekly handover meetings to discuss and support staffing level issues and mitigations.

MH&LD are also undertaking a rigorous review of commissioned arrangements as due to pressures in the system Nationally, the availability of beds in contracted arrangements has decreased during 2023/24.

Whilst such measures would reflect best practice, a greater degree of concentrated effort on plans to address key challenges such as vacancy, sickness and a recognised need to manage inpatient risk to increased acuity, complexity and dependency have also been an essential objective during this financial year.

In recognition of this, a number of other organisation wide approaches have and continue to be undertaken to assist in reducing the utilisation of bank and agency staffing.

External factors
It is identified that a number of drivers for cost, fall outside of the direct control of PtHB. Whilst all measures intended to reduce the reliance on agency will offer potential mitigation for this, some separate actions are taken in direct response.

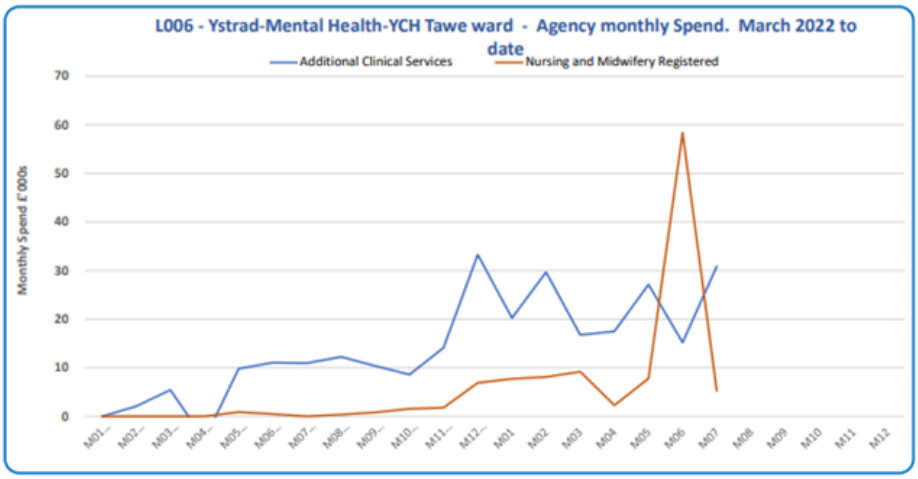
Driver	Impact	Action taken
Last minute cancellation by agency staff / error in booking by agency	Need to revert to more expensive off contract supply (where continued requirement for agency staffing confirmed)	Additional senior challenge to requests for alternative cover, alongside contractual engagement with suppliers by TSU. MH&LD specific bi-weekly huddles with TSU established to share concerns, datix themes and resolve issues dynamically.
Increase in rates by agency providers	10% price increase by Thornbury commenced July 2023.	Continued overall plan to move away from off-contract supply, and successful negotiation with additional providers ongoing.

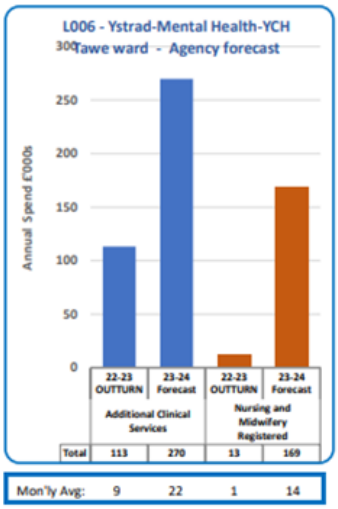
Increasing lack of capacity from on-contract suppliers.	Greater reliance on more expensive off-contract suppliers	Increased engagement with on-contract suppliers to enhance their offer, including review of rates and terms and conditions. Additional and reliable MH&LD provider successfully added to framework (PureHealth).

Circumstances unique to PTHB MH&LD – Inpatient Settings

1. Tawe Ward

F2 - Tawe Ward monthly Agency Spend March 2022 to date:





With less flexibility in the older adult system as a result of the ongoing temporary closure of Crug Ward at the outset of the Pandemic and redeployed staff retiring or leaving PTHB, additional pressures have been split between the two remaining Older Adult Wards of Tawe and Clywedog.

A greater number of detained patients plus increases in complexity, acuity and level of observations required in 2023/24 have meant a significantly increased level of additional staff required to keep patients safe. Tawe Ward has specifically seen deficits in staffing from November 2022 with further deterioration and a full bed state seen in Apr 2023 resulting in SBAR request for block booking of agency to keep the Ward open.

Vacancies, part retirement, long term sickness and Maternity cover saw Ward staffing down to only 3.8 qualified staff in Summer 2023 with such reliance on agency (50%) that a temporary closure was considered. A Programme Board was established to consider options for a different model to mitigate for lack of resilience in the staffing levels, however, the Programme Board identified opportunities to overcome this which were presented to assure the Board of a safe interim solution whilst awaiting the Accelerated Sustainable MH Transformation agenda to gain momentum in consideration of Pan Powys modernisation and shared care approach linked to the frailty agenda. Agency use has continued as part of this mitigation but delivery of the embedded staffing recovery plan eventually saw success in recruiting to registered nursing vacancies reducing from 3.71 wte to 2.2 wte by December 2023.

Mitigations:

- 2021-2023 posts were repeatedly advertised (10 times) plus a bespoke recruitment campaign. Reconfiguration of staffing and innovative solutions employed (please see Staffing recovery plan for detail with recent success). Transformation programme seeking to redress resilience, isolation and workforce issues, for e.g. Majority of staff female staffing and need for male presence for some patients. Little opportunity to share staffing with Clywedog due to distance.
- Conversion of B6 post filled, starting date 14th January 2024.
- 2.20 Band 5 wte vacancies remaining with interviews for most recent round of recruitment 19th January 2024.

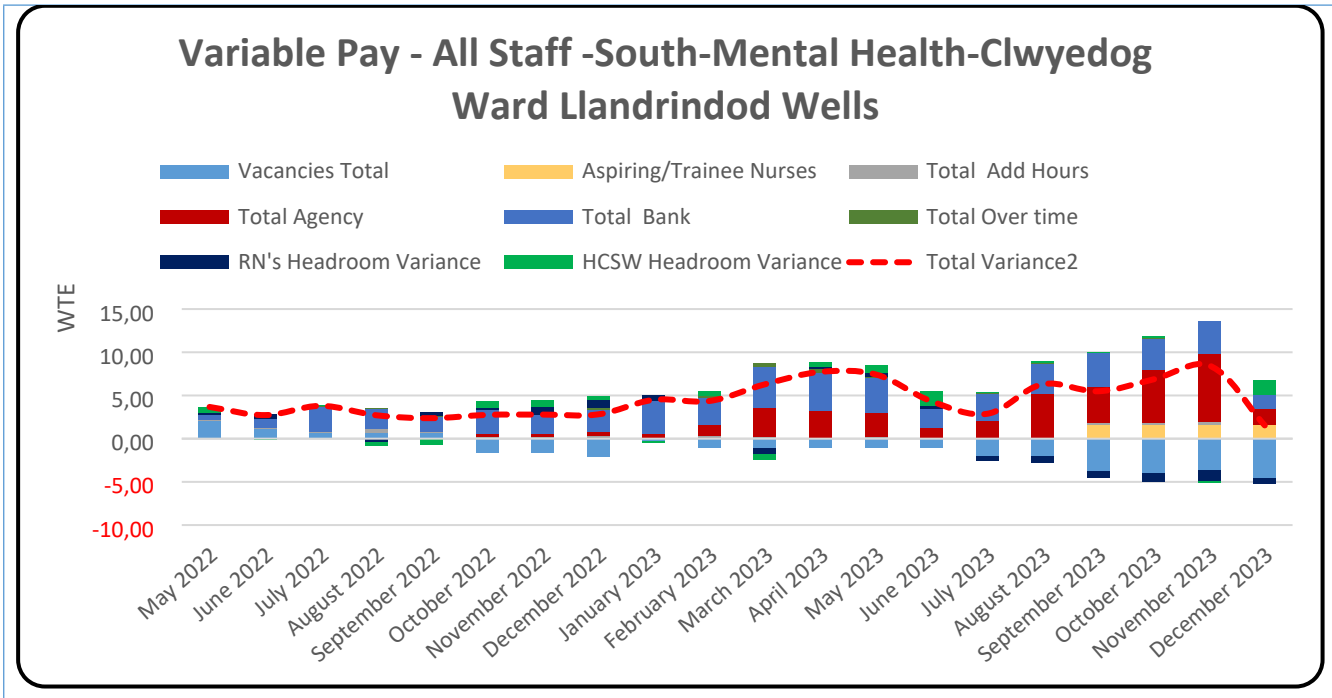
n.b. Following retirement of Ward Manager in September 2023 there has been a new Ward Manager in post. For a short period of time, the finalising of rosters were not undertaken at the appropriate time which has impacted on time of payment meaning that there has been a skew of the monthly figure (Oct and Nov 23). This has recently been remedied and a true position for Tawe will be clearer for month 9.

2. Acuity, Observation levels and lengths of stay.

There has been a significant number of unique and challenging individual patients and situations during 2023/24 that have required increased staffing levels – above agreed establishment. In the Older Adult Wards there are 12 patients who have required enhanced observations and have had a prolonged stay on Wards due to varying issues, co-morbidities**,** and pathways of care delays. This includes a level 3 patient requiring 1:1 for inappropriate sexualised behaviour for 249 days, two female patients with enhanced falls risk on level 3 for over 100 days, and ten patients with levels of aggression, risk to others and harm to self at level 3 observation or above.

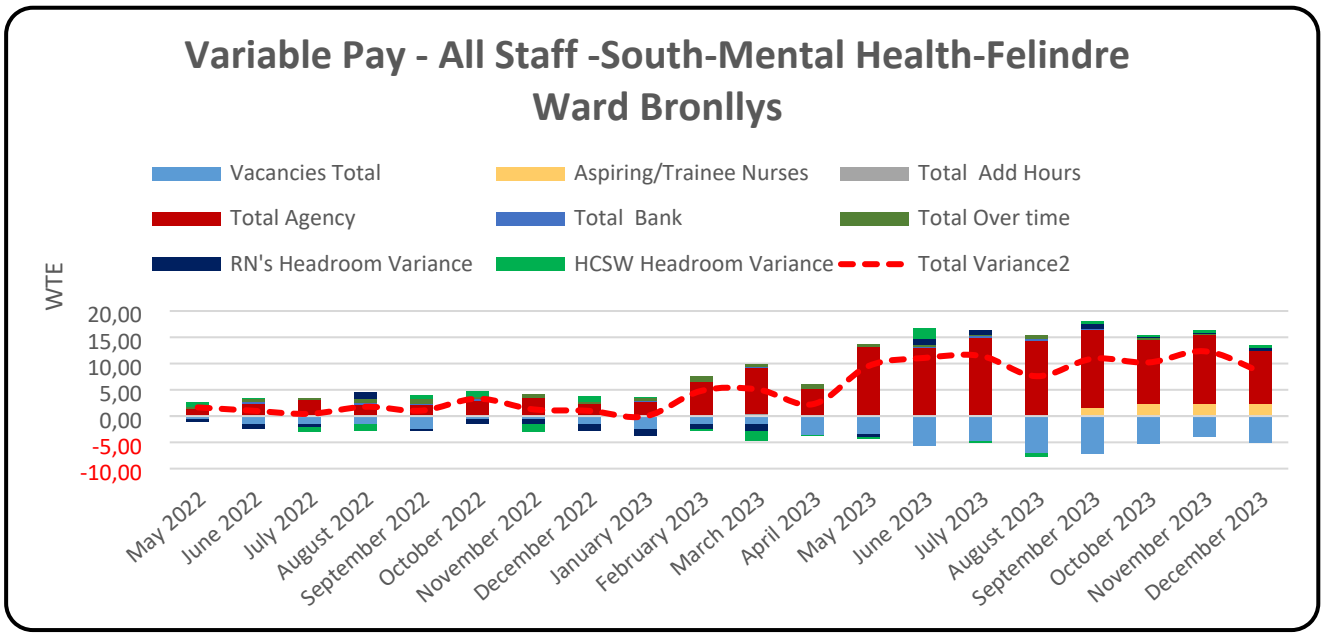
It is important to note that MH&LD Inpatient Units must assess risk in a dynamic and regular way. Whilst signed up to the principles of National safe staffing levels, if bed state or acuity is manageable below establishment then this occurs. However, during 2023/24 there have only short periods of time where it has been safe to do this. The minuted bed management process introduced for MH&LD provides evidence of consistent rationalisation of bed state and acuity to support Wards in decision making.

F3 - Variable pay March 2022 to December 2023 – Clywedog Ward



In the chart F3 above, the spike in variable pay for Clywedog Ward in November 2023 is mainly related to the admission of a tetraplegic patient requiring level 4 observations and significant physical health support over and above what Ward staff are trained to provide including bowel evacuation and significant skin integrity issues. Whilst non PTHB funded home carers were transferred to Clywedog during this period of time, an RGN was required to support the patients 24/7 physical health needs.

F4 - Variable pay March 2022 to Dec 2023 - Felindre Ward



Felindre Adult Acute MH Ward has also seen a number of challenging and complex individuals with high risks associated with their care. This includes a patient with learning

disabilities who has remained on Felindre Adult Acute MH Ward for 251 days from May 2023 reflecting the spike in variable pay in chart F4 above. Interestingly, finance colleagues have supported a piece of work which identified the cost of agency spend for the first three months of this individual's care which identified that the cost of a placement (had one been suitable/available) would have been higher than the agency staffing cost. In June and July there was also an unusually high staff sickness, leaving a deficit of between 4-6 qualified staff at various times. **T**here has also been an unprecedented situation where the Ward has provided care for a young person under the age of 18 which required specialist staffing. In November and December, due to the configuration of the Ward, the number of females admitted has outweighed the number of males significantly requiring a higher level of observations where utilisation of the male bed corridor has been required to accommodate this. Further to this, there have been numerous patients with increased co-morbidities and highly complex physical health needs have also meant the need for 24/7 support from RGN Agency.

Additional mitigations:

- Physical Health monitoring pilot initiated on Felindre ward to be evaluated and rolled out to Older Adult Wards

- Weekly observations review put in place by Head of Nursing / Ops – further review at weekly bed management meetings.

- A new structure for MH&LD has been developed and includes a formal performance and finance group that will report into Corporate Performance and Engagement meetings that feeds into the Directorate Management Team scrutiny process. This group will be undertaking a learning review of the observation levels for over 30 of the patients subject to level 3 observations to identify if there are any additional measures that can be put in place to manage the staffing configuration required for the sustained levels of acuity being experienced.

<u>Circumstances unique to PTHB MH&LD – Community Settings</u>

3. Community Mental Health Teams - Duty and Assessment

Until January 2022 Duty rotas in all teams were staffed with a combination of PTHB and PCC staff (where there were PCC staff) as defined in the Interim CMHT Operational Policy. Due to capacity issues, PCC made a unilateral decision to remove Approved Mental Health Professionals (AMHPs) from the Duty rota. PTHB was advised at the time of the change that non AMHP's would remain on the office duty rota and PTHB had been provided with identified staff members. Upon further scrutiny of these identified staff members, in real terms this equated to 1 Social Worker (approx. 0.8 WTE) based in Newtown CMHT and 0 Social Workers in Mid & South Powys CMHT's as each of the identified social workers were leaving their posts or awaiting their AMHP status in the coming months and would therefore be removed from Duty responsibilities as per directive. This has not improved in real time due to the fluidity of the workforce and a further PCC decision to train all social workers as AMHPs therefore seeing further capacity for Duty reduced.

With very few social workers now left to engage in Duty arrangements this massively impacts on demands for PTHB CMHT staff, now including Initial Assessment and Allocations. An impact assessment continues to be updated to highlight deficits and escalate the risks. As the Duty system provides access to urgent care it creates risk to life if not sustained. Demand has exceeded capacity and PTHB are holding the risks in adult community mental health settings. There were already vacancies in CMHTs with multiple recruitment attempts unsuccessful so for the past year the outstripping of capacity has left little resilience in the system. It was therefore agreed via SBAR to support with Agency whilst solutions are sought.

The increase in workload has impacted the ability of PTHB staff to deliver responsive care and interventions, with emerging delays for assessment and treatment for those accessing the CMHT. In the CMHTs where this has created greatest risk, Agency staff have been required to avoid interruptions and delays to care coordination work due to unexpected covering of duty due to sickness/unplanned leave or other circumstances including increase in volume of urgent work.

Mitigation:

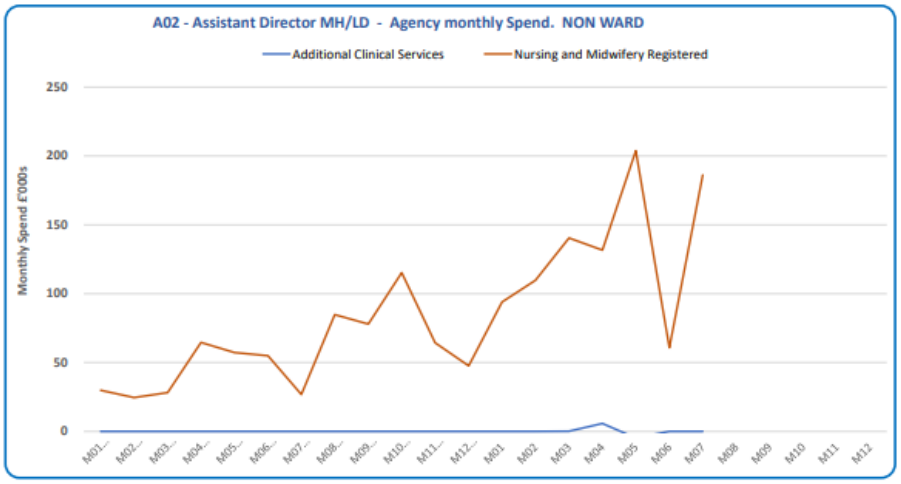
- Despite discussions and escalations, the risk remains high. A new Joint leadership team for MH PTHB and PCC has been created and a series of workshops are planned starting with Senior Management away day to define the operational vision for joint working with PCC invited to the ASMH Transformation Board to develop integrated vision for the future of Adult Community provision.

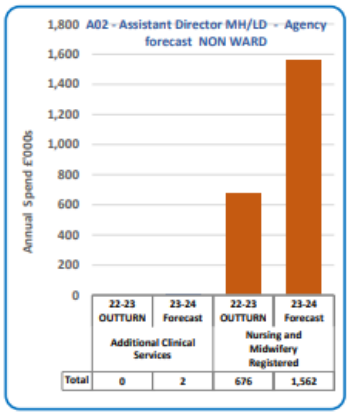
- A bid to 6 goals has been successful and an investment of £293,950 secured to develop a new Duty model – spend this year will support agency costs and testing as the model develops. Project plan is in development but intends to set out work over the last quarter of 2023/24 to implement from April 2024 which will see significant reductions in Agency spend. The opportunity to align to transformation in terms of moving to a Single Point of Access aligned with 111 press 2 has already been taken.

Even with the challenges being experienced, every opportunity is being taken to reduce locum usage. There have been nine locums in Teams right across Powys, in December 2023, two of the locum contracts have ended and one in Feb 2024 (post taken up by via student streamlining).

4. **Vacancies/Sickness in OA CMHTs North and South Powys.**

F5 – Non-Ward Agency Spend March 2022 – October 2023





Mon'ly Avg:	0	0	56	132

The Older Adult Mental Health Community Service is area with an ageing workforce and following the retirement of a number this financial year, has created significant vulnerabilities in service delivery for OA services across Powys as well as poor performance in meeting the requirements of the MH Measure. However, due to robust workforce strategy for this area and significant recovery planning, there has been recent success in recruitment and reconfiguration reducing the number of agency from 8 to 2 from the end of Q3 and in Q4.

The North OA CMHT have been supplemented with 3 agency locums as a result of multiple vacancies in service hence need for key roles to be covered as follows;

a) Cover for band 6 whilst staff member interim team lead.
b) OT- vacancy for significant period time with multiple failed recruitment attempts causing gaps in service and risk to patient safety (only one OT in OA service North).
c) MAS nurse vacancy – required cover due to need for waiting list recovery.

Mitigation:
The posts in a) and b) are back out to recruit with greater hopes of success in this round. The MAS Nurse post has been filled with planned start date of 2nd April 2024 seeing a reduction in 1 Agency member of staff.

South OA CMHTs have consisted of 5 agency locums in 2022/23 to date. An SBAR provided evidence of significant risk to service delivery given retirement of 4 key fte staff members in leadership roles;

a) 2 Agency CPNs in Llandrindod covering for 1 LTS, and 2 vacancies.
b) 1 x Agency CPN, 1 x Agency OT Brecon, small team with large demand and no resilience in service to find cross cover given vacancies in Llandrindod and DHTT**.**
c) DHTT – 2 vacancies covered by 1 locum**.**

Mitigation:
a) Both posts now recruited to, and locum contracts terminated Q4.

b) CPN post recruited to and locum contract due to end Q4, OT post recruited to and locum contract already terminated.
c) Post recruited to and locum contract due to end

In summary, as of Quarter 4 of 2023/24 all South Older Adult CMHTs and DHTT Agency staff and 1 in North Older Adults will have terminated contracts.

5. Psychological therapies including Silvercloud

Due to the inability to recruit to Psychology posts, agency locums are being utilised. This has been a necessary step to ensure the safe and effective functioning of services, including the Older Adult Psychology service, the Adult Psychology Service and the Complex Emotional Needs (CEN) Service. The net spend on locums into these service areas is carefully monitored so as to ensure this is affordable and within budget.

Up to end November 2023 the psychology service financial position was £87,000 underspent, even when factoring in all variable pay. A significant proportion of the psychology budget, including OA and Adult Psychology and CEN is from mental health service improvement funding to support the implementation of national guidance around evidence based psychological therapy provision and compliance with mental health referral to treatment target.

Work is being undertaken to progress options to reduce locums through conversion to roles more likely to be recruited to an taking a workforce development approach within service to find substantive solutions.

PTHB delivers Silvercloud Online cognitive behaviour therapy service on behalf of Wales. Additional staff to cover Wales have been Agency, all of which have been wholly funded by Welsh Government.

6. 111 press 2 for mental health

Mental Health 111 Press Option 2 (MH111#2) was proposed as the model to deliver some of the 'Beyond the Call' recommendations in 2021, and the Welsh Government provided funding to deliver, what they termed, a national 'jump forward' in 24/7 mental health care in Wales within 2 years. The MH111#2 program began in April 2022, built on the Health Board implementation of a national model jointly coordinated by the NCCU and NHS Wales 111 Program with Ministerial launch June 23.

This has been yet another significant, positive challenge for PTHB MH&LD in establishing and developing the service in 2023. Powys now has a fully operational 24/7 MH triage service delivered from two office sites North and South and includes;

- 7 x Band 5 Wellbeing practitioners - substantive staff full compliment
- 1 x Band 5 Service coordinator (administrative) in post
- 4 x Band 6 Senior MH practitioner Agency staff in post. Recruitment in progress for 2 x substantive posts.
- 1 x Band 7 Team Lead in post.
- 1 x Band 8a Interim service manager in post.

The Agency staffing have been fully funded by Welsh Government with an income from this and Service Improvement funding of £679,000.

FURTHER MITIGATION

Recognising that actions being taken across operational services, the Executive focus and challenge described, and that opportunities are being realised through the delivery of the variable pay action plan, there are also number of specific workforce developments that will additionally provide assurance. These include;

Aspiring Nurse Programme

- 5 to Mental Health wards with a start date of September 2023 negating the need for additional Band 2 HCSW requirements that have been being met through agency spend.

Workforce Strategy

- Success as can be seen in Older Adult community setting but rigorous planning for medium term and as part of ASM Transformation for MH in longer term.

Bank provision

- The Workforce team have been prioritising recruitment, with an individual tasked to aid communication with all those undergoing recruitment (and driving the necessary actions to progress these to completion).

- The implementation of 'Wagestream', the offer to bank staff (who indicate a preference for weekly payment). However, further evaluation is needed to determine success of this as not yet showing in analysis.

CONCLUSION:

2022/23 has been a challenging year for MH&LD services in all settings. The need to mitigate the risk of supporting complex presentations has at times needed the specialist LD, CAMHs or physical health agency provision to keep patients and the Ward environment safe. Community Teams have been challenged with the need to retain essential duty functions and older adults' teams have overcome challenges with vacancies seeing a reduction in locums in this final quarter of 2023/24 recognised in an improvement in financial position in the last two months. Overall variable pay must also been seen in the context of that which falls either within budget or covered by Welsh Government investment in new services such as Silvercloud for Wales and 111 press 2 for mental, both services have required significant hard work by dedicated Powys teams to establish initially with agency costs covered by Welsh Government investment that will convert to core staff in the next phases of recruitment planning.

Overall, there remains some fragile teams across MH&LD, where reliance on temporary staffing is a daily requirement to staff services. Where good practice occurs (early planning of rosters, seeking bank and long lining of on-contract agency), but operational changes (acuity of patients or staff absence) can undermine this planning, which sees an increase on high cost (off contract) variable pay as backfill is required at short notice. The work to introduce a new duty and assessment model is being aligned to Transformation and may take some time to bed in but is being prioritised by senior management.

As is often the case, there is no single driver for the continued reliance on agency spend and the associated costs, which continue to rise. Whilst there is reasonable assurance that effective operational management is in place to limit the impacts of this issue, a number of factors stand out. These include the continued vacancies experienced across teams, a need to rapidly respond to gaps in planned staffing, the complexity of care (and associated need to manage clinical risk in less than ideal clinical environments), the limitations of the market, and an increase in provider costs. In response, a number of actions have been highlighted within this paper, and the importance of the Accelerated Sustainable Transformation Programme for the future of Mental health services can therefore not be overstated.

In essence, the ongoing acuity and complexity of patients presenting to MH&LD services and the unique challenges for Powys in providing a sustainable and resilient service based on geography, isolated units and the ability to recruit and retain needs to be taken into consideration. But there remains a significant amount of scrutiny, challenge, control**,** and mitigation to reduce variable pay, demonstrable operational ownership, and organisation wide support to the actions and a long-term delivery plan. This work will be continued, and there is every expectation that further assurance will need to be provided through the coming year.

The following Impact Assessment must be completed for all reports requesting Approval, Ratification or Decision, in-line with the Health Board's Equality Impact Assessment Policy (HR075):

IMPACT ASSESSMENT					
Equality Act 2010, Protected Characteristics:					
	No impact	**Adverse**	**Differential**	**Positive**	**The proposal will not disproportionally affect any of the protected characteristics.**
Age			X		
Disability			X		
Gender reassignment			X		
Pregnancy and maternity			X		
Race			X		
Religion/ Belief			X		
Sex			X		
Sexual Orientation			X		
Marriage and civil partnership			X		
Welsh Language				X	
Risk Assessment:					
	Level of risk identified				
	None	**Low**	**Moderate**	**High**	
Clinical		X			
Financial			X		
Corporate		X			
Operational		X			
Reputational		X			

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 2.6

Delivery and Performance Committee	**Date of Meeting: 29 February 2024**
Subject:	**Digital Strategic Framework Update**
Approved and presented by:	Pete Hopgood – Director of Finance, Information and IT
Prepared by:	Vicki Cooper – Chief Digital Information Officer
Other Committees and meetings considered at:	Executive Committee – 21 February 2024

PURPOSE:

To provide an update against the delivery of the Digital Strategic Framework which aims to enhance the quality of community care provision through digital transformation and innovation.

RECOMMENDATION(S):

The Committee are asked to:

- **RECEIVE** the report and take ASSURANCE that the Health Board is progressing and delivering against the Digital Portfolio of Projects and Plans that underpin delivery of the Digital Strategic Framework.
- The Committee is also asked to:
  - **NOTE** the implementation of a Maturity Model to evaluate the performance and improvement to deliver the Digital Strategic Framework;
  - **NOTE** the efficiencies delivered;
  - **NOTE** the National Programmes updates and challenges impacting the PTHB delivery of Digital enablers;
  - **NOTE** the Infrastructure Improvements and Priority Plans.

Approval/Ratification/Decision[1]	Discussion	Information
✓	x	✓

EXECUTIVE SUMMARY:

The Digital Strategic Framework defines how, as an organisation, we will enhance the quality of community care provision for the people of Powys through digital transformation and innovation, now and over the next four years. This will be delivered in partnership with clinical services, and external alliances, supported by programmes of work that are performance measured through the Accelerated Sustainable Model and the Integrated Performance Framework.

The delivery and evaluation of the framework will be driven by a phased portfolio of programmes, a new target operating model, a digital roadmap, a digital support structure, and a set of success criteria and benefits. It will be implemented through multi-turn interaction with the clinical and corporate users.

We will use a matrix to benchmark our current Digital capability and performance with set goals for improvement and track our progress over time.

This report will provide the progress to date against the delivery of the Digital Strategic Framework and associated workstreams under the five themes:

- Citizen Centred Care and Support
- Leadership Partnership and Alliances
- Infrastructure and Security
- Enabling Efficiency and Effectiveness
- Big Data and Artificial Intelligence

Milestones within the portfolio of Digital Programmes and Projects are reported to the Digital Transformation Board chaired by the Executive Director of Finance, ICT and Primary Care.

DETAILED BACKGROUND AND ASSESSMENT:

There are a number of complex programmes scheduled for delivery, at various stages across the next one to four years. These have multiple interdependencies locally and with national drivers including Welsh Government (WG) directives, and Digital Health and Care Wales (DHCW) nationally led Programmes.

In order to measure the current position in terms of Digital Maturity within Powys THB ,we will introduce a maturity model which presents a progression to demonstrate how this is aligned to delivery of the Digital Strategic Framework.

Currently we assume from both anecdotal and benefits realisation reports that Powys THB services are leveraging at Maturity level 1 & 2 in line with the descriptions below. This is based on a number of factors:

Table 1

MATURITY LEVEL MATRIX	
LEVEL	**DESCRIPTION**
1. Initial	Processes are ad hoc and unstructured. There is little to no use of digital technology in PTHB healthcare delivery.
2. Repeatable	Basic digital processes are in place, but they are not consistently followed. There is some use of digital technology in PTHB healthcare delivery.
3. Defined	Standardised digital processes are in place and consistently followed throughout PTHB. Digital technology is regularly used in healthcare delivery.
4. Managed	Data is used to measure and improve digital processes. Digital technology is integrated into PTHB healthcare delivery
5. Optimized	Continuous improvement of digital processes is in place. Digital technology is fully integrated into healthcare delivery and used to drive innovation.

To better understand how this relates to the Delivery of the DSF, the maturity model above has been aligned to the priority outcomes as in Table 2 below:

Table 2

DIGITAL STATEGIC FRAMEWORK 2023 – 2027 MATURITY MATRIX	
LEVEL	**DESCRIPTION**
Level 1: Initiating	Limited digitalisation of care pathways, small number of operational dashboards, limited access to technology for self-care, limited Wi-Fi connectivity, complex data systems not fully integrated.
Level 2: Developing	Implementation of electronic document management system, more services utilising operational delivery dashboards, rising demand for care closer to home and digital capability in services, aligned governance and decision-making processes.
Level 3: Defined	Most people have access to technology for self-care, easily accessible Wi-Fi with 5g connectivity, development of leaders and confidence in digital and data, multi-professional teams adopting standard clinical practice for digital capability.
Level 4: Managed	Healthcare services are using their data to improve their service area and improve up value-based outcomes of population health, preventing admissions and supporting a multi-disciplinary approach across all clinical and community pathways.
Level 5: Optimised	Digital solutions that work seamlessly to enable clinicians more time to care, with efficient business processes resulting in minimal waste, and releasing resources to act when and where needed.

Maturity Level Summary

We are in the first year of planning for the delivery of the Digital Strategic Framework, and we match the NHS Wales Maturity Level based on an external consultancy survey and evaluations of Electronic Health Records (HIMMS, as well as a Useability Survey KLAS). Our national maturity is at level One for both areas.

This means we need to improve the digital features within electronic health systems and one way we are doing this is by introducing Electronic Prescribing, which we aim to deliver in Powys by 2026. The useability score is how easy and user-friendly the systems are**,** and this requires us to increase training and support, digital confidence through clinical collaboration and business change activities.

Digital First priorities have continued against the Integrated Performance Plan and workstreams for FY 23/24 and going forward to 2024/25 are being re-aligned to the Digital Strategic Frameworks five themes. This progress will feed into the Maturity level matrix as part of an annual review.

DEVELOPMENTS TO DATE

Citizen Centred Care and Support

- Improved communications are ongoing with patients
- Continuing to scale out the use of Text Messaging for appointment reminders to reduce 'Did Not Attend' (DNA)
- Implementation of a Portal to enable patients to request re-scheduling of an existing appointment
- Access includes both Welsh and English Language
- Online/Virtual consultations – Attend Anywhere was the platform implemented to support Virtual Consultations during the Pandemic. Use of the platform has declined, and as part of the annual review, Powys will transition to MS Teams as part of the value invested in our Microsoft O365 License model.
- Digitisation of a paper lite project to support information being digitally available at the point of clinical decision making.

Leadership Partnership and Alliances

A new **Target Operating Model (TOM)** to deliver Digital Services is in the process of being implemented, following the agreement to exit the S33 ICT service provision provided by Powys County Council.

The Target Operating model design is complete and will be live in FY 24/25 Q1, following the S33 tupe process. This will ensure digital staff work in partnership with clinical professionals to develop new working models combining clinical knowledge with wider organisational knowledge and experience of what digital tools can do and how they can help deliver services and the day-to-day role.

Powys THB is leading in some areas of Cyber Security and Infrastructure improvements; one area is that Powys is the only organisation to have zero weak passwords reported and has maintained this position for 6 months.

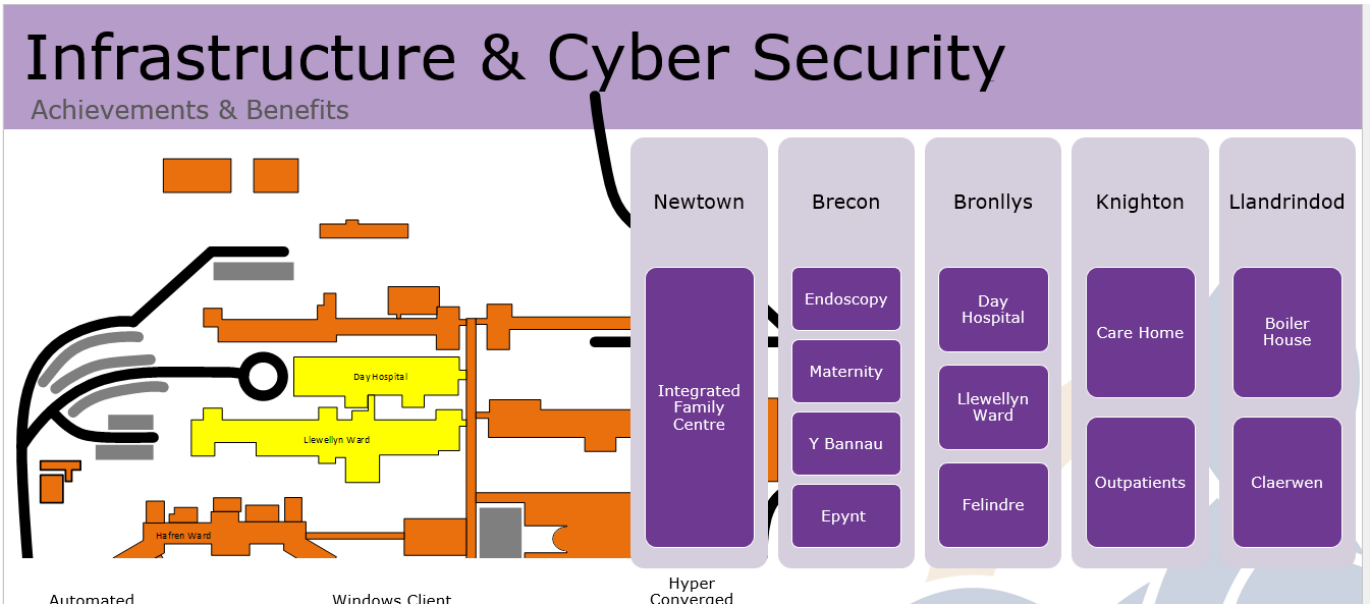
Infrastructure and Cyber Security

Measurable improvements have been made during Q3 in this area across health board sites. Several wards across the health board have benefited from strategic network, cabling, and Wi-Fi upgrades to enable wider ambitions in the digital strategic framework . Further work is planned with funding aligned for Q4 and funding for consistent progress is being sourced and secured for further improvements in FY24/25.

Core elements of a network redesign to increase availability capacity & stabilise connectivity have been implemented leading to a period of migration to the new topology in Q2 24/25 allowing completion of the work in Q3 24/25. The work is resourced and has project management support, and collaboration with Estates and Facilities.

The Telephony upgrade procurement has been delayed due to quality of responses on initial invitations to tender. Tender has been re-developed and has attracted more interested bidders. The tender has now been completed and awarded to a supplier 'Avoira' and plans begin for implementation in Q4 with transition activities moving into Q1 24/25 – This means we will complete the upgrade well ahead of the planned PSTN Switch Off

The diagram below shows the site-by-**site** improvements made through network/cabling upgrades and improved WiFi coverage.



What's Next:

- In terms of the devices and assets:
  - A replacement of 270 monitors is planned with prioritisation given to community staff to ensure all sites and services have a hot desk available (this supports areas with no access who are behind in mandatory training)
  - All Internet cafes in communal areas will have new upgraded faster devices available
  - As part of the planned device refresh 300 laptops will be built and deployed and 120 pcs meaning the device estate is fully refreshed at the end of FY 23/24
  - Workstations on Wheels for mobility and compartments to securely store medicines will be available on wards as part of the EPMA project
  - We will be replacing 5 Video Conference Screens with Microsoft Service Hubs for full MS Teams functionality and interoperability (285- and 350-inch screens)
  - As part of the Telephony programme upgrade the remaining legacy 2008 servers will be upgraded

Enabling Efficiency and Effectiveness

Digital IT Staff time is being released as part of the newly implemented Target Operating Model which includes an IT Service Management Solution called HALO. Through AI and automation many of the low-risk repetitive tasks such as new starters and approvals are creating measurable efficiencies:

- The New User and Leavers process has been automated meaning the time taken to process these requests can be done in as little as 6 minutes instead several days via the previous process.
- Automating requests such as 'access to ZOOM', this includes AI to ensure that requests to zoom ensure a timely response, and align to one of Cyber Security essential priorities, meaning access is only available for the time period it is required, such as 2 hours before and 1 hour after and then the access is removed.
- Social media apps can now be made available on corporate Smart Phones, as the request for access is made, it automatically moves through the comms team approval and then the system will auto add the apps to the correct groups and install the apps on staff phones, as a collective.
- Knowledge articles are continuing to be made available for self help guides and for user education and knowledge
- Requesting access to DHCW secure file system is now achieved in as little as 5 minutes whereas it could take several hours with chase emails or calls.

- Team viewer has been implemented which means support staff can quickly remote control to a user's pc which negates the need to use vpn
- District Nurses in Ystrad have been successfully piloting hot spots to use the devices in patient homes and other rural locations,

Mobile phones - The mobile phone provider has been transferred from EE and Vodafone to O2 to release cashable savings that will be used to upgrade all mobile phones to smart phones. We are aware many staff have been waiting for devices, and this has been challenging whilst we aim to recall many un-used devices across the organisation.

Print management – The fully managed Print solution is being implemented across PTHB Sites, engagement has been positive with staff welcoming the changes to have efficient modern equipment, which is accessible from any site. The new solution conforms with Information Governance guidance for example if documents are sent to a printer, they can only be printed using a unique code, and if not collected within 24 hours the print queue is deleted. This will reduce waste and reduce cost to the organisation

Scan 4 safety – The Scan 4 safety phase 1 (Theatres) is now complete and the project is moving to Phase 2 which is aligning the product to the patient

E-scheduling – Civica E-Scheduling for nursing is now fully implemented, there is however a snagging list that will need to be resolved for full optimisation. There is a Digital Support resource aligned to conduct a Plan Do Study Act exercise and findings will be shared with Service Leads and Heads of Service.

Cross Border – The Cross Border project is due to complete July 2024. There is a lesson learned log and next steps recommendation which is shared with DHCW and the Chief Digital Officer for Welsh Government. To initiate a wider strategic integration programme, the CDO for WG has agreed to lead and chair a Joint NHS Wales and NHS England forum with a view to fully integrated systems via an Integrated Shared Care Record approach.

Eye Care Digitalisation – During a continued national period of pause whilst programme management transitioned from CVUHB to DHCW, guidance continues by DHCW on possible routes of progressing the project. Shortlisted strategic options under consideration currently include a re-procurement. The outcome will enable shared care between Secondary and Primary Care for Ophthalmology patients.

Challenges

There is a need for training, upskilling, and deeper cultural change, to move fully to Digital First. There is a strong foundation for collaborative effort. Understanding

how to use new tools effectively and how this affects the way services work will require standardisation of ways of working, shared learning and review of current practice.

- There are significant paper processes still in use and where electronic systems are used, there are high volumes of data across various systems, some with poor or no interoperability. Wi-Fi is not yet optimum and whilst improvements are planned, there is a recognised mobile connectivity signal problem amongst Mid rural Wales.

Big Data and Artificial Intelligence

PTHB has taken significant steps towards the planned holistic approach and has implanted an NHS UK First Federated Lakehouse.

We are immensely **proud** to have a fully live Cloud Data Platform which acts as our 'one source of truth'. This enables us to collect data from a variety of applications (both Nationally and locally built). This platform acts as both an Operational & Analytical Data Store enabling elements such as predictive analytics, comprehensive Data Cataloging & Streaming live dashboards, all while being future proof, FHIR compliant & National Data Resource NDR aligned.

Further achievements include:

- Linking our on-premise data stores to the cloud to get all our data in one place to combine datasets that historically sat separately.
- The ability to produce 'live' dashboards from our in house developed Apps (i.e**.** as data is entered into an app it will be available on the dashboard within seconds to provide real time reporting.
- Data engineering tasks are being completed more quickly realising 40% increased efficiency through the use of AI tools.
- Full lineage on our data flows for transparency about where data comes from and where it is used.

App Development

One of the areas of App development is the Advanced Learning Needs (ALN) which is designed to capture data on the compliance of the Advanced Learning Needs teams with their deadlines.

- The current process involves manually creating and updating multiple rows of Microsoft Lists for each child or young person who needs ALN services. The proposed process involves using an app that allows adding one record and having a new tab per service based on selection, information will then be

process through automation to provide the necessary reporting and insight locally and nationally.

- This is potentially going to be adopted by other HB's

National Digital Programme Challenges:

It is a significant problem for Community Care provision, that the national DHCW clinical systems are predominantly Acute secondary care focussed, and in the main only joined up for NHS Wales organisations. This poses a clinical risk in terms of access to the patient history when needed most, for informed clinical decision making.

Powys THB Digital Services recommended and are progressing a full review of available clinical system functionality and will actively influence NHS Wales organisations, DHCW, and Welsh Government for the need to have an 'Integrated Shared Care Record,' for Primary, Community, Mental Health Services with interoperability with Acute secondary and commissioned services.

Also, there are All Wales systems that are legacy systems that require upgrades, such as Radiology Information Systems (RIS), the timescales are often tight and this questions the need for improved proactive planning for system replacements and upgrades, improved planning for resources and funding, business change and benefits realisation.

Workforce and Financial Sustainability

Digital transformation is the process of using digital technologies to create new or modify existing business processes, products, services, and customer experiences. It is a strategic priority, as it can enhance efficiency, quality, innovation, and customer satisfaction. However, digital transformation also poses significant challenges, such as the need for adequate and consistent resources, the development of digital skills and capabilities, the alignment of organisational culture and vision, and the management of change and risks.

Resource Challenge

One of the main challenges of digital transformation is the availability and sustainability of resources to support the digital transformation activities across the organisation. These resources include staff, equipment, software, and training. Without them, digital transformation projects may face delays, disruptions, or failures. Moreover, relying on short-term or ad hoc programme funding may compromise the long-term vision and delivery of the digital strategic framework.

Solution Workforce Planning

To address the resource challenge, the Digital Services will work in partnership with the Workforce Organisation Development and Clinical Informatics colleagues, utilising the Workforce Planning Toolkit, to strengthen the informatics capability within the organisation, both digitally and clinically. The Workforce Planning Toolkit is a tool that helps to identify the current and future workforce needs, gaps, and risks, and to develop and implement strategies to address them. The toolkit consists of four stages:

- Stage 1: Analyse the current workforce situation and the external and internal factors that affect it.
- Stage 2: Forecast the future workforce demand and supply, based on the organisational goals and objectives, and the expected changes in the environment.
- Stage 3: Identify the workforce gaps and risks, and prioritise them according to their impact and urgency.
- Stage 4: Develop and implement workforce strategies and action plans, such as recruitment, retention, development, redeployment, and succession planning, to close the gaps and mitigate the risks.

By using the Workforce Planning Toolkit, the Digital Services will be able to ensure that the organisation has the right people, with the right skills, in the right place, at the right time, to support the digital transformation initiatives and outcomes.

Financial Challenge

The Digital Transformation and Informatics service (DTI) is responsible for delivering major upgrades and improvements to the digital infrastructure and systems (corporate and clinical). To support its capital and revenue requirements, Digital Services submits bids to the Digital Priority Investment Fund (DPIF), a fund that allocates resources for digital projects across the NHS in Wales. However, the DPIF bidding process is often slow and unpredictable, which creates significant challenges and risks for the teams.

It is quite rare that despite DPIF bids being submitted before or at the start of the new Financial Year, bids are often not decided before Q4, and then there is often further slippage available, which means the Digital Services have to spend its allocated funds in a very short time frame. This leads to increased procurement activity in Q4, which puts pressure on the procurement team and the suppliers. The bids, procurement, and tender exercises are often complex and time-consuming, and they require careful evaluation and negotiation to ensure value for money and quality of service.

The network and infrastructure is identified as a priority area that requires a long-term programme of work. There is urgency to plan for the legacy networking and poor Wi-Fi, which affects the performance and productivity of the Health Board. Whilst some improvements have been made in 2022/23, thanks to the investment received, investment shown in the table below will support the continued refresh and upgrades in FY 2024/25. In terms of timeframes, improvements would be delivered more quickly and efficiently if there were increased resource capacity to plan, manage and deliver the major upgrades. This can also be applicable to System integration such as Digital Maternity system, if this were to be led locally within Powys rather than as a national procurement, the time to deliver would be dramatically improved.

The table below shows the successful DPIF bids made by the Digital Transformation and Informatics service to support capital and revenue requirements to deliver on major upgrades and improvements.

Table 3

FY 2023/24	Capital	Revenue (Non-Recurrent)	Description/Note
EPMA	£122,700	£1,068,099 (2022/23/24)	Capital Funding to support Workstations on Wheels (Medicines Carts) and Non-Recurrent Revenue to support the EPMA programme team (inc Pharmacy, Nursing, Digital & Medical/GP)
Core Network Infrastructure Upgrades/Device Refresh	£983,985	£0	Much of the network improvement work must take place out of business hours, which will impact on resource availability. Should the pace of improvement need to be brought forward, there will be a review of available resource to meet requirements.
Telephony Upgrade	£285,000	£0 (Revenue will be met through savings on unused line rental)	To support the equipment required to upgrade the Telephony infrastructure. This also plans for the PSTN switch off and will release savings from existing line rental and charges and will support the move to full Teams Telephony.
WCCIS	£0	£56,000	Non-Recurrent to support WCCIS Service Improvement
Digital Maternity System	£0	£145,461	Non-Recurrent revenue to recruit clinical staff to support the Digital Maternity Project
Total	£1,391,685	£1,139,560	

Arrangements for managing medium to long-term funding and savings risks will be made more visible at Board level. Digital Services therefore will put arrangements in place to:

a. Demonstrate that it is actively managing the medium and long-term risks associated with the sustainability of the Digital Priorities Investment Funding model.
b. Provide greater assurance to the Board on the development and delivery of digital as a key enabler for recurrent savings in the medium to long term to strengthen the future financial sustainability of the organisation.

Conclusion:

Powys has a vision for an Integrated Shared Care Record, but it is limited by some factors that need clinical and digital collaboration and innovation, and the ability to look for a solution that suits Powys is affected by national agendas and goals. There are insights gained from National Programme implementation, but there are still some areas where more confidence is needed that there is strong planning to proactively deal with end of life, upgrades**,** or replacements of old systems. There is also ongoing risk with the match between local demand and deadlines and those set by the national teams. We want to move fast**,** and we could deliver quickly if we were not dependent on the nationally led teams.

It is essential that digital is integrated into the planning of all models of care so that all the 'digital opportunities' for ways of working are understood and considered. Digital needs to be an integral part of the planning and investment as it will be the forerunner of the change we are trying to implement across the HB as part of the Accelerated Sustainable Model

There is a need for training, upskilling, and deeper cultural change, to move fully to Digital First. There is a solid foundation for collaborative effort. Understanding how to use new tools effectively and how this affects the way services work will require standardisation of ways of working, shared learning and review of current practice.

With the efficiencies and improvements being realised within the automation of IT and BI processes, this will release support staff time to collaborate more closely with clinicians and corporate services in areas where value will be realised, as clinical and technology strategies converge. The benefits of digital and clinical functions will become entwined. Clinical services and Digital Services are already working well together.

There are risks noted in relation to digital inflation, workforce, finance, supplier dependency and complexity in the current context. Nonetheless, there is also opportunity to use digital to drive efficiencies and improve patient outcomes.

THE PAPER IS ALIGNED TO THE DELIVERY OF THE FOLLOWING STRATEGIC OBJECTIVE(S) AND HEALTH AND CARE STANDARD(S):		
Strategic Objectives:	1. Focus on Wellbeing	☐
	2. Provide Early Help and Support	☐
	3. Tackle the Big Four	☐
	4. Enable Joined up Care	☐
	5. Develop Workforce Futures	☐
	6. Promote Innovative Environments	☐
	7. Put Digital First	☐
	8. Transforming in Partnership	☐
Health and Care Standards:	1. Staying Healthy	☐
	2. Safe Care	☐
	3. Effective Care	☐
	4. Dignified Care	☐
	5. Timely Care	☐
	6. Individual Care	☐
	7. Staff and Resources	☐
	8. Governance, Leadership & Accountability	☐

The following Impact Assessment must be completed for all reports requesting Approval, Ratification or Decision, in-line with the Health Board's Equality Impact Assessment Policy (HR075):

IMPACT ASSESSMENT – NOT REQUIRED					
Equality Act 2010, Protected Characteristics:					
	No impact	**Adverse**	**Differential**	**Positive**	**Statement** ***Please provide supporting narrative for any adverse, differential, or positive impact that may arise from a decision being taken***
Age					
Disability					
Gender reassignment					
Pregnancy and maternity					
Race					
Religion/ Belief					
Sex					
Sexual Orientation					
Marriage and civil partnership					
Welsh Language					
Risk Assessment:					
	Level of risk identified				**Statement** ***Please provide supporting narrative for any risks identified that may occur if a decision is taken***
	None	**Low**	**Moderate**	**High**	
Clinical					
Financial					
Corporate					
Operational					
Reputational					

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item :2.7

Delivery & Performance Committee	**Date of Meeting: 29th February 2024**
Subject:	**Commissioning Assurance Framework – Primary Care General Medical Services 2022/23**
Approved and presented by:	Director of Finance & IT, Deputy Chief Executive and Interim Director of Primary Care
Prepared by:	Assistant Director of Primary Care
Other Committees and meetings considered at:	Executive Committee – 7 February 2024

PURPOSE:

The purpose of this paper is to provide assurance to the Executive Committee regarding the General Medical Services Commissioning Assurance Framework process applied to the 2022/2023 contract year.

RECOMMENDATION(S):

The Committee is requested to

1. **RECEIVE** the update provided.
2. Take **ASSURANCE** that the General Medical Services Commissioning Assurance Framework monitoring process is providing assurance to PTHB on general practice contract management.

Approval/Ratification/Decision[1]	**Discussion**	**Information**
		✓

[1] Equality Impact Assessment (EiA) must be undertaken to support all organisational decision making at a strategic level

THE PAPER IS ALIGNED TO THE DELIVERY OF THE FOLLOWING STRATEGIC OBJECTIVE(S) AND HEALTH AND CARE STANDARD(S):		
Strategic Objectives:	1. Focus on Wellbeing	✓
	2. Provide Early Help and Support	×
	3. Tackle the Big Four	×
	4. Enable Joined up Care	✓
	5. Develop Workforce Futures	×
	6. Promote Innovative Environments	×
	7. Put Digital First	×
	8. Transforming in Partnership	×
Health and Care Standards:	1. Staying Healthy	×
	2. Safe Care	✓
	3. Effective Care	✓
	4. Dignified Care	×
	5. Timely Care	✓
	6. Individual Care	×
	7. Staff and Resources	✓
	8. Governance, Leadership & Accountability	✓

EXECUTIVE SUMMARY:

This report relates to 2022/2023 assurance monitoring.

The General Medical Services (GMS) Commissioning Assurance Framework (CAF) was developed following an internal audit recommendation. Future assurance monitoring from 2024/2025 onwards will be aligned to the PTHB Integrated Performance Framework and the national GMS Assurance Framework (currently in development).

GMS CAF reporting includes a framework on Quality & Safety, Finance, Access and Patient Experience. GMS CAF reporting is updated on a quarterly basis and internal assurance is delivered through both the Primary Care Department and the General Medical Services Contract Management Group.

The assurance on the delivery of GMS is summative and takes place throughout the year as ongoing data is reviewed and regular dialogue takes place with the contractors as necessary. If a problem is found, the Primary Care Department and/or the General Medical Services Contract Management Group is clear on the consequences and actions that need to be taken.

Some elements of the in-year assurance does not run in line with a usual financial year and covers the period from 1st October to the 30th of September. Therefore, Practice evidence submission, health board checking**,** and elements of payment takes place in Quarter 3 following a usual financial year end, which delays the completion of the CAF within a financial year. However, from 1st April 2023 all elements of the contract have been realigned to a financial year; therefore the 2023/2024 report will be available in the following quarter post year end. This will enable Executives to receive a more timely report.

As per the GMS CAF 'Escalation Process' levels and in line with contractual and regulation requirements there has been no requirement to formally escalate concerns to Executive level as no contractual/regulation breach took place in Powys practices during 2022/23 and all practices remained on Level 1 monitoring.

Level and assurance monitoring	No: of practices
Level 1 - Routine monitoring	16

Outside of the GMS contractual obligations, quality and service delivery was monitored throughout the year using the CAF RAG rating process to give assurance on the CAF indicators.

The general theme of non-compliance relates to achievement of national influenza immunisation target ambitions, childhood immunisation targets and compliance with the national prescribing indicators. These areas are monitored and considered by the PTHB Public Health Team and the Medicines Management Team. Further support to practices is offered through the relevant PTHB departments and discussed at Practice Review Visits.

Additions to the CAF monitoring process during this reporting period have included new Access Standards (14 Phase 1 & 6 Phase 2 standards) together with a Reflective report containing Practice analysis of the National Patient Survey and an Equality Impact Assessment.

DETAILED BACKGROUND AND ASSESSMENT:

The General Medical Services (GMS) Commissioning Assurance Framework (CAF) is updated on an annual basis to ensure it captures the appropriate monitoring and assurance. Future assurance monitoring from 2024/2025 onwards will be aligned to the PTHB Integrated Performance Framework and the national GMS Assurance Framework (currently in development), however it is recognised that the majority of the current CAF criteria will continue to be reported on but within the new reporting Framework.

General Medical Service contracts between health boards and general medical service providers are delivered within the National Health Service (General Medical Services Contracts) (Wales) Regulations 2004. These Regulations set out, for Wales, the framework for general medical services contracts under section 28k of the National Health Service Act 1977. The regulations are enforceable. Parameters not covered within the regulations are not enforceable and this is an important element when considering CAF assurance.

The National Health Service (General Medical Services Contracts) (Wales) Regulations 2023 are now in force and at the time of writing the new GMS Contract has been published. There are significant changes to the 2023/24 GMS contract which will be reported in the 2023/24 assurance report.

To support the CAF dashboard, set tolerance levels inform the process along with an overarching Framework. These supporting documents are detailed in:
Appendix 1: Commissioning Assurance Framework Primary Care Services: General Medical Services.

Appendix 2: 2022/2023 General Medical Services CAF tolerance levels

The CAF is updated on a quarterly basis and internal assurance is delivered through the General Medical Services Contract Management Group. In addition to this the Primary Care Department (PCD) monitors the CAF monthly.

This report is based around the year end GMS performance for 2022/2023 noting

- CAF dashboards are in place for all GMS contracts (including PTHB Presteigne Managed practice, however this Practice is now run by Shropdoc since July 2023 under an Alternative Provider for Medical Service (APMS) arrangement).
- A multitude of data and supporting documentation from a variety of sources informs the CAF dashboard.
- The CAF data displays a high-level summary, taken from more detailed reports that feed into the high-level summary.
- Exceptions linking to the agreed CAF RAG rating are actioned appropriately.
- The Primary Care Department and/or the GMS Contract Management Group identifies areas of concern and whether to 'step up' or 'step down' escalation to Executive level.
- The CAF incorporates both contractual and non-contractual requirements against the delivery of GMS. Contractual levers linked to the regulations enable contract sanctions to be progressed should the need arise. Other measures within the CAF provide assurance on the delivery of services, as opposed to contract levers.

- Only CAF indicators linked to the regulations are enforceable and parameters within the CAF not covered within the regulations are not enforceable.
- On 1st April 2022 Changes to the Access Standards were introduced including submission of reflective reports and evidence of 14 Phase 1 Standards and 6 Phase 2 standards. **(Appendix 4)** (Since April 2023 Phase 1 Standards have now been mandated into the new contract and Phase 2 standards and the Reflective report remain optional.)

Appendix 3 details the end of year 2022/23 GMS CAF dashboard.

Annual Return:
The Regulations requires all general medical practices to submit an annual return relating to the contract that they hold with the Health Board. The Annual Return template provides a consistent framework of information required annually from Powys general medical practices, including a declaration by the practitioners/partners in the practice that they have met their statutory and mandatory responsibilities under their contract. The Annual Return information required from a practice is reviewed and updated on an annual basis to ensure all relevant indicators are captured. The wealth of information obtained from the Annual Return forms a pivotal part of the governance and assurance programme for general practice. Individual practice Annual Returns are analysed by the Primary Care Department and any areas of non-compliance or areas requiring support are followed up.
The requirement of an Annual Return continues in National Health Service (General Medical Services Contracts) (Wales) Regulations 2023 Sch3, Part 8, Para 93 and within the new GMS Contract.

Practice Review Visits
Tri annual practice review visits take place with all practices. The visit covers a wealth of areas (contractual and non-contractual) including, the Annual Return, Prescribing Indicators, Enhanced Service Audit reviews, Vaccination & Immunisation uptake, Patient Engagement, Access and Primary Care Development issues. The Assistant Director of Primary Care is supported by the Assistant Medical Director and representatives from the Medicines Management team and Public Health who also attend the visits. During the 2022/23 cycle, five General Practice Review Visits were undertaken which included Knighton, Newtown, Llanfyllin, Welshpool and Haygarth. A Practice Review report is prepared post visit and an associated action plan. The visits are very informative and two-way dialogue is encouraged so that both the practice and the health board find the visit a useful experience.

GMS CAF Assurance 2022/23
As per the CAF 'Escalation Process' levels and in line with contractual and regulation requirements there was no requirement to formally escalate to Executive level as no contractual/regulation breach took place in Powys practices during 2022/23.

Level and assurance monitoring	No: of practices
Level 1 - Routine monitoring	16

A high-level summary of the GMS CAF details:

Contractual Compliance:

- 100% compliance with National Health Service (General Medical Services Contracts) (Wales) Regulations 2004.
- 100% participate in Additional Services (cervical screening, contraceptive services, vaccination and immunisations, childhood vaccination and immunisations; child health surveillance, maternity services and minor surgery (basic) procedures.
- 100% Performer List Compliance.
- 100% of practices maintained the required opening hours.
- 100% completed the GMS Annual Contract Return.
- 100% completed Enhanced Service Audits of Diabetes, Near Patients Testing and DOACs.
- 100% completed the National Diabetes Audit.
- 100% compliance with Wales National Workforce Reporting System

Non-Contractual Compliance:

- 100% participated in an agreed Quality Improvement Framework (QIF)
- 100% engaged in Cluster Development and collaboration
- 100% participated in the Access Standards and achieved 100% compliance.
- 100% participated in the Escalation Framework (this became mandated as contractual compliance in October 2023)

Areas of non-contractual compliance are detailed in the table below:

a) Childhood Immunisations & 6-8-week Baby Checks

	Brecon	Ystradgynlais	Crickhowell	Hay/arth	Builth Wells	Llandrindod Wells	Rhayader	Knighton	Presteigne	Llandiloes	Dyfi Valley	Welshpool	Newtown	Montgomery	Llanfair Caereinion	Llanfyllin
Childhood Imms																
1 Year																
6 in 1 Primary	99/102 97.1%	101/103 98.1%	49/53 92.5%	72/78 92.3%	45/47 95.7%	68/74 91.9%	27/28 96.4%	31/31 100%	22/24 91.7%	67/73 91.8%	50/51 98%	95/100 95%	116/120 96.7%	80/82 97.6%	42/44 95.5%	92/98 93.9%
Rotovirus	94/102 92.2%	102/103 99%	48/53 90.6%	71/78 91.0%	44/47 93.6%	68/74 91.9%	27/28 96.4%	29/31 93.5%	21/24 87.5%	65/73 89.0%	48/51 94.1%	95/100 95%	117/120 97.5%	78/82 95.1%	42/44 95.5%	91/98 92.9%
PCV Primary	98/102 96.1%	103/103 100%	50/53 94.3%	77/78 98.7%	46/47 97.7%	69/74 93.2%	28/28 100%	31/31 100%	22/24 91.7%	67/73 91.8%	50/51 98%	94/100 94%	116/120 96.7%	81/82 98.8%	43/44 97.7%	91/98 92.9%
Men B	97/102 95.1%	102/103 99%	49/53 92.5%	74/78 94.9%	45/47 95.7%	68/74 91.9%	27/28 96.4%	30/31 96.8%	22/24 91.7%	67/73 91.8%	50/51 98%	94/100 94%	116/120 96.7%	81/82 98.8%	43/44 97.7%	92/98 93.9%
2 years																
MMR 1 dose	100/105 95.2%	102/110 92.7%	51/54 94.4%	55/56 98.2%	39/40 97.5%	80/85 94.1%	16/18 88.9%	30/33 90.9%	25/27 92.6%	71/75 94.7%	50/53 94.3%	90/97 92.8%	116/120 96.7%	65/68 95.6%	43/44 97.7%	77/81 95.1%
PCV Final	100/105 95.2%	102/110 92.7%	51/54 94.4%	55/56 98.2%	39/40 97.5%	81/85 95.3%	16/18 88.9%	30/33 90.9%	25/27 92.6%	71/75 94.7%	49/53 92.5%	92/97 94.8%	116/120 96.7%	64/68 94.1%	43/44 97.7%	77/81 95.1%
Hib/Men C Booster	100/105 95.2%	102/110 92.7%	51/54 94.4%	55/56 98.2%	39/40 97.5%	77/85 90.6%	16/18 88.9%	30/33 90.9%	25/27 92.6%	71/75 94.7%	49/53 92.5%	91/97 93.8%	116/120 96.7%	64/68 94.1%	43/44 97.7%	77/81 95.1%
Men B Complete Course	100/105 95.2%	102/110 92.7%	51/54 94.4%	55/56 98.2%	39/40 97.5%	77/85 90.6%	16/18 88.9%	30/33 90.9%	25/27 92.6%	71/75 94.7%	49/53 92.5%	92/97 94.8%	116/120 96.7%	62/68 94.1%	43/44 97.7%	76/81 93.8%
5 years																
MMR 2 doses	119/135 88.1%	133/142 93.7%	50/54 92.6%	68/72 94.4%	56/62 90.3%	102/103 99.0	36/39 92.3%	35/39 89.7%	14/17 82.4%	67/70 95.7%	53/59 89.8%	101/113 89.4%	129/137 94.2%	62/68 94.1%	48/49 98%	87/92 94.6%
4-in-1 pre-school	120/135 88.9%	134/142 94.4%	50/54 92.6%	68/72 94.4%	57/62 91.9%	108/113 95.7	35/39 89.7%	35/39 89.7%	15/17 88.2%	67/70 95.7%	53/59 89.8%	102/113 90.3%	129/137 94.2%	63/68 92.6%	48/49 98%	84/92 91.3%
16 years																
3-in-1 teenage booster	146/165 88.5%	104/121 86.0%	87/92 94.6%	61/66 92.4%	65/72 90.3%	82/95 86.3%	18/23 78.3%	32/38 84.2%	34/38 89.5%	78/95 82.1%	54/69 78.3%	106/118 89.8%	146/165 88.5%	53/64 82.8%	56/65 86.2%	70/82 85.4%
MenACWY	150/165 90.9%	104/121 86.0%	88/92 95.7%	62/66 93.9%	65/72 90.3%	82/95 86.3%	18/23 78.3%	34/38 89.5%	33/38 86.8%	79/95 83.2%	54/69 78.3%	108/118 91.5%	145/165 87.9%	55/64 82.8%	59/65 90.8%	70/82 85.4%
Outstanding 6-8 week baby checks																
Q1	2/22 90.91%	2/24 85.71%	17/17 100%	1/13 92.31%	1/11 90.91%	16/16 100%	8/8 100%	3/8 62.5%	4/4 100%	18/18 100%	9/9 100%	1/21 95.24%	29/29 100%	17/17 100%	1/14 92.86%	20/20 100%
Q2	33/33 100%	9/9 100%	9/9 100%	2/11 81.82%	13/13 100%	22/22 100%	9/9 100%	2/11 81.82%	1/5 80%	9/9 100%	1/9 88.89%	34/34 100%	28/31 90.32%	1/15 93.33%	9/9 100%	1/23 95.65%
Q3	2/21 90.48%	8/8 100%	1/13 92.13%	2/15 86.67%	1/14 92.86%	1/13 92.31%	9/9 100%	8/8 100%	10/10 100%	2/23 91.3%	1/12 91.67%	25/25 100%	32/32 100%	1/14 92.86%	1/11 90.91%	8/22 63.64%
Q4	16/18 88.89%	14/17 82.35	8/10 80%	6/8 75%	10/13 76.92%	13/14 92.86%	8/8 100%	8/8 100%	10/10 100%	18/18 100%	12/12 100%	16/17 94.12%	29/30 96.67%	15/15 100%	7/8 87.5%	14/21 66.7%

- Practice participation in Childhood Vaccinations & Immunisations and Child Health Surveillance are identified as 'Additional Services' in the 2004 contract.
- 100% of practices participate in Additional Services, however there is no mandated contractual/regulatory compliance linked to targets.
- Childhood immunisation targets are monitored by the Healthy Child Wales Programme (HCWP), supported by the Primary Care Department due to the contractual requirement.
- The majority of children not vaccinated are small numbers in each age cohort which impact on the RAG assessment/ % target achieved.
- The reporting period has an impact on the data. When reviewed by the public health team children who are outside of the immunisation target timescale are vaccinated relatively quickly. For example, delays can be due to illness, practice appointment availability. However, this is not reflected in the target compliance/achievement.

- A 6–8-week physical examination process was introduced into the CAF for 2021/22. A jointly agreed SOP between Practices and the Health Board has continued with a steady improvement in 2022/23 with practices working towards improving the completion of the examination within the required time period and submitting results digitally.
- Focussed discussions take place in Practice Review Visits and also Health Visitors and the PTHB Immunisation Co-ordinator have a pivotal role in engaging with general practice and parents/guardians to encourage immunisation uptake.

b) Flu Targets

	Uptake in Wales (as of 25/04/23) source: Public Health Wales	Brecon	Ystradgynlais	Crickhowell	Haygarth	Builth Wells	Llandrindod Wells	Rhayader	Knighton	Presteigne	Llandloes	Dyfi Valley	Welshpool	Newtown	Montgomery	Llanfair Caereinion	Llanfyllin
National flu targets																	
Over 65 years 75%	76.30%	2972/4151 71.6%	2171/2916 75%	2564/3258 78.7%	1782/2499 71.3%	1768/2362 75%	2270/3100 73.2%	740/1034 71.6%	1052/1481 71%	936/1221 76.7%	1897/2682 70.7%	1277/1888 67.6%	2019/2694 75%	2160/2947 73.3%	1807/2243 80.6%	1201/1627 73.8%	2176/2937 74.1%
2-3 Year old 75%	44.20%	138/257 53.7%	80/247 32.4%	84/113 74.3%	58/134 43.3%	56/109 51.4%	120/167 71.3%	42/49 85.7%	32/69 46.4%	24/61 39.3%	80/155 51.6%	57/110 51.8%	94/207 45.4%	148/250 59.2%	104/160 65%	46/98 46.9%	85/192 44.3%
Clinical risk under 65 75%	44%	913/1785 51.1%	756/1835 41.2%	556/1022 54.4%	417/1029 40.5%	446/857 52%	768/1562 49.2%	187/383 48.8%	271/604 44.9%	201/408 49.3%	430/881 48.8%	398/916 43.4%	689/1570 43.9%	891/1881 47.4%	544/1010 53.9%	366/729 50.2%	572/1353 42.3%

- On 1st October 2022 Quality Assurance Indicator Framework (QAIF) clinical indicators transferred into the core contract and became mandated for all contracts, this included the QAIF flu targets; therefore, the national targets are the only measure in place now for flu vaccination achievement.
- 100% of practices participate in the national flu vaccination programme however there is no mandated contractual/regulatory compliance linked to national target achievement.
- Flu targets are monitored by PTHB Public Health Team, supported by the Primary Care Department due to the contractual requirement.
- PTHB Communications Department support the advertising of practice flu campaigns.
- Practices utilise various communication methods to try to increase uptake. This includes mailshots, text invitations, social media, posters, press releases, dedicated clinics (including a weekend offering in some practices) and also opportunistic screening.
- Focussed discussions take place in Practice Review visits, led by the Public Health Team and also the PTHB Immunisation Co-ordinator has a pivotal role in engaging with general practice to improve on vaccine uptake, especially those with a lower uptake.
- During 2023/24 the Public Health Team have offered practices an additional financial incentive to increase the vaccination uptake of the 2-3 year old. Data available to date indicates an improvement with this cohort. This will be reported on in the 2023/24 CAF report which will be available at the end of Q1 2024/25.
- Practices are often cautious around their flu vaccine orders as unused vaccine is a potential financial risk to them.

- The 2025/26 national flu programme will include a national central flu procurement approach and direct practice vaccine ordering will no longer take place. Direct ordering provides practices with additional financial incentive therefore practice incentive in the flu programme from 2025/26 may reduce if the practice profit margin is compromised. This is a national risk and is being looked at a part of the central procurement approach.

c) National Prescribing Indicators

National Prescribing Indicators (period ending March 2023)	National Indicators	Brecon	Ystradgynlais	Crickhowell	Haygarth	Builth Wells	Llandrindod Wells	Rhayader	Knighton	Presteigne	Llandiloes	Dyfi Valley	Welshpool	Newtown	Montgomery	Llanfair Caereinion	Llanfyllin
Antibacterial Items Per 1000 STAR-PU(13)	<209	276	328.9	247.2	197.9	271.7	371.3	273.6	263.8	256.6	278.8	264.5	256.9	379.3	252.2	272	266.7
4C Antibacterials Items Per 1000 patients	<7.12	12	11.7	9.9	10.2	11.7	19	8.1	12.6	11.9	11.7	10	9.8	18	5.6	10.8	14.8
Opioid Burden (UDG) ADQs per 1000 Patients	<3460	3899.1	6492.9	3596.4	2336	3590.6	5493.5	2998.4	3301.1	3710.1	3089.7	4468.5	4742.9	4971.2	3294.4	3461.6	3287.3
High Strength Opioids ADQ per 1000 Patients	<76.7	82.2	186.9	75.8	57.7	169	218	170.5	82.4	129.8	106.1	274.5	261.2	164.4	84.9	72.2	73.8
Opioid Patch Items as % of all Opioid Prescribing (21-22 target)	<7.51	7.1	6.8	17.5	8.3	5.5	8.9	17.9	5.6	12.2	10.5	8.5	18.9	14.4	11.9	10.9	12.6
Hypnotics and Anxiolytics (UDG) ADQ Quantity per 1000 STAR-PU(13)	<1439	1852	2187.5	1809.9	462.1	1467.9	2533.2	3258.4	1066.9	695.2	1762.5	1339.5	1799.5	2210.1	546.9	1109.2	1072.6
Gabapentin and Pregabalin DDDs Per 1000 Patients	<1173	1171.5	2224.5	1282.5	1334.9	1265.5	1624.6	1070.7	1334.3	1335	992.2	1427.9	1305.7	1382	868.1	1238.9	1277
Tramadol DDD per 1000 Patients	<287	321	472.2	254.6	103.5	184.3	358.4	121.6	194.4	224.4	371.9	394.4	319.8	410.5	220.7	359.5	310.7
NSAIDs ADQ per 1,000 STAR-PU	<1192	1092.6	1492.1	1121.1	923.7	836.1	1042.3	913.6	1235.3	873.6	1520.4	1294.9	1618	1446.4	1022.3	1062.6	1037.4
Ibuprofen And Naproxen Items as % of NSAIDs	>86	85.2	86.8	87.6	85.7	85.1	85.3	90.4	90.1	84.7	72.8	81.4	84.6	81.8	80	85.2	81.8
DPIs and SMIs % of All Inhalers	>34.1	41.3	30.6	49.2	38.7	27.7	32.7	24.8	27.5	18.2	30.5	30.7	14.8	33	21.8	34.1	25.4
Salamol MDIs Items as a % of all salbutamol MDIs (target >	>60	85	78.2	69.4	74.4	2.5	53.1	2.2	3.8	29.3	5.8	24.9	52.3	20.1	77.3	65.2	11.2
% Statins prescribed as high intensity statins	>67.93	64	58.4	61	60.3	64	67.8	51.1	58.4	68.1	57.9	74.3	59.3	63.6	76	66.1	71.5
Proton Pump Inhibitors DDDs per 1000 Pus (21-22 target)	<6464	8471.4	9610.3	7545.9	8132.6	8472.4	8869.8	7853.3	7365.8	7173.8	7595.3	8094.4	8439.6	9298.8	8312.8	7221.2	6321.5
Low Value for Prescribing £ per 1000 Patients	<115.14	422.3	130.9	184.5	52.5	82.3	77.7	344.3	23.9	109.4	98.8	229.4	173.1	171.3	103.1	180.4	93.1

- National Prescribing Indicators are monitored by the Medicines Management Team and Prescribing Review meetings are held annually with all Practices on an individual basis.
- In addition, focussed discussions take place in Practice Review visits, led by the Medicine Management Team.
- Medicines Management offer to undertake proactive audits with practices to identify areas for improvement. The majority of practices engage in this offer.

d) Finance/Commissioning

Activity Per 1,000 Registered Patients	Brecon	Ystradgynlais	Crickhowell	Haygarth	Builth Wells	Llandrindod Wells	Rhayader	Knighton	Presteigne	Llandiloes	Dyfi Valley	Welshpool	Newtown	Montgomery	Llanfair Caereinion	Llanfyllin	
Outpatient MMDS Actuals Activity per 1000s Registered Patients 2022-2023 data	305	294	270	315	342	338	275	277	291	236	231	214	210	262	245	217	4,322
Emergency Inpatients (All)	95.6	101.1	113.1	80.2	81	90.6	93.6	83.4	82.1	76.4	92.2	108.9	93.2	100.5	92	90.1	1,474
Outpatient MMDS Actuals Activity per 1000s Registered Patients 2021-2022 data	286	266	242	275	363	298	246	275	286	181	194	182	183	221	196	183	3877
Emergency Inpatients (All)	89.7	96.6	117.6	88	100.3	95.2	122.6	74.8	84.1	80.6	96	111.4	101.7	113.3	80.1	80.6	1533

- This information is taken from the PTHB contract dataset which captures all patient activity which has been delivered through the PTHB provider and other commissioned services.
- The values are representative of activity per 1000 patients.

- The RAG rating represents a comparison across Powys practices.
- The data for 2022-23 shows that overall, there was a reduction in the number of Powys GP registered patient emergency admissions into secondary care, compared to 2021-22. This is the case amongst most Practices, however, 5 of 16 practices show an increase in emergency admissions.
- There has been an increase in Powys GP registered outpatient activity. Only 1 practice had a reduction in this patient activity. Outpatient activity would be expected to increase in secondary care as the recovery from COVID continued through 2022-23.
- The Finance team plan for this data to be shared at GP Collaborative and cluster level to support and inform practice reflection and future pathways to support reductions in secondary care flow.

Sustainability and Escalation

The mandating of completion of the GP Escalation Tool came in during 2021/22. Practices are required to ensure that they update the Escalation Framework on a regular basis and specifically if there is a significant change in practice circumstances.

As of 31st March 2023 (end of 22/23 CAF reporting period) 8 practices (50%) were reporting the highest level of escalation. This was due to winter pressures and in particular high rates of staff absences at that time. Managing patient demand along with practice staff absence (vacancies and sickness) is an ongoing challenge for practices. Across some disciplines, Powys Practice absences are consistently higher than the all-Wales average**.**

31/03/2023	Level 1	Level 2	Level 3	Level 4
ABUHB	77.5	19.7	1.4	1.4
BCUHB	41.7	36.5	14.6	7.3
CVUHB	36.8	43.9	19.3	0.0
CTMUHB	43.5	37.0	17.4	2.2
HDUHB	22.9	29.2	33.3	14.6
PTHB	0.0	31.3	18.8	50.0
SBUHB	46.9	38.8	10.2	4.1
WALES	44.4	33.7	15.1	6.8

Current escalation reporting as at 29th January 2024 is as follows:

29/01/2024	Level 1	Level 2	Level 3	Level 4
ABUHB	51.5	26.5	17.6	4.4
BCUHB	21.9	39.6	27.1	11.5

CVUHB	14.3	25.0	16.1	44.6
CTMUHB	31.1	24.4	13.3	31.1
HDUHB	18.8	22.9	41.7	16.7
PTHB	0.0	43.8	37.5	18.8
SBUHB	33.3	26.7	24.4	15.6
WALES	27.3	29.7	24.1	19.0

Ongoing common themes for escalation include

- On the day demand, triage and face to face appointments
- MDT sickness (curently linked to covid, flu and Acute Respiratory Infections, Norovirus cases and other areas such as stress and exhaustion)
- Continued increase in challenging and abusive behaviour from patients, impacting negatively on support teams and team moral.
- Practices having to work longer hours, over and above core hours, to meet patient need/demand.
- Ongoing healthcare strikes are also having an impact on demand.

Nationally General Practice is experiencing significant workload challenges to meet patient demand. General practice sustainability and ongoing resilience during this current winter continues to be a concern. Currently PTHB is liaising closely with:

- Llanfyllin – sustainability support package in place
- Rhayader – sustainability discussions and support ongoing
- Crickhowell – Belmont Branch surgery closure agreed in May 2023 (closed in Nov 2023).

Workforce:

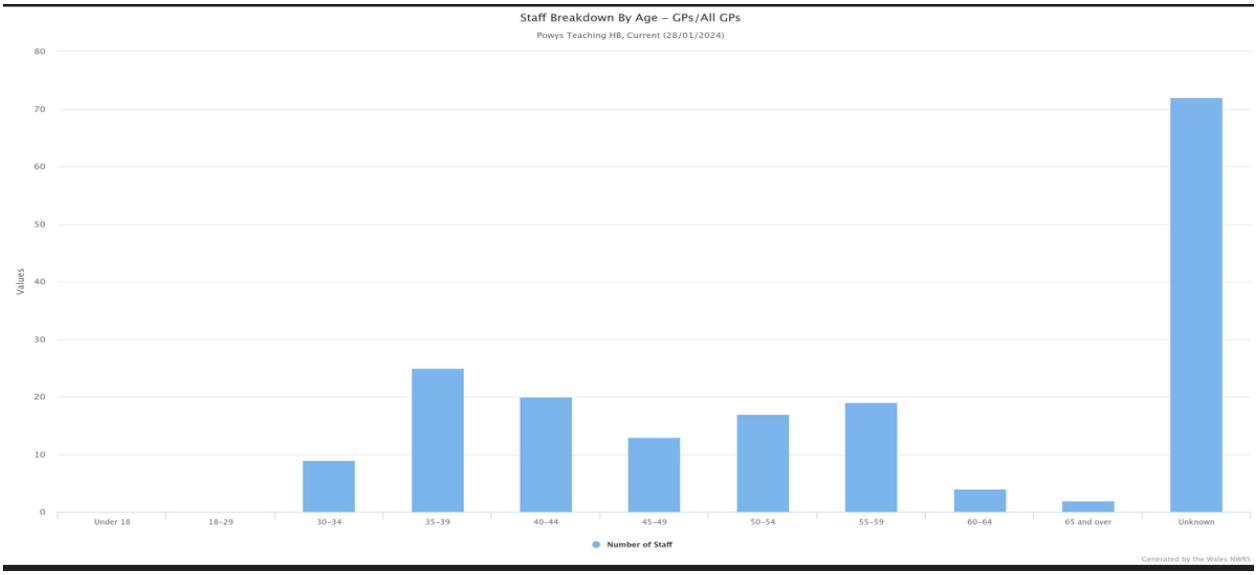
During 2021/22 the mandating of data recording and submission to Wales National Workforce Reporting System (WNWRS) was included in the contract. During 2022/23 practices have been required to ensure that they update their workforce data on a regular basis. This new introduction into the contract allows the health board to have a much better understanding of the general practice workforce. Below is a snap shot of some of the workforce data available. This can be drilled down on a practice by practice basis.

The PCD in conjunction with WOD are about to commence a review of the primary care workforce in general practice. It will use the information in the WNWRS and also the WOD workforce modelling tool to support workforce planning. This will

- Identify workforce needs
- Improve workforce planning and support sustainability
- Promote and encourage multi-professional working
- Improve access and capacity for student training and placement opportunities to promote longer term sustainability of Powys primary care

Ongoing general practice workforce sustainability is a risk for the health board.

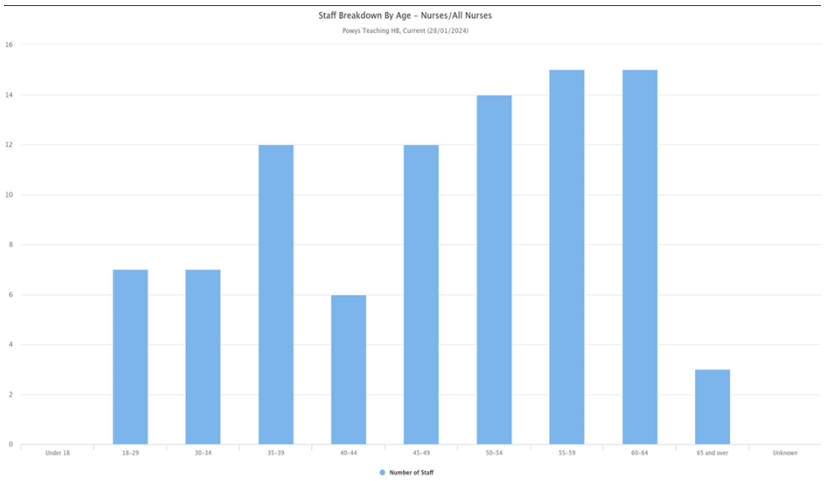
- **Current PTHB GP workforce age profile**



Welsh National Workforce Reporting System (WNWRS)

- 14% (25) of the GP workforce are aged 55 and above
- 3% (6) are aged 60 and above
- 1% (2) are 65 and above
- It is noted that there are 72 GPs currently unmatched to an age profile. This is currently being picked up with the WNWRS team; therefore the accuracy of the above statistics need to be confirmed.
- Many Gps from the 55 + bracket choose to retire as their pension pots can be full.

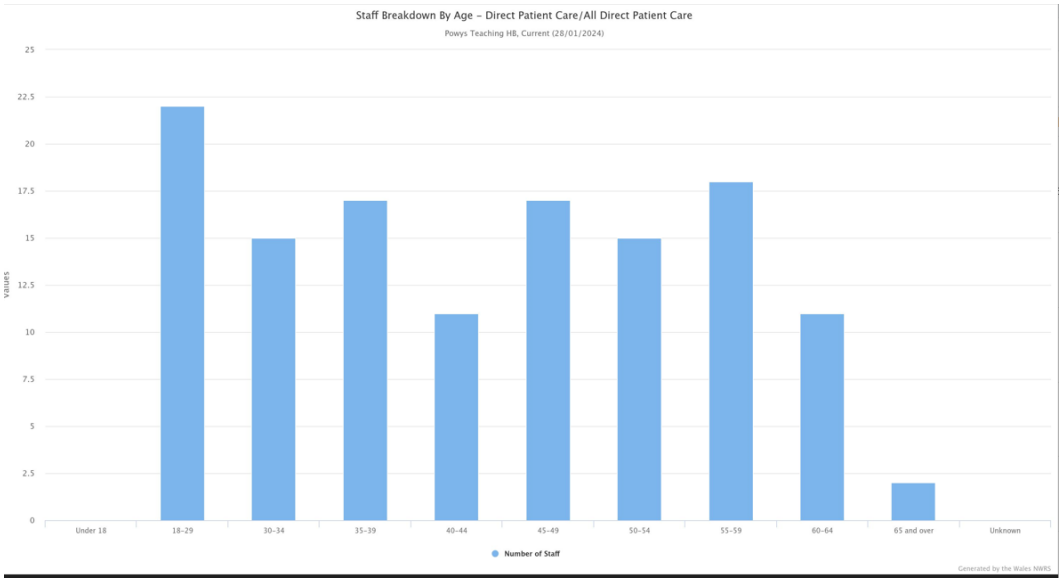
- **Current GP Nurse workforce age profile**



Welsh National Workforce Reporting System (WNWRS)

- 36% (13) of the nursing workforce are aged 55 and above
- 20% (18) are aged 60 and above
- 3% (3) are 65 and above

- **Current MDT workforce age profile**



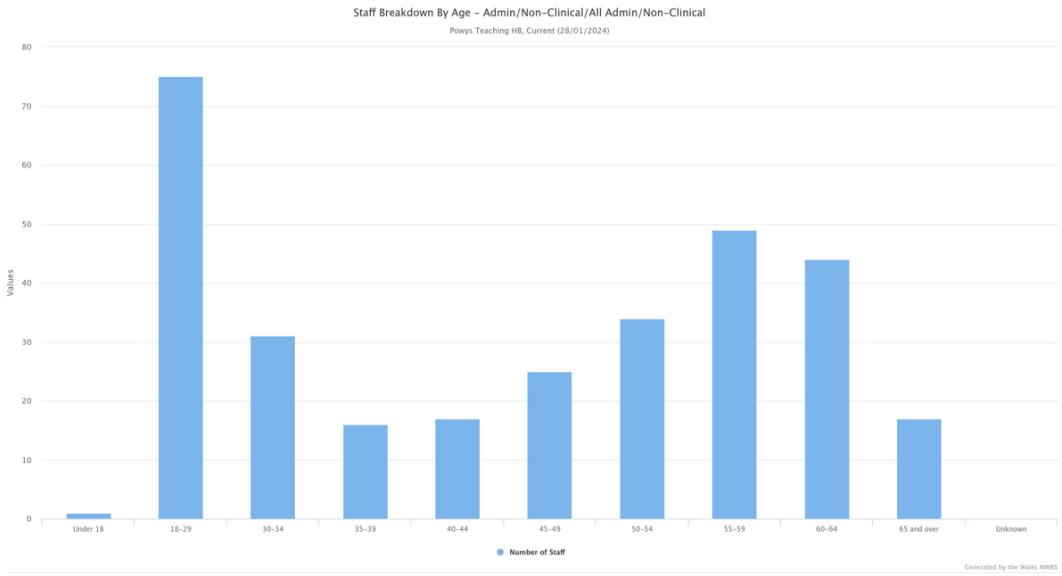
Welsh National Workforce Reporting System (WNWRS

This includes all clinical MDT members, for example Pharmacists, Physician Associates, HCAs etc (excluding GPs and Nurses as reported separately)

- 24% (31) of the nursing workforce are aged 55 and above

- 10% (13) are aged 60 and above
- 2% (2) are 65 and above

- **Current GP Administrator/Managers workforce age profile**



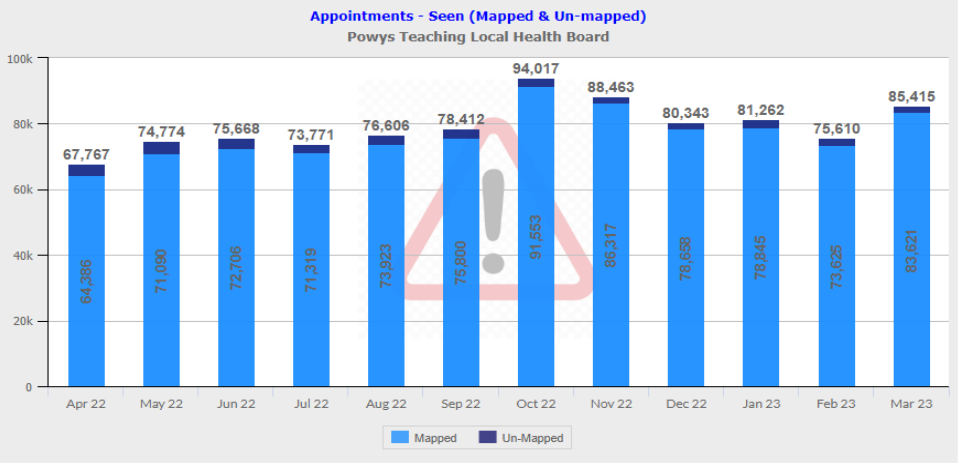
This includes the non-clinical workforce working in general practice.

- 36% (110) of the admin/management workforce are aged 55 and above
- 20% (61) are aged 60 and above
- 6% (17) are 65 and above

Patient Access Activity

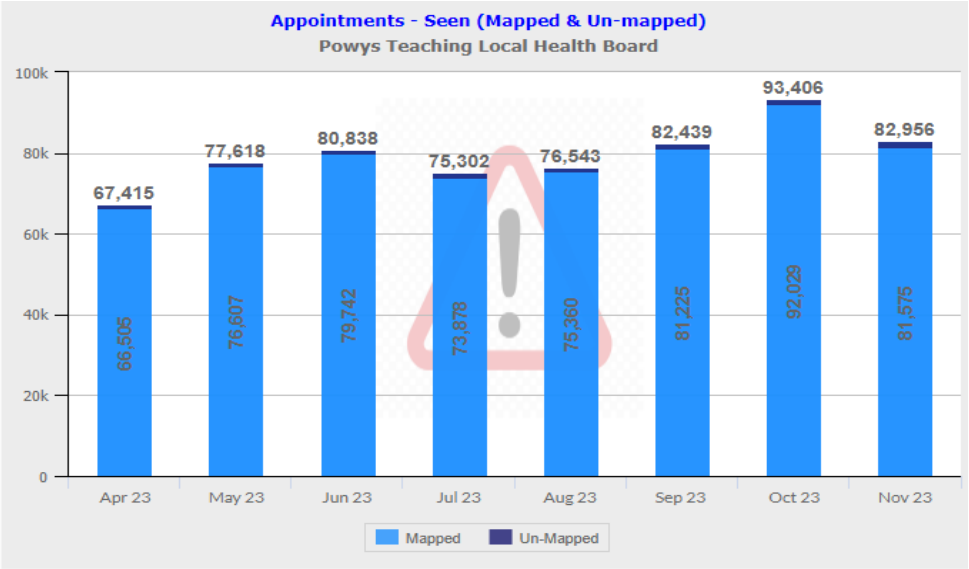
From the 1st October 2022, the collection and sharing of GMS activity/appointment data was mandated through the contract. Practices are required to update their appointment and contact data on a monthly basis and also make it available to patients. There are many caveats to the data that need to be taken into account, however the data below confirms the high demand and patient contact being undertaken in general practice.

- **2022/23**



Primary Care Information Portal – Activity

- **2023/24 (available to date)**



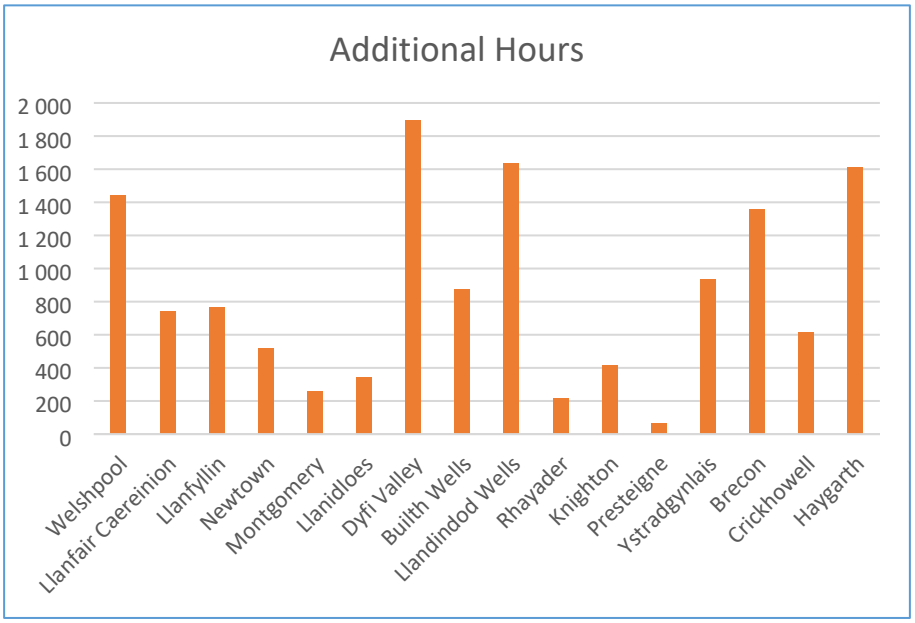
Primary Care Information Portal – Activity

Additional Capacity

From 1st April 2022, three year recurrent national funding on a 50% match funding basis was made available to enable GP Practices to take on additional clinical and administrative resource (paid on evidence of additional hours worked). Across Powys this equated to the practices collectively providing an additional 13,506 hours which equated to 13,691 patient appointments.

The majority of practices used the funding to increase clinical sessions utilising a variety of MDT team members depending on the clinical need to support patient

demand, however the funding could also be used for administrative hours to support patient services (as opposed to appointment offers). Roles used for the increasing capacity had a direct link to the employment costs and the hours they eqauted to, for example a GP session would be more expensive than a HCA session.



NEXT STEPS:

1) To continue to monitor GMS contractual and non-contractual compliance to offer ongoing assurance to PTHB
2) Update the PTHB GMS Commissioning Assurance Framework to reflect contract changes for 2023/2024.

Appendix 1 - Commissioning Assurance Framework – Primary Care General Medical Services

Appendix 2 - General Medical Services CAF Tolerance Levels

Appendix 3 - GMS CAF dashboard 2022/23

Appendix 4 – Access Standards Commitment 2022/23

The following Impact Assessment must be completed for all reports requesting Approval, Ratification or Decision, in-line with the Health Board's Equality Impact Assessment Policy (HR075):

IMPACT ASSESSMENT					
Equality Act 2010, Protected Characteristics:					
	No impact	**Adverse**	**Differential**	**Positive**	**Statement** ***Please provide supporting narrative for any adverse, differential or positive impact that may arise from a decision being taken***
Age	x				
Disability	x				
Gender reassignment	x				
Pregnancy and maternity	x				
Race	x				
Religion/ Belief	x				
Sex	x				
Sexual Orientation	x				
Marriage and civil partnership	x				
Welsh Language	x				
Risk Assessment:					
	Level of risk identified				**Statement** ***Please provide supporting narrative for any risks identified that may occur if a decision is taken***
	None	**Low**	**Moderate**	**High**	
Clinical		x			
Financial		x			
Corporate	x				
Operational		x			
Reputational		x			

POWYS TEACHING HEALTH BOARD COMMISSIONING ASSURANCE FRAMEWORK

Primary Care - General Medical Services

This framework describes a continuous assurance process that aims to provide confidence to internal and external stakeholders and the wider public that PTHB are operating effectively to commission safe, high-quality and sustainable services within their resources, delivering on their statutory duties and driving continuous improvement in the quality of services and outcomes achieved for patients.

Version 1

Approved Executive Committee 09.05.19

Revised: May 2021, GMS Contract Monitoring Group

Revised: January 2023

Contents

Tables

1. Introduction

This Commissioning Assurance Framework for Primary Care General Medical Services describes a continuous assurance process that aims to provide confidence to internal and external stakeholders and the wider public that PTHB is operating effectively to commission safe, high-quality and sustainable services within the resources available, delivering on statutory duties and driving continuous improvement in the quality of services and outcomes achieved for patients. Once agreed, this framework will be subject to a 12-month review.

PTHB aims to commission services that improve the health and wellbeing of the people of Powys. Commissioning is simply how we plan, agree and monitor the health services needed. We will do this by securing sustainable care that enables patients to receive modern, responsive, high quality yet cost-effective care and services that are effectively commissioned within PTHB's financial resource limits.

Powys Teaching Health Board is primarily a commissioning organisation. The largest proportion of its budget is devoted to securing health care services including unscheduled and planned care from neighbouring health boards and NHS Trusts. A significant proportion of the budget is devoted to primary care services to secure health care provision for general medical services, general dental services, general optometric services and community pharmacy services. PTHB, along with patients, the public and fellow commissioners, needs to be assured that we are able to demonstrate the effective use of public funds in commissioning safe, high quality and sustainable services within available resources.

Quality in Powys is everybody's business with ownership and understanding of both the challenges and the solutions shared across all organisations, professions and with the public. Our approach places quality at the heart of our work, ensuring we monitor, and make efforts to improve, the quality of healthcare we commission. Our aim is to ensure that together we drive up the quality of care and treatment of services provided for the people of Powys, and that there continues to be a culture of continuous quality improvement.

As a Health Board we need to ensure that we are delivering services that meet patient needs, and performance management gives us a way of making decisions about where to focus resources depending on needs at any one time. Over time, performance management allows relative measurement to be made so that we can see if improvements are being made and if extra efforts need to be made in particular areas to achieve those improvements. We also need to ensure that we provide effective and robust monitoring arrangements to ensure performance, quality and efficiency of all services delivered on our behalf. This framework describes PTHB's approach to commissioning assurance. It provides an overview of:

- The principles and behaviours which will underpin the approach to assurance;
- The contents of the assurance framework;
- How the assurance process will operate; and,
- PTHB's potential responses to the assurance process.

2. Background

Within Powys we have had to respond to more challenging performance and financial positions, as well as changes within the commissioning landscape. The lessons for future commissioning from The Francis Report 2013 are that commissioners have a critical role in driving quality. We will need to agree standards above those set by the Healthcare Inspectorate Wales (HIW), with the aim of driving improvement, and setting out longer term goals with all providers by way of

developmental standards and focus on improvements in effectiveness ensuring that our patients are the first and foremost consideration, and to ensure services commissioned by PTHB secure a consistent culture of care with patient's interest at the very heart.

This quality assurance framework will set out how we monitor and performance manage the quality of care we commission - including the crucial ability to recognise early and act on any systematic deterioration in care within a provider organisation.

3. Scope of the Commissioning Assurance Framework

The assurance process is a more risk-based approach which differentiates high performing Providers, those whose performance gives cause for concern, and those in between. It provides a robust, supportive and structured framework for those in more challenged circumstances, with a lighter touch approach for the best performers.

A continuous assurance approach helps to identify emerging patterns of poor performance or any areas of potential risk, with less reliance on fixed points. The process uses information derived from a variety of sources including, where necessary, face-to-face visits. The nature of the oversight, including the expected frequency of assurance meetings is dependent on the circumstances, the range of risks identified, and on the leadership response. The assurance framework recognises that assurance is a continuous process that considers the breadth of a Health Board's responsibilities.

It consists of the following five key areas:

- ✓ **Access to Care** - the timely access to health services to achieve the best health outcomes for patients
- ✓ **Quality and Safety** - ensure that services being commissioned are safe, personal, effective and continuously improving;
- ✓ **Finance & Activity** – patterns and variation from the planned level of activity or a variation in cost that indicates higher/lower target performance;
- ✓ **Patient Experience** - use patient and carer feedback, along with complaints and concerns raised with the THB, to strengthen our ability to detect early warning signs of deterioration in quality, as well as evidence of excellence that should be adopted and spread;
- ✓ **Governance and strategic change** – covers the degree of government or regulator intervention and sustainability (planned and unplanned service changes).

A set of broad principles has been identified, which should underpin how our commissioning assurance is undertaken:

- Assurance should be transparent and demonstrate to internal and external stakeholders and the wider public the effective use of public funds to commission safe and sustainable services.
- Assurance is primarily about providing confidence.
- Assurance should build on what we are already doing to hold ourselves accountable locally to communities and stakeholders, for both statutory requirements and for national and local priorities.
- Assurance should minimise bureaucracy and additional reporting requirements by drawing on available data and aligning with other regulatory and planning processes – there should be minimal additional paperwork.
- Assurance should be proportionate and respect the time and priorities of PTHB and our Providers.
- Assurance should be summative and take place over the year as on-going conversations.

- Assurance processes should be able to swiftly identify performance outside pre-set tolerances.
- The tone, process and outcomes need to focus on development as well as performance.
- Accountability, learning and development will be integral to the process.
- Whilst uncompromising on the facts which describe the quality of services patients are receiving, we will be open minded in understanding the reasons for variation and, where a problem is found, clear on the consequences and actions we will need to take.

4. Components of the Commissioning Assurance Framework

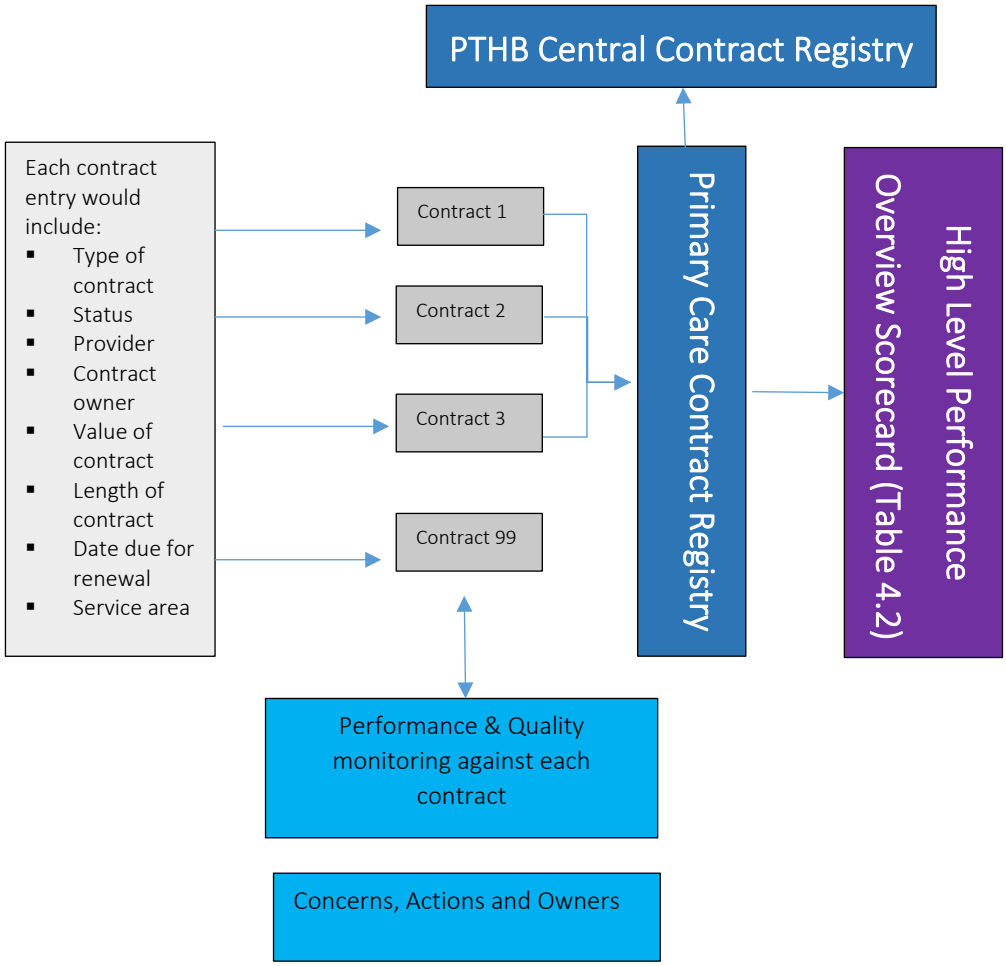
General Medical Service contracts between health boards and general medical service providers are delivered within the National Health Service (General medical services Contracts) (Wales) Regulations 2004. These Regulations set out, for Wales, the framework for general medical services contracts under section 28K of the National Health Service Act 1977. The regulations are enforceable. Parameters not covered within the regulations are not enforceable.

4.1 Register of Providers

Where PTHB is the commissioner the principles of good contract management remain an important part of the wider commissioning process. It is about more than ensuring providers meet their agreed obligations. It can help PTHB to identify and manage its own and provider risks, demonstrate value for money, potentially achieve savings and continuous improvement.

It means understanding what the contract contains, who has responsibility for managing it, and whether performance and costs are on track. The best results are achieved when those who are involved in commissioning and running the service work together to manage the agreement and have clear agreed processes and procedures in place to help them do so.

A “register” of primary care general medical contracts will be held within the Primary Care Team and will include all general medical contracts and agreements issued for primary care general medical services within PTHB. This “register” will feed into the central “register.”



4.2 Levels of Assurance

The prioritisation mechanisms for quality assurance that we will utilise are as follows:

Green	On target. The number of milestones met greater than number of milestones not yet met (with no significant outliers)	Routine Monitoring - Evidence and data will be provided through the Quality Schedules and/or information from national assessments and usual data sources
Amber	Risk to delivery (number of milestones met equals milestones not met) Missing objective/target but on agreed performance improvement trajectory	Enhanced monitoring via an exception report and associated remedial actions and trajectory for improvement
Red	Not on target Number of milestones not met is greater than those met Persistently not meeting threshold (3 months); and highly unlikely to achieve recovery within specified period	Escalated performance monitoring requiring detailed action plan and agreed as minimum monthly (in some cases fortnightly) reviews where commissioners have serious concerns about contract delivery, quality, and patient safety

Table 4.2 Levels of Assurance

The Health Board's Performance Management Framework uses a red / amber / green system to facilitate the appropriate prioritisation and escalation of performance issues. The rating system for providers will utilise the same level of assurance.

Tolerances may be agreed by the Executive Committee, for example, in relation to financial performance.

4.3 Developing and Implementing a Rating System for Providers

As a Health Board we need to provide effective and robust monitoring arrangements to ensure performance, quality and efficiency of all services delivered on our behalf. We will have in place systems and processes for anticipating and responding to performance trajectories and risk assessments include measures of safety, effectiveness, and user experience. There is strong evidence to suggest a rating should be based on a combination of indicators compiled from routinely available data, and information from inspections and patient experience and not just data alone.

Each provider will be rated to help PTHB compare services and to highlight where care is good or outstanding and expose where care is inadequate or requires improvement. We will use the following categories for assessment; Access – Scheduled and Unscheduled Care, Quality & Safety, Patients Experience and Finance (Activity & Cost). Information is also collected in relation to Governance and Strategic change. The PTHB scoring system is used in addition to help provide assurance within the Health Board in relation to the services provided to its residents. This will be displayed in a high level dashboard to show at a glance the provider rating. (Arrows will be used to indicate the direction of monthly changes.) Absence of required information will be recorded and the score will reflect whether there is an agreed development plan to provide such information.

Provider	Date	G Y A1 A2 R Performance Framework Rating Assessment				
		Access	Finance & Activity	Quality & Safety	Patient Experience	Overall Rating
1	Sep 18					Level 1
2	Sep 18					Level 1
2	Sep 18					Level 2
3	Sep 18					Level 3R
4	Sep 18					Level 4
5	Sep 18					level 4+

Table 4.3 High Level Performance Overview Scorecard

4.4 Internal Commissioning Assurance incorporated as part of the General Medical services Contract Monitoring Group

Internal Commissioning Assurance is delivered through the General Medical Services Contract Monitoring Meetings which provide the opportunity for key people to meet on a bi-monthly basis to look at general practice data. The meeting will usually comprise representatives from primary care and finance who consider and review key information relating to each of the general practice providers within Powys.

The data and discussion enables PTHB to form conclusions on whether there are any areas of concern and whether to 'step up' or 'step down' **Escalation Process** (see Section 4.6). This provides us with a mechanism for monitoring and follow-up which can then be used to strengthen our assurance and enables us to show how we are using the data to improve patient outcomes.

Key data is captured on one A3 sheet on each GP contractor and records exceptions and key trends drawn from for example:

*Quality & Safety	Finance (Cost & Activity)	Access	Patient Experience
▪ Compliance with NHS Wales General medical services Regulations 2004 ▪ Compliance with GP Performer Regulations ▪ Clinical governance self-assessment ▪ Serious incidents (including themes) ▪ Complaints and claims ▪ Internal / External Audit ▪ Health Inspectorate Wales (HIW) reports ▪ Enhanced Service audits ▪ National audits (Diabetes/ COPD/CKD) ▪ GMS annual contract returns ▪ Information Governance self-assessment ▪ Childhood immunisations targets ▪ Flu immunisations targets ▪ Quality Assurance Improvement Framework achievement ▪ National Prescribing indicators (linked to finance) ▪ Outpatient referral rates(linked to finance) ▪ Inpatient Admission rates(linked to finance) ▪ 6-8 Weeks Baby Checks	▪ Post payment verification reports	▪ Access Standards ▪ Opening hours ▪ Appointment availability ▪ Open lists Unscheduled care hospital admission rates	▪ Public service ombudsman responses ▪ Health Inspectorate Wales (HIW) reports ▪ Community Health Council Reports ▪ Concerns and compliments from any source ▪ Patient Experience performance, e.g. survey
Sustainability Status			

*A development plan will be necessary to achieve the full collection of indicators identified above.

The A3 sheet includes commentary highlighting to the meeting participants where further investigation may be needed or where further consideration may be given.

4.5 Contract Quality Review & Performance Management

The annual GMS returns as detailed in the National Health Service (General Medical Services Contracts) (Wales) Regulations 2004 (Part 5, records, information, notifications and rights of entry, paragraph 79) and practice review visits will support the contract review and performance management process. The expected frequency of the GMS return will be annual and the practice review visits will be undertaken through a tri-annual visit programme, however more frequent meetings maybe undertaken dependent on the circumstances, the range of risks identified, and on the leadership response, for example HIW action plans.

Assurance on compliance will be sought and information reviewed in line with the contract requirements as determined by the NHS Wales General Medical Services Regulations. These processes will be led and co-ordinated by the Primary Care Team and General Medical Services Monitoring Group.

A critical gap in the system of oversight of quality and safety was identified in the Francis report, which arose from the inability of commissioners to collect information on provider quality and to understand and make use of the contractual mechanisms that were available to them. PTHB recognises the importance of information and an understanding of how to act on it, and will use contractual mechanisms such as audit, inspection and investigation to understand quality in general medical services. Where possible the triangulation of data relating to patient safety and quality of care will be undertaken. In addition, analysis of the concerns process and patient experience mechanisms will be utilised to evaluate impact on quality and patient safety.

A regular assessment of the provider escalation level will take place during the General Medical Services Contract Monitoring Meeting in line with the escalation process set out below. The retention of contract monitoring records will be kept within the PTHB Primary Care Department.

4.6 Escalation Process for Providers

This Framework sets clear thresholds for intervention in underperforming providers and a rules-based process for escalation. Provider performance is assessed against a series of indicators using the most current data available, and the results will trigger intervention by commissioners in the case of performance concerns, where the escalation process will be a 'step-up, step-down' process. There will be a proportionate approach which takes into account the degree of risk for Powys residents.

	Level of Monitoring	Escalation	GMS monitoring Meeting Frequency
Level 1 Green	Routine Monitoring - Evidence and data will be provided through the Quality Schedules and/or information from national assessments and usual data sources	None - Routine monitoring	Continuous process Quarterly formal Routine Monitoring,
Level 2 Amber	Enhanced monitoring via exception and associated remedial actions and trajectory for improvement includes GMS monitoring Meeting	Enhanced monitoring	Bi- monthly – Enhanced Monitoring
Level 3 Red	One Red area Escalated performance monitoring requiring detailed action plans for exceptions	If Contractual/regulation breach, escalated to DPCCMH *Reported to Delivery & Performance Group*	quarterly – Escalated Monitoring DPCCMH to receive papers and attend and if appropriate attend Contractor Review Meeting if required
Level 4 Red +	Two or more Red areas Chief Exec made aware – Provider meeting may be arranged Escalated performance monitoring requiring detailed action plan for exceptions and agreed as minimum monthly (in some cases fortnightly) reviews where commissioners have serious concerns about quality and patient safety	If Contractual/regulation breach, escalated and *Reported to Finance & Performance Committee*	quarterly – Escalated Monitoring CEO/ DPCCMH led escalated meetings if there are significant and persistent concerns (supported

Table 4.6 Escalation Table

Reasons for Escalation include:

- Any issues that present an immediate challenge to service continuity, which may affect the reputation of the commissioner and/or the provider and could result in any closure or partial closure of a service;
- Alarms or concerns arising from the examination of qualitative and quantitative data.
- Alternatively a worrying set of workforce metrics or credible soft intelligence which is not readily accounted for by the provider;

- When a concern about quality has been identified and acknowledged by the provider and commissioner but where the mitigating actions to improve the situation are showing little signs of having an impact and patients continue to be at risk, or potentially at risk;
- Repeated failure to deliver agreed improvement plans;
- Evident or suspected poor leadership and/ or governance, particularly clinical governance;
- Serious media exposure / covert reporting;
- Increase of the number and type of minor concerns that begin to raise more fundamental questions of governance or competence of the provider to deliver a safe service;
- Highly critical independent service review reports which identify repetitive serious failures;
- Serious concerns raised by HIW, CHC, and WG Intervention process or professional bodies.

An example of how the escalation process would be applied against the high level dashboard is set out below:

Provider	Date	G Y A1 A2 R Performance Framework Rating Assessment					Escalation Level
		Access	Finance & Activity	Quality & Safety	Patient Experience	Overall Rating	
1	Sep 18					Level 1	**Level 1** – routine monitoring
2	Sep 18					Level 1	
2	Sep 18					Level 2	**Level 2** - Enhanced monitoring
3	Sep 18					Level 3	**Level 3** Escalated to DPCCMH monitoring
4	Sep 18					Level 4	**Level 4** Escalated to DPCCMH/ intervention Chief Exec informed
5	Sep 18					level 4+	**Level 4** Escalated to DPCCMH/ potential Chief Exec intervention

Table 4.6a Example of escalation level against high level performance overview

Dependent on the level of escalation, the following people would be required to attend the GMS Contract Monitoring Group or Review meetings. A table of Lead Executives for escalated providers will be kept updated. Other Executives will also provide cover where needed.

Level	Attendance at GMS Monitoring Group meetings	GMS Monitoring Group Meeting Frequency
Level 1 – Routine monitoring	▪ Deputy/Assistant Director of Primary Care ▪ Assistant Medical Director ▪ Head of Primary Care - Contracting ▪ Primary Care Manager	Continuous process Quarterly formal Routine Monitoring,

	▪ Medicines Management rep ▪ Finance Business Partner	
Level 2 Enhanced monitoring	▪ Deputy/Assistant Director of Primary Care ▪ Assistant Medical Director ▪ Head of Primary Care - Contracting ▪ Primary Care Manager ▪ Medicines Management rep ▪ Finance Business Partner	Bi monthly – Enhanced Monitoring
Level 3 Escalated to Exec Director	▪ DPCCMH ▪ Deputy/Assistant Director of Primary Care ▪ Assistant Medical Director ▪ Head of Primary Care ▪ Primary Care Manager ▪ Medicines Management rep ▪ Finance Business Partner ▪ Quality & Safety representative	quarterly – Escalated Monitoring including DPCCMH
Level 4 Escalated to Exec Director Intervention Chief Exec informed.	▪ Executive Director/s ▪ Deputy/Assistant Director of Primary Care ▪ Medical Director Assistant Medical Director ▪ Head of Primary Care ▪ Primary Care Manager ▪ Medicines Management rep ▪ Finance Business Partner ▪ Quality & Safety representative	2 weekly /4 weekly Escalated Monitoring CEO/DPCCMH led escalated meetings if there are significant and persistent concerns

Table 4.6b. Escalations Levels - Attendance required at GMS Contract Monitoring Group Meetings

4.7 Chief Executive Level Escalation and Provider Meetings

Where PTHB has persistent and significant concerns that actions are not reducing risks at Level 4 the Chief Executive Officer/DPCCMH will seek a series of focused meetings with relevant executives and the contract holder. A plan focusing on the major risks will be agreed and monitored via an improvement plan.

4.8 De-escalation Process

As the performance improves and risk assessments indicate a reduction in level of intervention required, de-escalation will be discussed and agreed with the DPCCMH/CEO.

PTHB Commissioning Assurance Framework –
Primary Care, General Medical Services Tolerance levels
April 2022 - March 2023

This document supports the PTHB Commissioning Assurance Framework - Primary Care, General Medical Services and details the threshold levels that support and inform the framework.

1.Practice Information

1.1 Registered Address of Practice & Branch Surgery Details

This can include the main site and branch surgeries.

"practice premise" means an address specified in the contract as one at which services are to be provided under the contract.

1.2 Opening Hours (Contractual)

Background:
GMS regulations define that core hours are 8am to 6.30pm, Monday to Friday (excluding bank holidays) to deliver essential and additional services as detailed; some practices may use margin cover provided by the out of hours provider for the 1st and last 30 mins of the day – this is a private arrangement with the practice and the OOH provider.

"core hours" means the period beginning at 8am and ending at 6.30pm on any day from Monday to Friday except Good Friday, Christmas Day or bank holidays.

Tolerance level:

Compliant	
Non-Compliant	

1.3 Practice List Size

This is managed by Shared Services Partnership and reported to the Health Board quarterly: -

"contractors list of patients" means the list prepared and maintained by the Local Health Board.

This is managed by Shared Services Partnership and reported to the Health Board quarterly: -

"contractors list of patients" means the list prepared and maintained by the Local Health Board.

1.4 Dispensing List Size

The proportion of the Practice List Size that accesses Dispensing Services from the practice pharmacy: -

“dispensing services” means the provision of drugs, medicines or appliances that maybe provided as pharmaceutical services by a medical practitioner in accordance with arrangements made under regulation 20 of the Pharmaceutical Regulations.

1.5 National Sustainability Assessment Framework Risk Score

A framework for assessing the sustainability of GP practices has been in place since April 2015. Whilst the sustainability assessment framework has provided for a consistent decision-making process, concerns have been expressed by some GP practices about the effectiveness of delivery.
2. The revisions to the sustainability assessment framework streamlines the process to enable a GP practice request for support to be reviewed on a more effective and efficient basis.
3. The revised sustainability assessment framework continues to prioritise the criteria for assessment to include practices at risk of closure within 12 months and/or those at risk of a reduction in the range of services provided through external factors which may impinge on the sustainability of the practice

The revisions to the sustainability assessment framework streamlines the process to enable a GP practice request for support to be reviewed on a more effective and efficient basis.
The revised sustainability assessment framework continues to prioritise the criteria for assessment to include practices at risk of closure within 12 months and/or those at risk of a reduction in the range of services provided through external factors which may impinge on the sustainability of the practice.

High Risk	*= or >80*
Medium Risk	*>55 -<79*
Low Risk	*<55*

1.6 Compliance with NHS Wales General services regulations 2004 (Contractual)

Background:

The Health Board and the Contractor enter into a general medical services contract under which the Contractor is to provide primary medical services and other services in accordance with the provisions of this Contract.

Any serious incident that, in the reasonable opinion of the Contractor, affects or is likely to affect the Contractor’s performance of its obligations under the Contract; must be reported to the Health Board in a timely manner.

Compliance with Legislation and Guidance 485

The Contractor shall comply with all relevant legislation and have regard to all relevant guidance issued by LHB, Assembly or the Assembly

Tolerance level:

Compliant	
Non-compliant	

1.7 Escalation Levels (Contractual)

GMS NEGOTIATIONS 2022-23, Contract Implementation Group:

Requirement:

Practices are required to ensure that they update the Escalation Framework on a regular basis – as a minimum monthly, but specifically if there is a significant change in practice circumstances.

The function to submit a “no change” response already exists within this system to simplify the submission requirement.

Tolerance level:

Compliant	
Non-compliant	

2. Quality and Safety

2.1 Performer compliance with All Wales Performer Regulations 2004 (Contractual)

Background:
The National Health Service (Performers Lists) (Wales) Regulations 2004 require a Local Health Board to prepare and publish a Medical Performers List (MPL) of all general medical practitioners approved by the Local Health Board for the purposes of assisting in the provision of primary medical services. A general medical practitioner is not eligible to assist in the provision of primary medical services, unless his or her name is included in a medical performers list.

Medical Performer Lists - All health boards must maintain a list of general medical practitioners registered to provide NHS primary care medical services as outlined in The National Health Service (Performers Lists) (Wales) Regulations 2004 and subsequent amendment. Inclusion and removal of GPs onto and off the Medical Performers Lists is undertaken by NHS Wales Shared Services Partnership (NWSSP).
In order to be included on a Medical Performers List, practitioners must have an Enhanced Disclosing and Barring Service Disclosure and two recent clinical references. Health boards should work with each other, NWSSP and equivalent organisations nationally and internationally to share concerns and information regarding medical professionalism.

Tolerance level:
This tolerance will be applied against each medical performer delivering general medical services.

Tolerance level:

Included	
Conditionally suspended/conditionally included	
Conditionally removed/suspended	

2.2 GMS Annual Contract Return (Contractual)

Background:
The National Health Service (General Medical Services Contracts) (Wales) Regulations 2004 requires all general medical practices to submit an annual return relating to the contract that they hold with the Health Board.

Part 5, records, information, notifications and rights of entry, paragraph 79, annual return and review states:

***79**.-(1) The contractor shall submit an annual return relating to the contract to the Local Health Board which shall require the same categories of information from all persons who hold contracts with that Local Health Board.*

(2) *Following receipt of the return referred to in sub-paragraph (1), the Local Health Board shall arrange with the contractor an annual review of its performance in relation to the contract.*

(3) *Either the contractor or the Local Health Board may, if it wishes to do so, invite the Local Medical Committee for the area of the Local Health Board to participate in the annual review.*

(4) *The Local Health Board shall prepare a draft record of the review referred to in sub-paragraph (2) for comment by the contractor and, having regard to such comments, shall produce a final written record of the review.*

(5) *A copy of the final record referred to in sub-paragraph (4) shall be sent to the contractor.*

This template provides a consistent framework for information required annually from Powys general medical practices, including declaration by the practitioners/partners in the practice that they have met their statutory and other mandatory responsibilities under their contract.

The annual return information required from a practice will be reviewed and updated on an annual basis. Following first year of completion the previous year's return will be used as a baseline for the review/update.

Practices are required to complete the return by the 30th April, each calendar year.

Powys Teaching Health Board (PTHB) will review the information included in the annual return as part of its governance programme for general practice.

Completed - YES	
Non-completed - NO	

Tolerance level:

No action required	
Remedial action required	
Immediate action required	

2.3 WNWRS (Contractual)

GMS NEGOTIATIONS 2022-23, Contract Implementation Group

• Mandating of data recording and submission to Wales National Workforce Reporting System (WNWRS) through the contract (previous agreement).

Requirement:

Practices are required to ensure that they update the workforce (headcount and wte) elements of WNWRS on a regular basis, ensuring that all changes in relation to new starters and leavers are recorded.

As a minimum, practices will need to access, review and check their dashboard view on a monthly basis.

A reminder that NWSSP - L&R will be able to identify those GPs and Health Professionals employed in GP practices who are captured by GMPI through the WNWRS. Therefore, being listed on the WNWRS is a necessary part of the arrangements.

Tolerance level:

Compliant	
Non-compliant	

3. Quality Assurance Improvement Framework

The Quality Assurance and Improvement Framework (QAIF) has been introduced as part of the contract reform in 2019, it replaces the Quality and Outcome Framework (QOF), which was originally introduced as part of the new GMS contract in 2004.

3.1 Clinical Governance Toolkit

Background:

The All-Wales Clinical Governance Practice Self-Assessment Tool (CGPSAT) encourages practices to bridge the gap between understanding and thinking about their governance systems and completing the actions needed to improve them.
Commissioning Assurance Framework is set at acceptable if score is 2 or above as stipulated in previous QOF guidance.
Practices are asked to consider how mature their systems are by means of a matrix with levels from 0-5.

Tolerance level:

Completed - YES	
Not completed – NO	

3.2 Information Governance Toolkit

Background:

The Welsh Information Governance Toolkit is a self-assessment tool to enable organisations to measure their level of compliance against National Information Governance Standards and ascertain whether information is handled and protected appropriately.
The assessment will help identify those areas, which require improvement and assist in informing the IG improvement plan. It may also provide reassurance to staff and patients that their information is processed securely and appropriately and provide assurance to other organisations when establishing joint working arrangements to provide care.
The IG toolkit consists of simple to follow assessments, comprising of a range of rudimental questions requiring tick box answers, one line statements and the facility to upload or link to documents as evidence.

Tolerance level:

Completed - YES	
Not completed - NO	

Attainment Level	Summary Requirement

1	Responsibility for driving improved information governance has been assigned to appropriate individuals within the organisation. This forms part of their job description and daily duties
2	Responsible individuals have received appropriate training to take ownership of the information governance agenda and identified improvements from previous IG Toolkit submissions. These have formally been documented to form an IG Improvement/Action Plan
3	The IG arrangements and progress against the IG Improvement/Action Plan are reviewed by the IG Lead and DPO, and is reported to the relevant forum on a regular basis

3.3 Quality Improvement Covid Learning/Patient Safety/ Optional QI Project

In 2021-22, 'GP Activity Data' was a mandatory project within the QI process.
The project had two requirements: one to map GP appointment data as extracted by Audit+; the other to submit a monthly proforma, quantifying administrative and other activity completed in GP practices.

Overview of QI projects sub domain;
To be able to claim any points for achievement of projects in the QI projects sub domain, the practice must complete the mandatory data and patient safety projects.

Data & Patient Safety QI Mandatory Projects;

- Activity/Appointment Data
- Patient Safety Clinical Data

Legacy 2020-21 QI project.
In place for one further QI cycle to allow embedding of learning, governance advantages and collaborative conversations for the Patient Safety Programme - Reducing medicines related harm through a multi-faceted intervention for the collaborative population.

Practice Choice QI project;
The practice has a choice of selecting a 70 point QI basket project not previously undertaken (Reducing stroke, ceilings of care, urinary tract infection)

Or

a collaborative freestyle mini project in agreement with Health Board (35 points)

And

Green Inhaler mini project (35 points) Total 205

A) The Covid Learning QI project replaces the mandatory requirement from 2019/20 to undertake quality improvement training. For 2021-2022 this is automatic achievement.

B/C) The Quality Improvement domain is based on the introduction of a "basket" of quality improvement projects which are to be delivered at cluster level (due to covid the projects are to be delivered by practice not cluster level). The basket of projects available for 2021-22 will be:

a. *Patient Safety Programme - Reducing medicines related harm through a multi-faceted intervention for the cluster population.*
b. *Reducing stroke risk through improved management of Atrial Fibrillation in for the cluster population.*
c. *Ceilings of care / Advanced Care planning.*
d. *Urinary tract infection to multi-disciplinary Antimicrobial Stewardship 2021-22*

In practice, GMS contractors will be required to agree at practice level and implement two QI projects in 2021-22

B) Patient Safety – mandatory. To be reviewed by the Medicines management Team on completion.

Tolerance level:

Achieved	
Not achieved	

C) Quality Improvement – choice from b, c, d set out above.

Declaration to be received from the practices stating project has been completed.

Tolerance level:

Achieved	
Not achieved	

3.4 Access standards GMS Access Standards

On 20 March 2019, the Minister for Health and Social Services announced the Access to In-Hours GMS Services Standards. Underpinned by clear measurables, expected achievements by March 2021 and supported by a delivery milestone under the Primary Care Model for Wales, the Standards set clear requirements on practices in terms of minimum expectations relating to access, including an increased digital offering. It is also important to recognise the role of the public in making the right choice when seeking help and advice. A cultural shift is also required to recognise that a GP, or the GP surgery, is not always the most appropriate professional or location for the issue. Health boards have supported practices in adopting the principles of the Primary Care

Model for Wales based around triage and signposting to ensure patients are seen by the right person at the right time in the right place.

The Access Standards have 2 phases; Phase 1 - The GMS access standards introduced in April 2019, will remain as pre-qualifiers. All practices are expected to achieve, maintain and embed those working practices in order to make any claim for achievement of the phase 2 standards. Phase 2 – The reflective phase, this allows practices time to reflect, listen to patient experience and make improvements to access.

3.4.1 GMS Access Standards Phase 1

Phase 1 The GMS access standards introduced in April 2019, will remain as pre-qualifiers for participation in phase 2 of the standards and to quality for the QAIF Access Standard payment for 2022/23. All practices are expected to achieve, maintain, and embed those working practices in order to make any claim for achievement of the phase 2 standards. Practices will be required to report quarterly and be prepared to supply evidence via the PCIP Access Reporting Tool.

1. Does your telephone system have a recording function for incoming and outgoing lines?
2. Does your telephone system have the ability to stack calls?
3. Are you able to interrogate your telephony system to analyse data on calls?
4. Are you able to confirm if your telephone introduction message is recorded bilingually and lasts no longer than 2 minutes?
5. Can you confirm if your practice offers patients and care homes access to order repeat prescriptions through a digital solution?
6. Can you confirm if your practice offers a digital method for patients to request non-urgent appointments or a call back?
7. Does your practice have the necessary governance arrangements in place for this process?
8. Can you confirm that your practice publicises information for patients on how to request an urgent, routine and advanced consultation?
9. Can you confirm that your practice publicises information for patients on how to request a consultation via the practice leaflet and practice website?
10. Can you confirm that your practice displays information on the Access Standards?
11. Does your practice offer same day consultation for children under 16 with acute presentations?
12. Does your practice offer same day consultations for patients clinically triaged as requiring an urgent assessment?
13. Does your practice offer pre-bookable appointments?
14. Does your practice actively signpost to alternative cluster based services, health board wide and national services?

Tolerance level:

All standards achieved	
4+ standards achieved	
3+ standards achieved	
Less than 3 standards achieved	

3.4.2 GMS Access Standards – Phase 2

Practices will be required to report quarterly and be prepared to supply evidence (which could include but is not limited to practice's appointment system, patient experience survey outcomes and up to date data infographics) via the PCIP Access Reporting Tool

Service Delivery & Communication

1. All existing patient facing staff to undertake the national care navigation training package and all new patient facing staff complete the national care navigation training package within 3 months of start date [if virtual course is available from HEIW]. Practices will supply names of new starters and date of training undertaken.
2. Appointments are available for advanced booking each day with declaration confirming that every patient contact is supported throughout the day. (Patients will be offered an appropriate consultation, whether urgently or through advanced booking consistent with the patient's assessed clinical need, without the need for the patients to contact the practice again).
3. To maintain a planned and forward looking approach to consultations, practices to undertake a regular assessment of their scheduling appointment system to ensure a mix of remote, face to face, urgent, on the day and pre-bookable.

Patient Engagement

4. Practices must regularly maintain an automated and standardised public facing dashboard and make this available via a range of communication methods to meet the needs of their patients. (An Infographic will be made available via the PCIP for practices to use).
5. Practices to undertake the national patient experience survey which should include 25 completed questionnaires per 1000 registered patients from a range of practice population and captured through a range of methods.

Digital

6. Practices undertake care navigation on digital requests in a similar and equitable fashion to telephone requests.

40 points for achievement of all of the above.

Reflective Report

Practices are required to produce a reflective report. As a minimum, the report should include;

- An Equality Impact Assessment to review population and access needs. National guidance will be produced to support practices with this.
- Utilise results of the national patient experience survey to develop an action plan which will demonstrate how practices plan to move forward with implementing and communicating change effectively.
- That they have reflected on patient experience and can demonstrate improvements made, improvements made are to be discussed at collaborative level.
- Intelligence from their telephone system to show how they have interrogated the data, and evidence call demand comparisons.

60 points (annex a includes further detail on the report requirements)

Tolerance level:

All standards achieved	
4+ standards achieved	
3+ standards achieved	
Less than 3 standards achieved	

4. Immunisations

4.1 National Flu Targets

Winter respiratory vaccination strategy : Autumn/Winter 2022 to 2023:

winter-respiratory-vaccination-strategy-

Our ambition is to achieve 75% take up across the board for both the COVID-19 and flu vaccine
Our ambition is to achieve 80% take up for the chronic obstructive pulmonary disease risk group for both the COVID-19 and flu vaccine

4.2 Childhood Immunisations Targets

Background:

The contractor shall —

(a)offer to provide to children all vaccinations and immunisations of a type and in the circumstances for which a fee was provided for under the 2003-04 Statement of Fees and Allowances made under regulation 34 of the National Health Service (General Medical Services) Regulations 1992;

(b)provide appropriate information and advice to patients and, where appropriate, their parents, about such vaccinations and immunisations;

(c)record in the patient's record kept in accordance with paragraph 72 of Schedule 6 any refusal of the offer referred to in paragraph (a);

(d)where the offer is accepted, administer the vaccinations and immunisations and include in the patient's record kept in accordance with paragraph 72 of Schedule 6

(i)the name of the person who gave consent to the vaccination or immunisation and that person's relationship to the patient;

(ii)the batch numbers, expiry date and title of the vaccine;

(iii)the date of administration;

(iv)in a case where two vaccines are administered in close succession, the route of administration and the injection site of each vaccine;

(v)any contra-indications to the vaccination or immunisation; and

(vi)any adverse reactions to the vaccination or immunisation.

(3) The contractor shall ensure that all staff involved in administering vaccines are trained in the recognition and initial treatment of anaphylaxis.

Tolerance level:

Over 95%	
90% - 95%	
Less than 90%	

To include:-

1 year
6 in 1 Primary
Rotovirus
PCV Primary
Men B
2 years
MMR
PCV Final
Hib/Men C Booster
Men B Complete Course
5 years
MMR 2 doses
4-in-1 pre-school booster
16 Years
3-in-1 teenage booster
MenACWY
National Immunisation Target 95% or higher
National Immunisation Target 90-95%
National Immunisation Target less than 90%

4.3 Child Health Surveillance (6-8 Baby Checks)

Background
The Contractor shall:-
(1) A contractor whose contract includes the provision of child health surveillance services shall, in respect of any child under the age of five for whom it has responsibility under the contract –
(a) provide all the services described in sub-paragraph

(2), other than any examination so described which the parent refuses to allow the child to undergo, until the date upon which the child attains the age of five years; and (b) maintain such records as are specified in sub- paragraph(3).
(2) The services referred to in sub-paragraph
(1)(a) the monitoring –

(i) by the consideration of any information concerning the child received by or on behalf of the contractor, and
(ii) on any occasion when the child is examined or observed by or on behalf of the contractor (whether pursuant to paragraph
(b) or otherwise), of the health, well-being and physical, mental and social development (all of which characteristics are referred to in this paragraph as "development") of the child while under the age of 5 years with a view to detecting any deviations from normal development;
(b) the examination of the child at a frequency that has been agreed with the Local Health Board in accordance with the nationally agreed evidence based programme set out in the fourth edition of "Health for all Children"(a).
(3) The records mentioned in sub-paragraph (1)(b) are an accurate record of - (a) the development of the child while under the age of 5 years, compiled as soon as is reasonably practicable following the first examination of that child and, where appropriate, amended following each subsequent examination; and (b) the responses (if any) to offers made to the child's parent for the child to undergo any examination referred to in sub- paragraph (2)(b)

100% achievement	
Non Achievement	

5. Audit

5.1 Post Payment Verification reporting

Background: NHS Wales Shared Services Partnership (NWSSP), Primary Care Services (PCS) are responsible for undertaking Post Payment Verification (PPV) duties on behalf of Health Boards (HBs) across Wales. PPV teams undertake PPV checks within General Medical Services, General Ophthalmic Services and Community Pharmacy.

The purpose of the PPV process is to provide assurance to HBs that the claims for payment made by primary care contractors are appropriate and that the delivery of the service is as defined by NHS service specification and relevant legislation.

Tolerance level:

File Closed/No revisit required	
Revisit within 3 years	
Revisit within 12 months	

5.2 Enhanced Service Audits (Contractual)

Background:

Within all the enhanced services there is a requirement for regular review and audit by General Practice on an annual basis.

On an annual basis PTHB selects 3 out of the total of Powys enhanced services and requests practices submit details of their audit.

The audits for submission are agreed the Medical Director and the Quality & Safety Department and form part of the PTHB Annual Audit Plan. The audits are to provide the Health Board with assurance on the service being delivered in the practice. The findings of the audits are discussed as part of the Practice Review Visits and/or on an individual practice basis if there are areas of concern.

Tolerance level:

Completed	
Issues of concern/actions needed	
Not completed	

AUDIT 1 – Diabetes

No action required	
Partial action required	
Immediate action required	

AUDIT 2 - NPT

No action required	
Partial action required	
Immediate action required	

AUDIT 3 - NOAC

No action required	
Partial action required	
Immediate action required	

5.3 National Diabetes(contractual)/COPD/CKD audits

Background:

The audit programme has been commissioned by the Healthcare Quality Improvement Partnership (HQIP) as part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP) and currently covers England, Scotland and Wales.

The programme is led by the Royal College of Physicians (RCP), works closely with a broad range of organisations including Asthma UK, the British Thoracic Society, British Lung Foundation, Primary Care Respiratory Society UK, Royal College of General Practitioners and the Royal College of Paediatrics and Child Health.

The results of the audit on portal and shared with relevant SN teams

Tolerance:

Completed	
Not completed	

6. Patient Experience

6.1 Public Service Ombudsman enquiry/ Investigation

Background:
The Public Services Ombudsman for Wales has legal powers to look into complaints about public services and independent care providers in Wales. They are independent of all government bodies and provide a free and independent service.

Tolerance level:

Ombudsman process not invoked	
Ombudsman process invoked	

6.2 Community Health Council Reports

Background:
Community Health Councils are an independent voice of people in Wales who use the NHS services. CHCs visit practices are their findings are produced in a report with an action plan of requirements to be met. Practices are required to share this with the Health Board to allow monitoring and escalation of any immediate necessary actions.

Tolerance level:

Complete – no recommendations identified	
Non urgent recommendations identified	
Urgent requiring immediate action	

6.3 Health Inspectorate Wales Reports

Background:
Health Inspectorate Wales regulate and inspect NHS services and independent healthcare providers in Wales against a range of standards, policies, guidance and regulations to highlight areas requiring improvement. Regulations and standards to make judgements about the quality, safety and effectiveness of healthcare services.

Inspections monitor and review Quality of Patient experience; Delivery of safe & effective care and Quality of Management & Leadership. Reports are then published online alongside improvement and action plans for the healthcare provider to follow to bring specific areas up to a standard of acceptable quality.

Tolerance level:

Complete – no recommendations identified	
Non urgent recommendations identified	
Urgent requiring immediate action	

7. National Prescribing Indicators (PAR)

The PAR report summarises the costs incurred by practices and health boards in a given month. A more detailed analysis of National Prescribing Indicators is provided at the end of each quarter, giving an indication of both cost and frequency of prescribing. The individual practice's budget for expenditure on prescribed drugs and appliances in a year, as determined by the health board. The indictors are calculated against the National indicators for the medication.

Tolerance level:

Achieving national indicator	
Nearly achieving indicator	
Not achieving indicator	

8. Commissioning/Finance

The commissioning information is based on secondary care activity showing the numbers based on 1000 registered per practice patients for 2021/22. The areas looked at are:

A) Outpatient Activity per 1000 registered patients
   The numbers represent the outpatient activity generated by each practice
B) Emergency Inpatients per 1000 registered patients
   The numbers represent the emergency inpatient by practice.

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Powys Teaching Health Board - Summary of General Medical Services Commissioning Assurance Framework Submissions

Tolerance Levels	Practice	Contractual	Target %	Source of data	Updated	Brecon	Ystradgynlais	Crickhowell	Haygarth	Builth Wells	Llandrindod Wells	Rhayader	Knighton	Presteigne	Llanidloes	Dyfi Valley	Welshpool	Newtown	Montgomery	Llanfair Caereinion	Llanfyllin
	1. Practice Information																				
1.1	Registered Address of Practice & Branch Surgery					M. Ty Henry Vaughan, Bridge Street, Brecon, LD3 8AH Br. Sennybridge	M. Meddygfa Pengorof, Ystradgynlais, SA9 1DS Br. Ystalyfera Br. Abercrave	M. War Memorial Health Centre, Crickhowell, NP8 1AG *Br. Gilwern*	M. The Health Centre, Forest Road, Hay on Wye, HR3 5DS Br. Talgarth	M. Maes y Coed, Glandwr Parc, Builth Wells, LD2 3DZ Br. Llanwrtyd	Spa Road East, Llandrindod Wells, LD1 5ES	The Surgery, Caeherbert Lane, Rhayader, LD6 5ED	The Surgery, Wylcwm Street, Knighton, LD7 1AD	Lugg View, Presteigne, LD8 2RJ	M. Arwystli Medical Practice, Mount Lane, Llanidloes, SY18 6EZ Br. Caersws	Machynlleth Health Centre Forge Road, Machynlleth SY20 8EQ	M. Salop Road, Welshpool, SY21 7ER Br. Guilsfield	The Surgery, Park Street, Newtown, SY16 1EF	M. Montgomery Medical Practice, Well Street, Montgomery, SY15 6PF Br. Ladywell Surgery, Newtown	Caereinion Medical Practice, The Health Centre, Llanfair Caereinion, SY21 0RT	M. Llanfyllin Medical Centre, High Street, Llanfyllin, SY22 5DG Br. Four Crosses Br. Llanrhaedr
	No. of GP partners/salaried partners					14															
1.2	Opening Hours as per contract	Yes				Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	Main surgery owned/rented					Owned	Owned	Owned	Rented	Owned	Owned	Rented	Owned	Rented	Owned	Rented	Owned	Owned	Rented	Owned	Owned
	Branch surgery 1 owned/rented					Owned	Owned	Owned	Rented	Rented					Owned				Rented		Owned
	Branch surgery 2 owned/rented						Owned														Owned
1.3	Practice List Size			SSP - Quarterly	Jan-23	15523	12439	9278	8678	7603	10704	3348	4837	3617	9069	6709	11341	13372	7839	5929	11173
1.4	Dispensing List Size (11 practices)			E.P./M.Management	Dec-22	5731	12413	2003	5151						5937	4257	5165	2738	7834	5348	9633
1.5	National Sustainability Assessment Framework Risk Score			*practice data*	*July I23*																
	Community Hospital SLA				2022-23	Yes	Yes	No	Yes	No	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	No	Yes	Yes
	Name of hospital					Brecon War Memorial	Ystradgynlais		Bronllys		Llandrindod	Llandrindod	Knighton		Llanidloes	Machynlleth	Welshpool	Newtown		Newtown	Newtown
1.6	Compliance with NHS Wales GMS Regs 2004	Yes				Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
1.7	Monthly Update of Escalation Levels	Yes		PCIP	23/03/2023	22/12/2022	20/12/2022	16/05/2022	10/01/2023	09/01/2023	10/01/2023	05/01/2023	04/01/2023	21/03/2023	15/12/2022	16/03/2023	10/01/2023	20/03/2023	20/03/2023	12/12/2022	21/03/2023
2	**2. Quality and safety**																				
2.1	GP performer compliance	Yes																			
	Conditionally Included - all	Yes																			
	Conditionally Suspended	Yes																			
	Conditionally Removed	Yes																			
2.2	GMS Annual Return completed	Yes		Information from practices	*Sent annually, deadline 23.4.2023*																
	No action required																				
	Partial action required																				
	Immediate action required																				
2.3	WNWRS	Yes		WNWRS Data Quality Report	*Mar-23*											12/01/2023					
3	**3. QAIF (Quality Assurance Improvement Framework)**																				
3.1	**Clinical Governance toolkit completed**			*annuallly PCIP portal*	*Sep-22*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
3.2	**IG toolkit Practices will be required to complete the next toolkit activity by 31 March 2024 and annually from 1 April 2024 onwards**				*All completed 21-22, no requirement for 22-23*																
3.3	**Quality Improvement (Submission Date Sep 22)**			annually PCIP portal	*annually due april 23*																
3.3 (a)	*GP Activity/Appointment Data Project (mandatory)*			*from practice*	*21-22 submitted September 2022 - projects re-set in April 2023 for submission*																
3.3 (b)	*Patient Safety Clinical Data Project (mandatory)*			*from practice*																	
3.3 (c)	*Optional QI project*			*from practice*																	
3.4	**GMS Access Standards Qtr 4 22/23**			annually PCIP portal																	
3.4.1	Phase 1 Achieved (14 Standards)				*Nov-22*																
3.4.2	Phase 2 Achieved (6 Standards)				*May-23*																
4	**IMMUNISATIONS**																				
4.1	**National flu targets 22/23 Welsh Health Circular**		***(Ambitions)***		***As at April 2023***																
	Over 65		75%	annually due April 23		2972/4151 71.6%	2171/2916 75%	2564/3258 78.7%	1782/2499 71.3%	1768/2362 75%	2270/3100 73.2%	740/1034 71.6%	1052/1481 71%	936/1221 76.7%	1897/2682 70.7%	1277/1888 67.6%	2019/2694 75%	2160/2947 73.3%	1807/2243 80.6%	1201/1627 73.8%	2176/2937 74.1%
	2-3 Year Olds		75%			138/257 53.7%	80/247 32.4%	84/113 74.3%	58/134 43.3%	56/109 51.4%	120/167 71.3%	42/49 85.7%	32/69 46.4%	24/61 39.3%	80/155 51.6%	57/110 51.8%	94/207 45.4%	148/250 59.2%	104/160 65%	46/98 46.9%	85/192 44.3%
	Clinical Risk under 65		75%			913/1785 51.1%	756/1835 41.2%	556/1022 54.4%	417/1029 40.5%	446/857 52%	768/1562 49.2%	187/383 48.8%	271/604 44.9%	201/408 49.3%	430/881 48.8%	398/916 43.4%	689/1570 43.9%	891/1881 47.4%	544/1010 53.9%	366/729 50.2%	572/1353 42.3%
4.2	**Childhood Immunisation targets**			**Public Health**	**Apr 22-March 23**																
	1 year																				
	6 in 1 Primary					99/102 97.1%	101/103 98.1%	49/53 92.5%	72/78 92.3%	45/47 95.7%	68/74 91.9%	27/28 96.4%	31/31 100%	22/24 91.7%	67/73 91.8%	50/51 98%	95/100 95%	116/120 96.7%	80/82 97.6%	42/44 95.5%	92/98 93.9%
	Rotovirus					94/102 92.2%	102/103 99%	48/53 90.6%	71/78 91.0%	44/47 93.6%	68/74 91.9%	27/28 96.4%	29/31 93.5%	21/24 87.5%	65/73 89.0%	48/51 94.1%	95/100 95%	117/120 97.5%	78/82 95.1%	42/44 95.5%	91/98 92.9%
	PCV Primary					98/102 96.1%	103/103 100%	50/53 94.3%	77/78 98.7%	46/47 97.7%	69/74 93.2%	28/28 100%	31/31 100%	22/24 91.7%	67/73 91.8%	50/51 98%	94/100 94%	116/120 96.7%	81/82 98.8%	43/44 97.7%	91/98 92.9%
	Men B					97/102 95.1%	102/103 99%	49/53 92.5%	74/78 94.9%	45/47 95.7%	68/74 91.9%	27/28 96.4%	30/31 96.8%	22/24 91.7%	67/73 91.8%	50/51 98%	94/100 94%	116/120 96.7%	81/82 98.8%	43/44 97.7%	92/98 93.9%
	2 years																				
	MMR 1 dose					100/105 95.2%	102/110 92.7%	51/54 94.4%	55/56 98.2%	39/40 97.5%	80/85 94.1%	16/18 88.9%	30/33 90.9%	25/27 92.6%	71/75 94.7%	50/53 94.3%	90/97 92.8%	116/120 96.7%	65/68 95.6%	43/44 97.7%	77/81 95.1%
	PCV Final					100/105 95.2%	102/110 92.7%	51/54 94.4%	55/56 98.2%	39/40 97.5%	81/85 95.3%	16/18 88.9%	30/33 90.9%	25/27 92.6%	71/75 94.7%	49/53 92.5%	92/97 94.8%	116/120 96.7%	64/68 94.1%	43/44 97.7%	77/81 95.1%
	Hib/Men C Booster					100/105 95.2%	102/110 92.7%	51/54 94.4%	55/56 98.2%	39/40 97.5%	77/85 90.6%	16/18 88.9%	30/33 90.9%	25/27 92.6%	71/75 94.7%	49/53 92.5%	91/97 93.8%	116/120 96.7%	64/68 94.1%	43/44 97.7%	77/81 95.1%
	Men B Complete Course					100/105 95.2%	102/110 92.7%	51/54 94.4%	55/56 98.2%	39/40 97.5%	77/85 90.6%	16/18 88.9%	30/33 90.9%	25/27 92.6%	71/75 94.7%	49/53 92.5%	92/97 94.8%	116/120 96.7%	62/68 94.1%	43/44 97.7%	76/81 93.8%
	5 years																				
	MMR 2 doses					119/135 88.1%	133/142 93.7%	50/54 92.6%	68/72 94.4%	56/62 90.3%	102/103 99.0	36/39 92.3%	35/39 89.7%	14/17 82.4%	67/70 95.7%	53/59 89.8%	101/113 89.4%	129/137 94.2%	62/68 94.1%	48/49 98%	87/92 94.6%
	4-in-1 pre-school booster					120/135 88.9%	134/142 94.4%	50/54 92.6%	68/72 94.4%	57/62 91.9%	108/113 95.7	35/39 89.7%	35/39 89.7%	15/17 88.2%	67/70 95.7%	53/59 89.8%	102/113 90.3%	129/137 94.2%	63/68 92.6%	48/49 98%	84/92 91.3%
	16 years																				
	3-in-1 teenage booster					146/165 88.5%	104/121 86.0%	87/92 94.6%	61/66 92.4%	65/72 90.3%	82/95 86.3%	18/23 78.3%	32/38 84.2%	34/38 89.5%	78/95 82.1%	54/69 78.3%	106/118 89.8%	146/165 88.5%	53/64 82.8%	56/65 86.2%	70/82 85.4%
	MenACWY					150/165 90.9%	104/121 86.0%	88/92 95.7%	62/66 93.9%	65/72 90.3%	82/95 86.3%	18/23 78.3%	34/38 89.5%	33/38 86.8%	79/95 83.2%	54/69 78.3%	108/118 91.5%	145/165 87.9%	55/64 82.8%	59/65 90.8%	70/82 85.4%
	National Immunisation Target 95% or higher																				
	National Immunisation Target 90-94%																				
	National Immunisation Target less than 90%																				
4.3	Outstanding 6-8 week baby checks			Child Health Department																	
	For births between 01.04.2022 and 30.06.2022 (Q1)					2/22 90.91%	2/24 85.71%	17/17 100%	1/13 92.31%	1/11 90.91%	16/16 100%	8/8 100%	3/8 62.5%	4/4 100%	18/18 100%	9/9 100%	1/21 95.24%	29/29 100%	17/17 100%	1/14 92.86%	20/20 100%
	For Births Between 01.07.2022 and 30.09.2022 (Q2)					33/33 100%	9/9 100%	9/9 100%	2/11 81.82%	13/13 100%	22/22 100%	9/9 100%	2/11 81.82%	1/5 80%	9/9 100%	1/9 88.89%	34/34 100%	28/31 90.32%	1/15 93.33%	9/9 100%	1/23 95.65%
	For Births Between 01.10.2022 and 31.12.2022 (Q3)					2/21 90.48%	8/8 100%	1/13 92.13%	2/15 86.67%	1/14 92.86%	1/13 92.31%	9/9 100%	8/8 100%	10/10 100%	2/23 91.3%	1/12 91.67%	25/25 100%	32/32 100%	1/14 92.86%	1/11 90.91%	8/22 63.64%
	For Births between 01.01.2023 and 31.03.2023 (Q4)					16/18 88.89%	14/17 82.35	8/10 80%	6/8 75%	10/13 76.92%	13/14 92.86%	8/8 100%	8/8 100%	10/10 100%	18/18 100%	12/12 100%	16/17 94.12%	29/30 96.67%	15/15 100%	7/8 87.5%	14/21 66.7%
5	**4. AUDIT**																				
5.1	**PPV reporting -**				***No reports for 2022/23***																
	Date completed																				
	Reclaim value percentage																				
	Reclaim value																				
	Outcome																				
	File closed																				
	Practice to be re-visited																				
5.2	**Enhanced Services audit results 2022/23**				***Update due April 2023***																
	AUDIT 1 - NPT completed	Yes		practice responses																	
	AUDIT 2 - NOAC completed	Yes		practice responses																	
	AUDIT 3 - DIABETES completed	Yes		practice responses																	
	No action required				*Awaiting final report from MM and Diabetic Nurse*																
	Partial action required																				
	Immediate action required																				
5.3	**National ES audit completed 21/22**																				
	Diabetes	Yes		practice responses	Data not available on PCIP for 22/23																
	COPD -Not Mandatory			practice responses																	
	CKD Not Mandatory			practice responses																	
6	**5. PATIENT EXPERIENCE**																				
6.1	**Public service ombudsman enquiry /investgation**																				
6.2	**Community Health Council report**																				
	Narrative/Issues																				
6.3	**Health Inspectorate Wales report**																				
	Date completed			HIW	As and when visits occur																
7	**Prescribing Audit Budget Report (PAR Report)**																				
7.1	**National Prescribing Indicators (period ending March 2023)**																				
		National Indicators																			
	Antibacterial Items Per 1000 STAR-PU(13)	<209		Sharon Marshall	Updated June 2023	276	328.9	247.2	197.9	271.7	371.3	273.6	263.8	256.6	278.8	264.5	256.9	379.3	252.2	272	266.7
	4C Antibacterials Items Per 1000 patients	<7.12		Sharon Marshall	Updated June 2023	12	11.7	9.9	10.2	11.7	19	8.1	12.6	11.9	11.7	10	9.8	18	5.6	10.8	14.8
	Opioid Burden (UDG) ADQs per 1000 Patients	<3460		Sharon Marshall	Updated June 2023	3899.1	6492.9	3596.4	2336	3590.6	5493.5	2998.4	3301.1	3710.1	3089.7	4468.5	4742.9	4971.2	3294.4	3461.6	3287.3
	High Strength Opioids ADQ per 1000 Patients	<76.7		Sharon Marshall	Updated June 2023	82.2	186.9	75.8	57.7	169	218	170.5	82.4	129.8	106.1	274.5	261.2	164.4	84.9	72.2	73.8
	Opioid Patch Items as % of all Opioid Prescribing (21-22 target)	<7.51		Sharon Marshall	Updated June 2023	7.1	6.8	17.5	8.3	5.5	8.9	17.9	5.6	12.2	10.5	8.5	18.9	14.4	11.9	10.9	12.6
	Hypnotics and Anxiolytics (UDG) ADQ Quantity per 1000 STAR-PU(13)	<1439		Sharon Marshall	Updated June 2023	1852	2187.5	1809.9	462.1	1467.9	2533.2	3258.4	1066.9	695.2	1762.5	1339.5	1799.5	2210.1	546.9	1109.2	1072.6
	Gabapentin and Pregabalin DDDs Per 1000 Patients	<1173		Sharon Marshall	Updated June 2023	1171.5	2224.5	1282.5	1334.9	1265.5	1624.6	1070.7	1334.3	1335	992.2	1427.9	1305.7	1382	868.1	1238.9	1277
	Tramadol DDD per 1000 Patients	<287		Sharon Marshall	Updated June 2023	321	472.2	254.6	103.5	184.3	358.4	121.6	194.4	224.4	371.9	394.4	319.8	410.5	220.7	359.5	310.7

	NSAIDs ADQ per 1,000 STAR-PU	<1192		Sharon Marshall	Updated June 2023	1092.6	1492.1	1121.1	923.7	836.1	1042.3	913.6	1235.3	873.6	1520.4	1294.9	1618	1446.4	1022.3	1062.6	1037.4
	Ibuprofen And Naproxen Items as % of NSAIDs	>86		Sharon Marshall	Updated June 2023	85.2	86.8	87.6	85.7	85.1	85.3	90.4	90.1	84.7	72.8	81.4	84.6	81.8	80	85.2	81.8
	DPIs and SMIs % of All Inhalers	>34.1		Sharon Marshall	Updated June 2023	41.3	30.6	49.2	38.7	27.7	32.7	24.8	27.5	18.2	30.5	30.7	14.8	33	21.8	34.1	25.4
	Salamol MDIs Items as a % of all salbutamol MDIs (target > 60%)	>60		Sharon Marshall	Updated June 2023	85	78.2	69.4	74.4	2.5	53.1	2.2	3.8	29.3	5.8	24.9	52.3	20.1	77.3	65.2	11.2
	% Statins prescribed as high intensity statins	>67.93		Sharon Marshall	Updated June 2023	64	58.4	61	60.3	64	67.8	51.1	58.4	68.1	57.9	74.3	59.3	63.6	76	66.1	71.5
	Proton Pump Inhibitors DDDs per 1000 Pus (21-22 target)	<6464		Sharon Marshall	Updated June 2023	8471.4	9610.3	7545.9	8132.6	8472.4	8869.8	7853.3	7365.8	7173.8	7595.3	8094.4	8439.6	9298.8	8312.8	7221.2	6321.5
	Low Value for Prescribing £ per 1000 Patients	<115.14		Sharon Marshall	Updated June 2023	422.3	130.9	184.5	52.5	82.3	77.7	344.3	23.9	109.4	98.8	229.4	173.1	171.3	103.1	180.4	93.1
						276	276	276	276	276	276	276	276	276	276	276	276	276	276	276	276
	% Change comparing March 23 to March 22 (Quarter 4) Prescriber Basic Price/Cost per 1000 Patients																				
	Prescriber Basic Price					11.80%	11.90%	6.60%	14.00%	18.80%	13.00%	12.60%	31.20%	15.00%	9.20%	25.10%	15.80%	15.10%	12.70%	1.50%	15.70%
	Cost per 1000 Patients					12.30%	11.10%	6.80%	13.60%	18.40%	11.70%	12.10%	31.40%	13.90%	8.30%	25.50%	14.50%	14.90%	11.80%	1.90%	13.40%
	DSQS Claims for 2022-23 Practice Folder Supplied (deadline 31/03/2023)			Emlyn Pritchard	Updated June 2023	03/05/2023	31/03/2023	31/03/2023	31/03/2023						16/05/2023	26/04/2023	31/03/2023	31/03/2023	31/03/2023	31/03/2023	21/04/2023
8	**Finance/Commissioning**																				
	Activity Per 1,000 Registered Patients			finance - Christian Thomas	updated Dec 22 with 21-22 data																
8.1	**Outpatient MMDS_Actuals Activity per 1000s Registered Patients 2021-2022 data**			finance - Christian Thomas		**286**	**266**	**242**	**275**	**363**	**298**	**246**	**275**	**286**	**181**	**194**	**182**	**183**	**221**	**196**	**183**
8.2	**Emergency Inpatients (All)**			finance - Christian Thomas		89.7	96.6	117.6	88.0	100.3	95.2	122.6	74.8	84.1	80.6	96.0	111.4	101.7	113.3	80.1	80.6

Access Commitment 2022/23

The Access Standards have 2 phases;
Phase 1 - The GMS access standards introduced in April 2019, will remain as pre-qualifiers. All practices are expected to achieve, maintain and embed those working practices in order to make any claim for achievement of the phase 2 standards.
Phase 2 – The reflective phase, this allows practices time to reflect, listen to patient experience and make improvements to access.

Phase 1

The GMS access standards introduced in April 2019, will remain as pre-qualifiers for participation in phase 2 of the standards and to quality for the QAIF Access Standard payment for 2022/23. All practices are expected to achieve, maintain and embed those working practices in order to make any claim for achievement of the phase 2 standards. Practices will be required to report quarterly, and be prepared to supply evidence via the PCIP Access Reporting Tool.

1. Does your telephone system have a recording function for incoming and outgoing lines?

2. Does your telephone system have the ability to stack calls?

3. Are you able to interrogate your telephony system to analyse data on calls?

4. Are you able to confirm if your telephone introduction message is recorded bilingually and lasts no longer than 2 minutes?

5. Can you confirm if your practice offers patients and care homes access to order repeat prescriptions through a digital solution?

6. Can you confirm if your practice offers a digital method for patients to request non-urgent appointments or a call back?

7. Does your practice have the necessary governance arrangements in place for this process?

8. Can you confirm that your practice publicises information for patients on how to request an urgent, routine and advanced consultation?

9. Can you confirm that your practice publicises information for patients on how to request a consultation via the practice leaflet and practice website?

10.Can you confirm that your practice displays information on the Access Standards?

11.Does your practice offer same day consultation for children under 16 with acute presentations?

12.Does your practice offer same day consultations for patients clinically triaged as requiring an urgent assessment?

13.Does your practice offer pre-bookable appointments?

14.Does your practice actively signpost to alternative cluster based services, health board wide and national services?

Phase 2

Service Delivery & Communication

1. All existing patient facing staff to undertake the national care navigation training package and all new patient facing staff complete the national care navigation training package within 3 months of start date [if virtual course is available from HEIW]. Practices will supply names of new starters and date of training undertaken.

2. Appointments are available for advanced booking each day with declaration confirming that every patient contact is supported throughout the day. (Patients will be offered an appropriate consultation, whether urgently or through advanced booking consistent with the patient's assessed clinical need, without the need for the patients to contact the practice again).

3. To maintain a planned and forward looking approach to consultations, practices to undertake a regular assessment of their scheduling appointment system to ensure a mix of remote, face to face, urgent, on the day and pre-bookable.

Patient Engagement

4. Practices must regularly maintain an automated and standardised public facing dashboard and make this available via a range of communication methods to meet the needs of their patients. (An Infographic will be made available via the PCIP for practices to use).

5. Practices to undertake the national patient experience survey which should include 25 completed questionnaires per 1000 registered patients from a range of practice population and captured through a range of methods.

Digital

6. Practices undertake care navigation on digital requests in a similar and equitable fashion to telephone requests.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 2.8

Delivery and Performance Committee	**Date of Meeting: 29 February 2024**
Subject :	Community Pharmacy Performance Report 2023/2024
Approved and Presented by:	Kate Wright, Medical Director
Prepared by:	Emlyn Pritchard, Head of Primary Care Medicines Management / Jacqui Seaton, Chief Pharmacist
Other Committees and meetings considered at:	Executive Committee 14 February 2024

PURPOSE:

The Community Pharmacy Performance Report provides an account of Powys' community pharmacy activities undertaken during 2023/24. It is intended to update the Delivery and Performance Committee on community pharmacy contractual framework and the health board's involvement with contract monitoring. The report outlines progress to date, areas of concern and plans for the next 12 months.

RECOMMENDATION(S):

The Delivery and Performance Committee is requested to:

- **RECEIVE** the Community Pharmacy Performance report; and
- Take **ASSURANCE** that a community pharmacy contractual framework is in place and performance against that framework is appropriately monitored.

Approval/Ratification/Decision[1]	**Discussion**	**Information**
✓	✖	✖

[1] Equality Impact Assessment (EiA) must be undertaken to support all organisational decision making at a strategic level

THE PAPER IS ALIGNED TO THE DELIVERY OF THE FOLLOWING STRATEGIC OBJECTIVE(S) AND HEALTH AND CARE STANDARD(S):		
Strategic Objectives:	1. Focus on Wellbeing	✓
	2. Provide Early Help and Support	✓
	3. Tackle the Big Four	✓/×
	4. Enable Joined up Care	✓
	5. Develop Workforce Futures	✓/×
	6. Promote Innovative Environments	✓/×
	7. Put Digital First	✓/×
	8. Transforming in Partnership	✓/×
Health and Care Standards:	1. Staying Healthy	✓
	2. Safe Care	✓
	3. Effective Care	✓
	4. Dignified Care	✓/×
	5. Timely Care	✓
	6. Individual Care	✓
	7. Staff and Resources	✓
	8. Governance, Leadership & Accountability	✓

EXECUTIVE SUMMARY:

The Chief Pharmacist is responsible for managing the community pharmacy contract. This is managed on a day-to-day basis by the Head of Primary Care Medicines Management.

There are 23 community pharmacies located within the geography of Powys, 8 in the north, 7 in the mid and 8 in the south.

In September 2021 the health board published its first Pharmaceutical Needs Assessment (PNA) setting out the needs and gaps in pharmaceutical services across Powys. There is a requirement to update the PNA every 5 years, or sooner if there is any significant change to pharmaceutical service provision.

A new contractual framework for community pharmacy was introduced in April 2022 and all 23 of our community pharmacies have successfully transferred to the new contract.

The new community pharmacy contract has resulted in the delivery of more consistent services across our geography (e.g. clinical services).

Significant progress has been made with monitoring community pharmacy activities and this information is being used to evaluate and challenge current service provision to ensure that our population can consistently access and obtain benefit from this valuable resource.

Given the financial pressures facing the health board, monitoring the spend against the monies allocated to community pharmacy is a priority.

Community pharmacy contract visits have been reinstated and all pharmacy sites will have received a contract monitoring by the end of 2023/24.

A Community Pharmacy Contract Assurance Framework has been developed and is updated quarterly.

The Medicines Management Team is working closely with Welsh Government to help address some of the challenges that are unique to Powys (e.g. the implementation of 56-day prescribing).

Community pharmacy contractors are facing challenging times, particularly with regards to funding and workforce. Across the UK, Boots and Lloyds pharmacies closed a number of their stores during 2023/24 and there is a risk that this trend could continue. There is also an increasing trend of contractors submitting requests to reduce their opening hours.

DETAILED BACKGROUND AND ASSESSMENT:

Pharmaceutical Needs Assessment (PNA)

Powys Teaching Health Board published its first PNA in September 2021.

A PNA is a legal document which all Health Boards were mandated (The National Health Service (Pharmaceutical Services) (Wales) Regulations 2020) to produce and publish by 1st October 2021. The Regulations require that a PNA must be undertaken every 5 years (or sooner if a Health Board identifies changes to the need for pharmaceutical services which are of a significant extent).

Our PNA is published on the health board's website and it describes:

- The current health needs of the population
- The current provision of pharmaceutical services by pharmacies, dispensing appliance contractors and dispensing doctors both within and outside of the health board's area,
- Any changes that may arise during the lifetime of the document such as demographic changes, housing developments, regeneration projects, and changes to the location of other NHS service providers
- Any current gaps in service provision or any that will arise during the lifetime of the document.

The only gap in pharmaceutical services identified in the PNA was in Llanwrtyd Wells, due to the absence of access to the following pharmaceutical services in that area:

- Emergency Hormonal Contraception
- Smoking Cessation Service level 3
- Influenza Vaccination
- Common Ailments Service
- Emergency Medicines Supply

Following a change of ownership of the pharmacy (February 2022), all of these services are now provided, filling the gap identified in the PNA. A supplementary statement, to sit alongside the PNA, was published on the health board's website in May 2022.

Distribution

Powys health board currently has 23 community pharmacies, distributed as follows:

North Cluster – 8 pharmacies

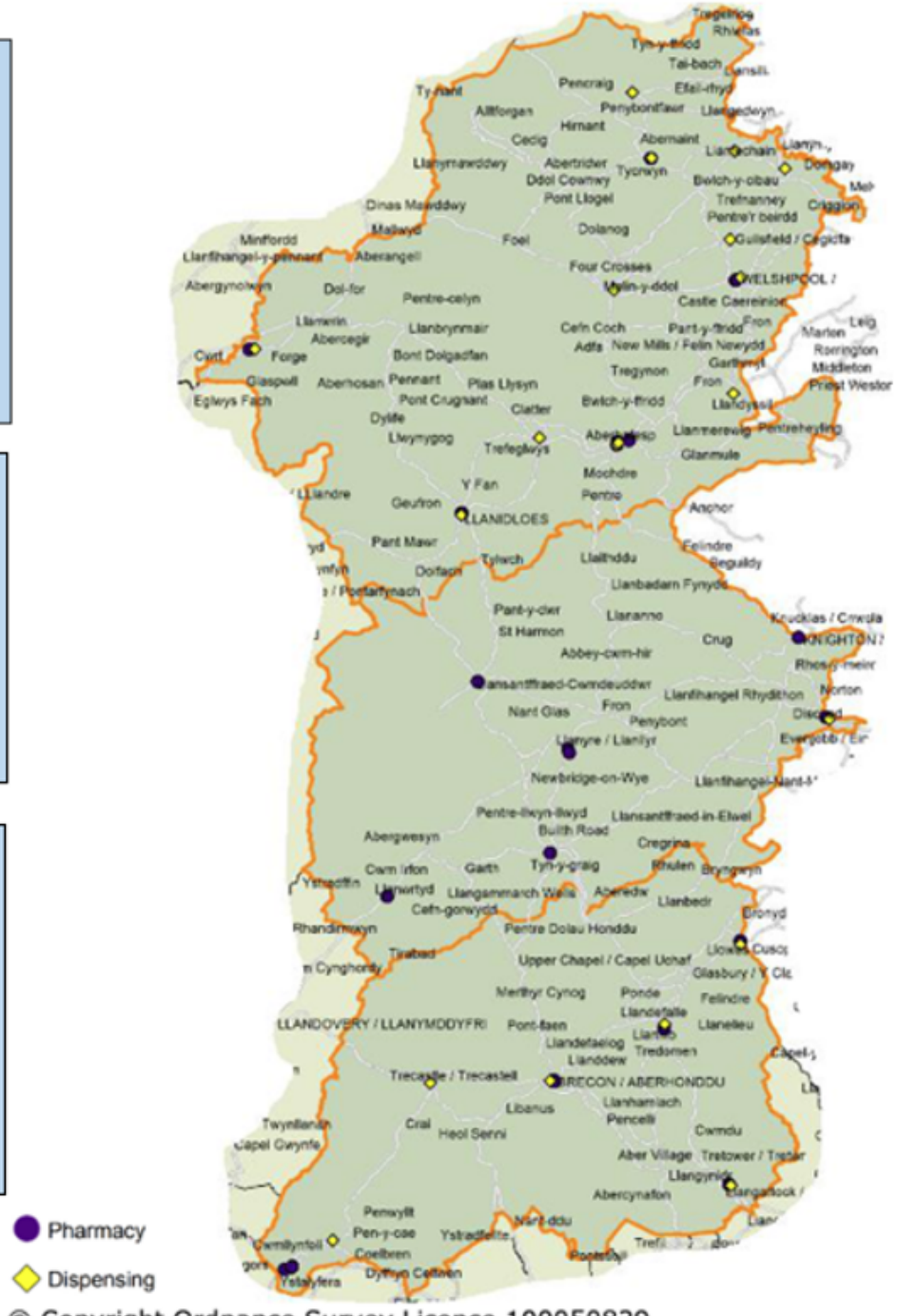
- Danby's – Llanfyllin
- Boots – Welshpool
- Rowlands – Welshpool
- Rowlands – Machynlleth
- Morrisons – Newtown
- Boots – Newtown
- Allied – Newtown
- Llanidloes Pharmacy

Mid Cluster – 7 pharmacies

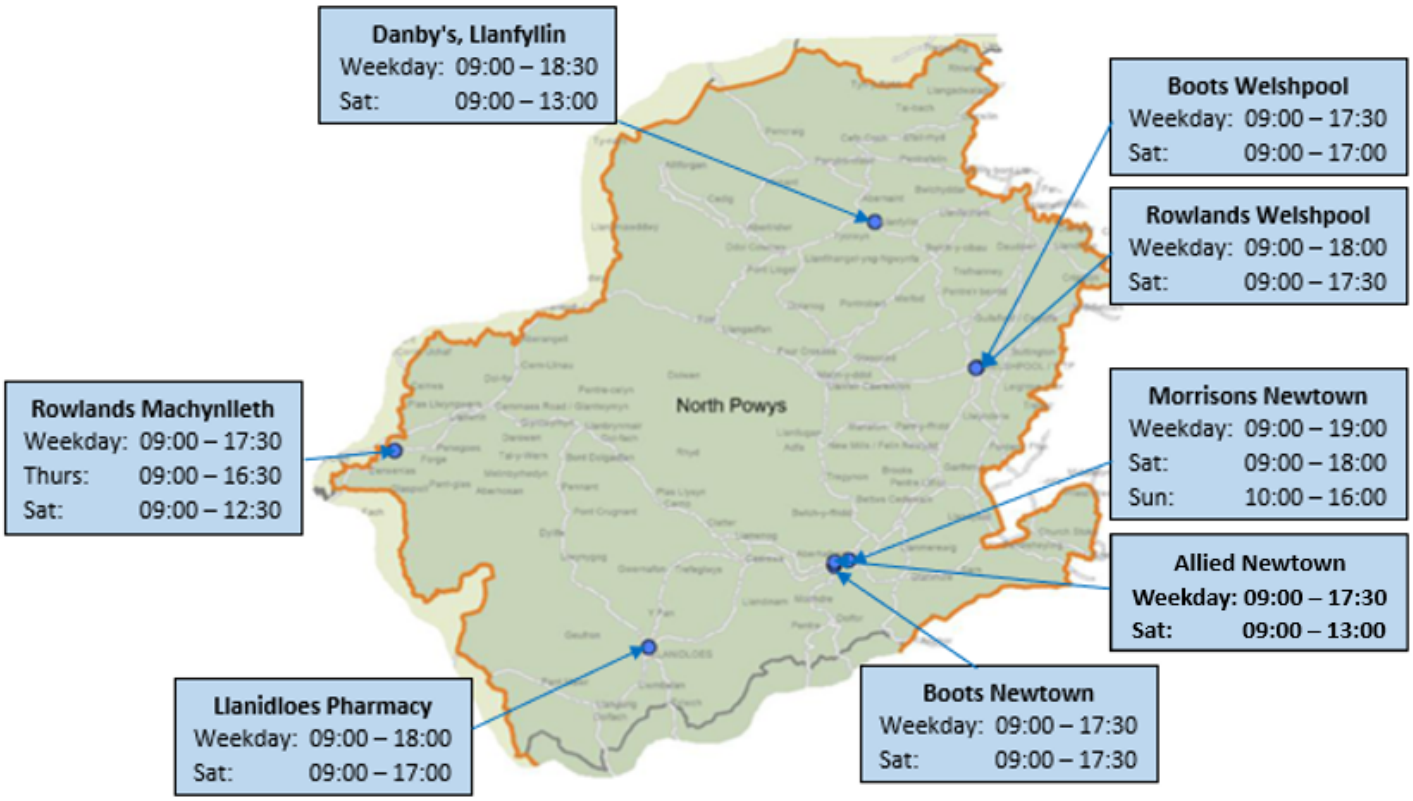
- Boots – Knighton
- Rowlands – Rhayader
- Lakeside Pharmacy
- Boots – Llandrindod Wells
- Presteigne Pharmacy
- Boots – Builth Wells
- Llanwrtyd Pharmacy

South Cluster – 8 pharmacies

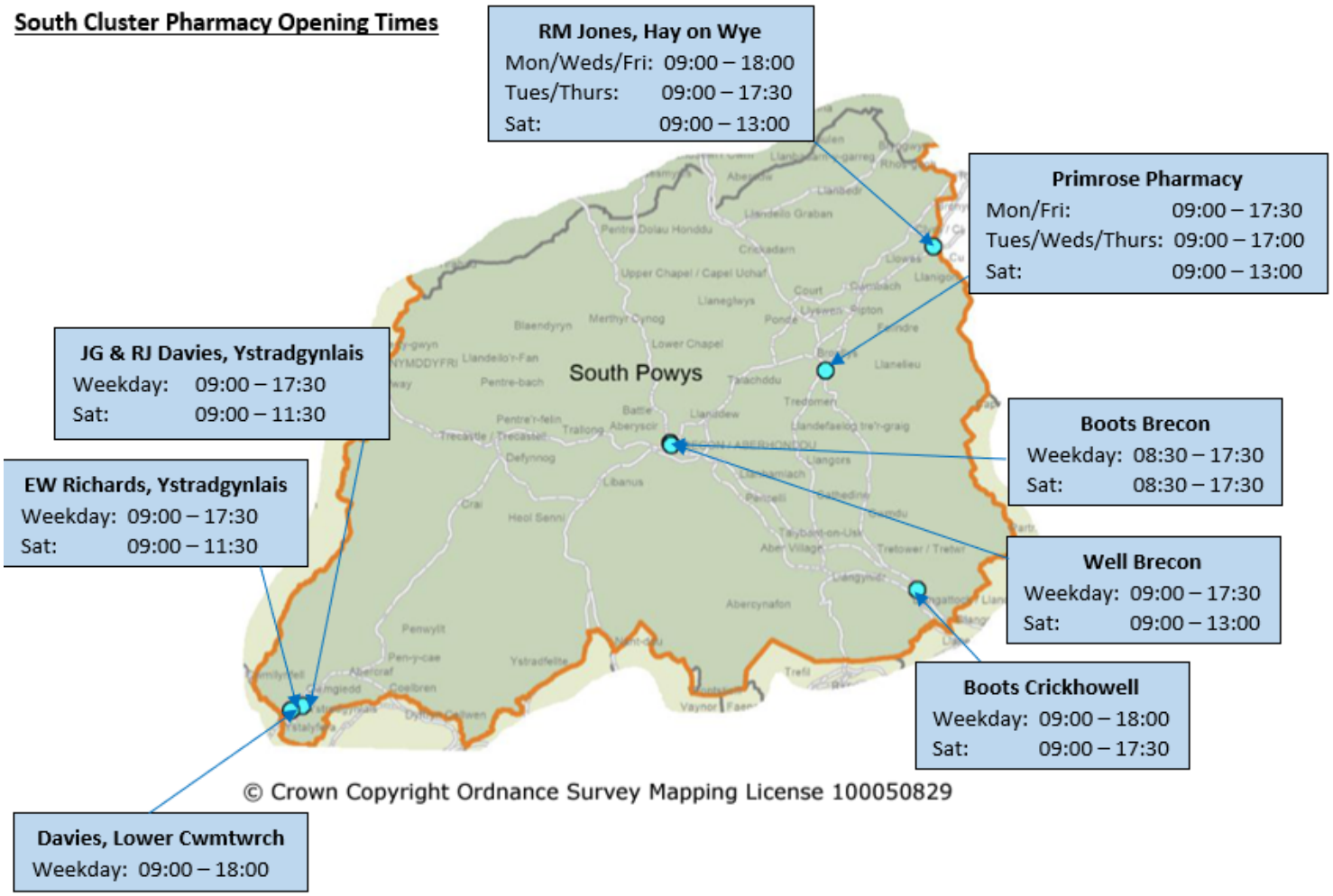
- RM Jones - Hay
- Primrose Pharmacy – Talgarth
- Well - Brecon
- Boots - Brecon
- Boots - Crickhowell
- RJ Davies - Lower Cwmtwrch
- EW Richards - Ystradgynlais
- JG & RJ Davies - Ystradgynlais



North Cluster Pharmacy Opening Times



Mid Cluster Pharmacy Opening Times



Opening Times

The community pharmacy contract mandates that, unless otherwise agreed with the health board, a pharmacy must provide pharmaceutical services for at least 40 hours per week. These hours are deemed ***core hours*** and pharmacies may choose to declare to open for ***supplementary hours*** in addition.

Any change in core hours requires health board approval, where as contractors can simply serve notice to amend their supplementary hours.

With the exception of the pharmacy is Llanwrtyd Wells (which has reduced opening hours), pharmacies typically open from 09:00 to 17:30, Monday – Friday.

Since the publication of the last report, the pharmacy contract previously held by Lloyds Pharmacy in Newtown has been transferred to Allied Pharmacy. Pharmaceutical services continue to be delivered from the same premises, but with reduced opening hours (the pharmacy reduced its weekday supplementary opening hours in 2023 and now closes at 17:30 rather than 18:30).

Saturdays

21 of our 23 pharmacies open on Saturdays (20 have core hours stipulated in their contracts), 12 of these pharmacies cover the hours of 09:00 to 17:00.

Boots in Crickhowell does not have any core hours on a Saturday, meaning that they could serve notice to reduce or discontinue Saturday opening in the future.

Saturday services are not provided by the pharmacy in Llanwrtyd Wells nor by Davies Chemist Ltd, Lower Cwmtwrch.

Sundays

Morrisons (Newtown) opens from 10:00 to 16:00 but it does not have any contracted core hours on Sundays, meaning that they could serve notice to reduce or discontinue Sunday opening in the future.

Commissioned Rota Services

In addition to core and supplementary opening hours the health board commissions a number of pharmacies to extend their opening hours on weekday evenings and to open on Sundays. See Table 1 below.

Table 1: Regularly Commissioned Rota Agreements

Pharmacy	Commissioned Rota		Comments
JG & RJ Davies, Ystradgynlais, Davies Chemist Ltd, Ystradgynlais, EW Richards, Ystradgynlais *Davies Chemist Ltd, Ystalyfera**	11:30 – 12:30	Sunday	Rota is commissioned where each pharmacy opens every fourth Sunday. *Davies Chemist Ltd, Ystalyfera is not a PTHB contractor.
Lakeside, Llandrindod Wells Boots, Llandrindod Wells	17:30 – 18:30	Mon - Fri	Rota is commissioned where each pharmacy covers the additional hours on alternate weeks.
Boots, Knighton	17:30 – 18:30	Mon - Fri	Every week.
Boots, Builth Wells	17:30 – 18:00	Mon - Fri	Every week.
Presteigne Pharmacy	17:45 – 18:00	Mon - Fri	Every week.
Llanidloes Pharmacy	17:30 – 18:00	Mon - Fri	Every week.
Boots, Welshpool	17:30 – 18:00	Mon - Fri	Every week.
Danby's Llanfyllin	17:30 – 18:15	Mon - Fri	Every week.

Since the publication of the last report, both pharmacy contractors in Brecon have ceased providing rota services (weekday evenings and Sundays). Workforce challenges and inadequate rota payments have been cited as reasons for withdrawing from the service.

In addition to the regular commissioned rota services detailed in Table 1, the health board commissions pharmacy contractors to open on bank holidays. As a minimum, the Medicines Management Team aims to have provision in the Newtown, Llandrindod Wells, Brecon and Ystradgynlais areas. Expressions of interest are sent out at least three months before each bank holiday and responses are collated before commissioning is agreed.

Community pharmacy rota services, including commissioned rota on bank holidays, cost the health board approximately £120,000 per annum. The extent to which the rota services are used is currently unknown. This is an area that will be audited over the coming months.

Essential Small Pharmacy Scheme (ESPS)

Pharmacies that dispense fewer than 35,160 prescriptions annually; and are more than 1 kilometre from the next nearest pharmacy are eligible for an additional ESPS payment.

During 2023/24 the pharmacy in Llanwrtyd Wells qualified for the ESPS payment for the first time and receives, on average, an additional £2,700 a month. This is potentially due to the reduction in prescription volume as the local practice moved to 56-day prescribing in line with national recommendations.

ESPS payments are ringfenced within the overall community pharmacy contract allocation so do not create a cost pressure to the health board.

Temporary Closures

Community pharmacy contractors have a contractual obligation to notify the health board, at the earliest opportunity, when they are unable to open for their full contracted hours, providing details of the reason for closure and assurance that all actions have been taken to ensure that patients can access the medicines that they need and that GP surgeries and other care providers have been informed.

Between April and December 2023, the health board received 20 closure notices from a total of 10 contractors. 12 of the closure notices were for closures of less than two hours and had minimal impact on the delivery of services. Six closure notices were for Boots pharmacies where a pharmacist needed to cover two separate pharmacies on the same day due to issues with locum pharmacist availability.

These figures have decreased compared with the same time period last year (28 closures) where high levels of COVID-related absence and difficulty obtaining locum pharmacists led to much higher rates of closure rates.

Escalation Status

Community pharmacy contractors are encouraged (but not mandated) to update their escalation status on the Primary Care Information Portal whenever their status changes. The Medicines Management Team is automatically notified when a status is updated, this allows work to be undertaken to understand the rationale for escalation and to support contractors to mitigate the impact on patients and members of the public.

Table 3 summarises the status categories and the current statuses of our community pharmacies.

Table 2: Pharmacy Escalation Status

Escalation Status	No. Pharmacies (15/01/23)	Summary
5	**0**	Closed in normal business hours
4	**0**	Business continuity issues (interruption to utilities / adverse weather) Reduced staffing levels or increased demand is having a significant impact on the provision of services.
3	**0**	Business continuity issues (interruption to utilities / adverse weather) Reduced staffing levels or increased demand is having an impact on the provision of services
2	**6**	Open as usual and either reduced staffing levels or increased demand on services. Sufficient capacity to meet demand.
1	**15**	Open and delivering services as usual
0	**2**	Status has not been updated

New Community Pharmacy Contractual Framework

A new, more clinically focussed, community pharmacy contract was introduced on 1st April 2022, bringing in a wide range of reforms under four key themes:

- A commitment to quality, collaboration, and integration within primary care
- A workforce with the skills needed to deliver outstanding pharmaceutical care
- Expanding the clinical role of community pharmacists
- Valuing the contribution community pharmacies make to the NHS

Clinical Community Pharmacy Service

Under the new contract, there is a new national directed service: Clinical Community Pharmacy Service (CCPS) which all pharmacies in Powys have committed to provide. There are four components to the CCPS:

- Emergency Contraception
- Common Ailments Service
- Emergency Medicines Supply
- Seasonal Influenza Vaccination

In order to increase engagement with the CCPS, changes have been made to the Establishment Payment (currently £25k annually) that contractors receive. Previously, this fixed payment was available to all contractors, subject to a volume (of prescription items dispensed) threshold. Since April 2022, pharmacies now receive 50% of this payment routinely and must commit to provide all four of the component services in order to receive the second 50%. The Medicines Management Team works closely with contractors to provide assurance around the quality of service provision and also analyses service claims data to ensure that the services are appropriately offered across Powys in line with the commitment. Processes are in place to escalate service provision queries (e.g. if it is recognised that a particular pharmacy is providing more emergency contraception than would be expected or if emergency supplies are being made during the hours that GP surgeries are open).

Although outside the new contractual framework, pharmacies are also commissioned to provide some 'additional pharmacy services' including smoking cessation support, waste reduction scheme, respiratory rescue medicines service, supervised administration, palliative care medicines, receipt of patient sharps, needle and syringe exchange service, inhaler review service, medicines administration record (MAR) provision etc. These are commissioned locally. Details of which pharmacies provide these services can be accessed via the health board's website. Not all of these services are provided by all Powys community pharmacies, which can be confusing for our population and therefore our ambition is to ensure a consistent service offer from all pharmacies in the future.

Pharmacist Independent Prescribing Service

There is a national drive to increase the number of community pharmacists that are trained and working as independent prescribers. To support this, a new national directed service: Pharmacist Independent Prescribing Service (PIPS) was included in the contract from April 2022. This service allows the provision of a national extended minor illness service and/or national contraception service, or other health board commissioned services, depending on local priorities.

There are now six community pharmacy sites actively prescribing for patients in Powys:
- Llanidloes Pharmacy
- Davies Chemist, Lower Cwmtwrch
- RM Jones, Hay on Wye
- Primrose Pharmacy, Talgarth
- JG and RJ Davies, Ystradgynlais (new service in 2023)
- Llanwrtyd Pharmacy (new service in 2023)

Llanidloes pharmacy has an established service focussed on an extended common ailments formulary and respiratory and urinary tract infections. Davies Chemist, Lower Cwmtwrch is also providing contraceptive services.

It is anticipated that Well Pharmacy in Brecon will be commissioned to provide the prescribing service before the end of the financial year and there are a further five Powys community pharmacists currently enrolled on the independent prescribing course.

The main challenge faced by pharmacists who wish to train as independent prescribers is the ability to identify a Designated Prescribing Practitioner (DPP) to provide supervision, support and practical experience in a clinical area during training. There is currently a limited pot of money to reimburse DPPs for their time (Independent prescribing set up costs in Table 4), although this funding is not guaranteed beyond 2023/24.

The Medicines Management Team continues to engage with pharmacist independent prescribers and has managed to secure funding via the Primary and Community Care Academy for pharmacists to attend a contraception course delivered by the Faculty of Sexual & Reproductive Health in January 2024. It is hoped that pharmacists will be able to use this opportunity as evidence towards expanding their prescribing scopes of practice to include regular contraception.

Monitoring the Community Pharmacy Contract and Pharmacy Service Provision

The Head of Primary Care Medicines Management chairs quarterly forum meetings which invite Community Pharmacy Wales (CPW), independent contractors and representatives from the Community Chemists Association to discuss the ongoing implementation of the community pharmacy contract in Powys.

The Medicines Management Team has developed a Community Pharmacy Contract Assurance Framework (CAF). The CAF is updated quarterly and allows for the Medicines Management Team to monitor compliance with the contract and highlights contractors where improvement or escalation may be required. Themes covered in the CAF include:

- Contract Monitoring
- Temporary closures
- Concerns, complaints and incident reporting
- Stakeholder identification
- Service delivery and compliance with service specifications
- Waste management

Community pharmacy contractors are asked to complete three toolkits annually which are used to declare adherence to specific elements of the community pharmacy contract, they also inform priority of contract monitoring visits:

- Clinical Governance Toolkit
- Information and Security Management System (ISMS) Toolkit
- Controlled Drugs Checklist

These checklists are in the process of being updated by Digital Health and Care Wales (DHCW), and once updated they will be sent to contractors for completion January–March 2024.

Community pharmacy contract monitoring visits were suspended in 2020 due to the COVID-19 pandemic. The Medicines Management Team has resumed contract monitoring visits and to date, 16 pharmacies received contract monitoring visit during 2023-24.

Visits have predominantly been led by the Head of Primary Care Medicines Management with significant input from medicines management pharmacy technicians; visits have focussed on all elements as described within the NHS Wales Terms of Service for community pharmacy contractors and additional elements such as commissioned pharmacy services and collaboration visits.

Following a contract monitoring visit, contractors are provided with an agreed list of actions and defined timescales for their completion; learning is regularly shared and engagement with our pharmacy contractors has improved.

After this initial year of catch-up visits, the Medicines Management Team will visit 50% of pharmacy contractors every year moving forward.

Community Pharmacy Finances and Clinical Services Evaluation

Each year the health board receives a financial allocation for community pharmacy. During 2023024 this amounted to £5.437 million (including an uplift in November 2023). The allocation is split into several separate budgets; separate allocations are ringfenced at either a health board or national level.

The Medicines Management Team, in collaboration with finance colleagues, has strengthened its financial governance of the community pharmacy allocation.

Historically, the health board has overspent on its clinical services allocation and the Medicines Management Team is working to ensure the limited budget is spent on services that will offer the greatest benefit to our population.

Robust monitoring of all community pharmacy commissioned services is now in place, allowing evaluation of service provision and identification of areas for improvement, investment and disinvestment such as:

- Pharmacies providing emergency supplies of medicines to patients during normal GP surgery opening hours
- Pharmacies regularly providing services to non-Welsh residents
- Pharmacies commissioned, but not actively providing services

The monitoring tools that have been developed also allow the Medicines Management Team to identify changes in service provision over time and highlight contractors who are consistently offering valuable services to Powys residents.

Information for the Public and Contractors

The Medicines Management Team is committed to making information easily accessible to the clinicians and members of the public. The Medicines Management pages of the PTHB

website include a section on community pharmacy. These pages are regularly updated and contains information on:

- Community pharmacy contact details
- Services provided by each community pharmacy
- Bank holiday rota arrangements
- Pharmaceutical Needs Assessment

Contractors can also access the Community Pharmacy Repository (password-protected) via the same area of the website. The page hosts information, service level agreements, PGDs and other forms for all services currently provided by community pharmacies in Powys.

The Medicines Management Team plans to develop the website further to ensure that patients and clinicians can easily access information relating to pharmacy services. The Team is committed to working with the health board's translator to ensure that our website meets the standards stipulated by the Welsh Language Commissioner.

Challenges/Opportunities for Improvement

56-Day Prescribing

The community pharmacy contractual framework has been transitioning from the traditional contract where contractors are reimbursed predominantly for dispensing prescriptions and providing over the counter advice to one where clinical services are delivered. Reimbursement under the contract has also followed this course; dispensing fees have reduced and funds have been transferred into budgets ringfenced for the provision of clinical services.

Both Presgripsiwn Newydd / A New Prescription (Dec 2021) and the Review of Dispensing Volumes in Community Pharmacies (Jan 2022) recommended the move from 28 to 56-day prescribing. This move would bring Wales in line with other UK nations and offers benefits to patients, the environment, GP practices and community pharmacy.

Implementing this change continues to be a significant challenge for Powys. 79% of our registered population are registered with dispensing practices and 38% of our registered population access their medicines from the dispensary in the dispensing practice with which they are registered. This is a significant contrast to other health boards where only 4% of patients access their medicines from a GP practice dispensary.

The dispensing elements of the GMS contract are closely linked to the English contract and have not been amended following the recommendations described above. Dispensing doctors who implement 56-day prescribing are therefore likely to be left out of pocket as remuneration for GMS dispensing contractors is predominantly via dispensing fees.

Dispensing practices are reluctant to move to 56 day prescribing even for those patients who do not access their medicines from the practice dispensary due to precedent that it will set.

In April 2022 the Medicines Management Team conducted an audit to understand the financial impact that switching from 28 to 56-day prescribing would have on dispensing practices. The results showed that the 11 dispensing practices in Powys would collectively lose in the region of £900,000 per annum from the reduced dispensing fees. No other health board faces a challenge of this scale.

The Medicines Management Team have directly supported several non-dispensing practices in Mid Powys to implement 56-day prescribing. It is anticipated that the other non-dispensing practices will also implement this change in 2024. Access to 56-day prescriptions is currently dependent on whether a patient is registered with a dispensing or a non-dispensing practice and it is anticipated that this position will be challenged by patient groups.

If 28-day prescribing remains in place, patients in Powys will have to make more trips to collect their prescriptions, GP practices will spend more time generating and signing prescriptions and community pharmacists will continue to spend more time dispensing prescriptions rather than focussing on delivering clinical services. There is also the environmental impact of increased travel and paper generation if 28-day prescribing remains in place.

The risk associated with not being able to deliver this change puts pressure on our community pharmacy contractors as it reduces their ability to deliver their contract and overall profitability.

Despite three of our GP practices moving to 56-day prescribing, prescription items dispensed by community pharmacies across Powys have increased by 2% (Aug-Oct 2023 vs. Aug-Oct 2022).

The Medicines Management Team is working closely with Welsh Government to find a solution to this challenge and has also taken steps to ensure that Powys has a voice when guidance like this is being considered.

Accelerated Cluster Development (ACD) and Community Pharmacy Collaborative Leads (CPCLs)

A CPCL is a nominated pharmacist or technician who leads a community pharmacy collaborative within a cluster. Roles are appointed following a nomination and voting process undertaken by the pharmacies within each cluster.

The CPCL plays a critical role in shaping engagement and providing leadership and representation for pharmacies within the primary care cluster.

Previously, all pharmacies were able to participate in the collaborative working incentive; pharmacy professionals were able to organise collaborative meetings with other healthcare providers and claim payment under the contract. Since April 2023, pharmacies are only able to claim collaborative payments for meetings that are organised by their CPCL.

Despite multiple engagement events and promotion by both the health board and CPW, neither the mid-cluster nor the south-cluster have CPCLs in place. The vacancy has existed in the mid-cluster since April 2022 and in the south-cluster since September 2022.

Contractors have provided feedback about their reluctance to take on the CPCL role:

- Insufficient remuneration
- Meetings too frequent
- Meetings held at times that are not convenient for community pharmacy businesses.
- Increased workload associated with the role.

Without a CPCL, all contractors in both clusters will be affected as they will be unable to claim for any collaborative working payments.

The Medicines Management Team is working closely with Welsh Government and CPW to identify ways of attracting pharmacists and technicians into these posts.

The Use of Patient Group Directions (PGDs) by Pharmacy Technicians

A 2023 DHSC consultation asked stakeholders to consider proposals to change the Human Medicines Regulations (2012) to enable pharmacy technicians to supply and administer medicines to patients using PGDs.

Benefits of this to the provision of clinical services in community pharmacy are clear – pharmacy technicians would then be able to hold clinics for services reliant on PGDs such as influenza vaccination, emergency contraception and common ailments. Future developments could see pharmacists using their prescribing qualifications routinely and PGDs in community pharmacy limited to pharmacy technician use.

The Pharmacists Defence Association has refused to support the consultation and has highlighted concerns regarding the underpinning education of pharmacy technicians:

- Pharmacy technicians are qualified to level 3, whereas healthcare professionals currently authorised to operate under a PGD have minimum underpinning education at level 5.
- Around half of the current pharmacy technician workforce were added to the register via a grandparent clause and education records are not held for this group.

If this consultation is adapted and approved for use within NHS Wales, the Medicines Management Team will support contractors to implement this change.

2024/25 Community Pharmacy Contract Negotiations

Negotiations are currently ongoing for the contract planned for implementation in April 2024. CPW and health board representatives have been invited to attend multiple meetings to discuss the proposals submitted.

Datix Cymru / Once for Wales Concerns Management System

Community pharmacy contractors are required to have an incident reporting system in place (Datix Cymru), along with arrangements to investigate and respond to critical incidents (NHS Pharmaceutical Services (Wales) Regulations 2020).

Datix Cymru provides the ability for contractors, health boards and the NHS Wales Delivery Unit to analyse incident trends and share learnings.

Contractors are encouraged to report:

- All incidents involving controlled drugs (CDs).
- Dispensing incidents that have been fully investigated and reported internally.
- Incidents involving Violence and Aggression towards community pharmacy teams.

Since its launch in April 2022, 140 Datix incidents have been reported by 19 of our 23 community pharmacies.

The introduction of Datix to community pharmacy has had a significant impact on the health board's workload. Once an incident report is submitted via Datix, the contractor is unable to add any additional information or close the incident down once the investigation is complete. This responsibility has now fallen to the health board's Medicines Management Team. This has been escalated to the national team as the community pharmacy contract only requires health boards to gain assurance that contractors have an incident reporting system in place, along with the ability to analyse incident data. All health boards are reporting that the additional workload is unsustainable.

The Medicines Management Team is working closely with contractors to ensure that they are all using the system and to improve the quality of Datix reports in order to reduce the intervention required by the health board.

Risk of Pharmacy Closures, Retraction of Opening Hours and Commissioning Rota Services

The risk of pharmacy closures, reduction in opening hours and our inability to provide access to pharmacy services out of hours, is an increasing concern for the health board.

During 2023 Lloyds Pharmacy, previously the second biggest pharmacy chain in the UK, withdraw from the pharmacy market in Wales. Most of its 77 stores in Wales (including the one in Newtown) have been sold to smaller chains or independent pharmacy owners, the others have closed. Boots also announced that it would be closing 300 (of approximately 2,200) stores across the UK, thankfully none in Powys, although we need to be mindful that Boots stores in Powys are not immune from future closures.

In the past, many pharmacies would have committed to opening for more than their contracted 40 core hours. Pharmacies operated by multiples such as Boots and Lloyds and those located within supermarkets would have opened late into the evening and would open commercially over the weekend. However, across Wales there has been an increase in pharmacies serving notice on their supplementary opening hours. Workforce challenges, rising running costs and the aftereffects of the COCID-19 pandemic are frequently cited as reasons.

Although, to date we have not had any pharmacy closures in Powys, we have seen pharmacies pulling out of routine rota service provision (we now have no evening or Sunday rota in Brecon) and we struggle to attract pharmacy contractors to provide rota services during bank holiday periods, meaning that our citizens have to travel considerable distances to access services. No pharmacy contractors in Welshpool, Newtown or Brecon were prepared to open over the Christmas period in 2023 and the Medicines Management Team resorted to commissioning services further afield: Llanidloes Pharmacy covered the north of Powys and the pharmacy in Hay on Wye covered the Brecon area. Workforce challenges and inadequate rota payments are sited as the reasons by contractors.

We currently have 6 pharmacies in Powys with core opening hours in excess of 40 hours. As the pharmacy contract now only requires contractors to provide 40 core opening hours, health boards are starting to see requests from contractors to reduce their core hours to bring them in line with the contract. Welsh Ministers recently overruled a health board's decision to decline a contractors request to reduce their core opening hours on a Saturday. This is despite the health board providing clear rationale for their decision. The health board is now left with a gap in service provision and a requirement to amend their PNA to highlight the gap. Of the 6 pharmacies in Powys offering in excess of 40 core opening hours, if they were to request a reduction it could potentially mean that 3 of them stop offering services on a Saturday.

The community pharmacy contract allows health boards to mandate opening hours and the Medicines Management Team has explored this option. However, in order to issue a direction, the health board must undertake an assessment, involve Community Pharmacy Wales (CPW), and be satisfied that the pharmacy no longer meets the needs of the local population. CPW have indicated that they would encourage all pharmacy contractors to appeal any directions of this nature. There is a clause within the contract that states that health boards may only direct opening where it is satisfied that the contractor will receive "reasonable remuneration" in respect of the additional hours; CPW and contractors often raise the issue of insufficient rota payments. Even if the health board did direct pharmacy opening, there is no guarantee that the contractor will be able to identify the workforce to provide the service.

NEXT STEPS:

Over the next 12 months the Medicines Management Team will build on the progress that has been made to date.

Contract monitoring visits will continue during 2024/25 – 50% of pharmacies will receive a visit.

The 'Contract Assurance Framework' for community pharmacy will be further developed and updated quarterly.

A 'Contract Breach Process' will be introduced to strengthen contract management.

The provision of the Clinical Community Pharmacy Service (CCPS) and "additional pharmacy services" will continue to be closely monitored to ensure access across the whole county.

Pharmacy opening hours and the provision of 'rota services' will be reviewed to ensure that they are of value to our population and providing value for money.

The Medicines Management Team will work closely with Welsh Government to address some of the challenges that are unique to Powys (e.g. 56-day prescribing).

The process for dealing with Datix reports from community pharmacies will be reviewed within the health board and challenges escalated to Welsh Government. The Medicines Management Team will continue to work with contractors to improve the quality of incident reporting and sharing learnings.

Information relating to service provision that is being provided to community pharmacy on a regular basis will be reviewed and further developed.

The Medicines Management Team will commit to improving collaborative working with community pharmacies and providing more regular support visits.

The Medicines Management Team will continue to promote and support pharmacists to become independent prescribers and to use their qualifications to deliver services across Powys.

Service specifications for locally commissioned services will be reviewed and updated in 2024.

The following Impact Assessment must be completed for all reports requesting Approval, Ratification or Decision, in-line with the Health Board's Equality Impact Assessment Policy (HR075):

IMPACT ASSESSMENT					
Equality Act 2010, Protected Characteristics:					
	No impact	**Adverse**	**Differential**	**Positive**	This report is intended as an update on progress made and does not require approval, ratification or decision.
Age	✓				
Disability	✓				
Gender reassignment	✓				
Pregnancy and maternity	✓				
Race	✓				

Religion/ Belief	✓				
Sex	✓				
Sexual Orientation	✓				
Marriage and civil partnership	✓				
Welsh Language	✓				

Risk Assessment:

	Level of risk identified				
	None	**Low**	**Moderate**	**High**	This report is intended as an update on progress made and does not require approval, ratification or decision.
Clinical	✓				
Financial	✓				
Corporate	✓				
Operational	✓				
Reputational	✓				

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item:2.9

Delivery and Performance Committee	**Date of Meeting: 29 February2024**
Subject:	**Annual Report on the work of the Corporate Health and Safety Group**
Approved and Presented by:	Claire Madsen, Executive Director Therapies and Health Sciences
Prepared by:	Jason Crowl, Assistant Director Health and Safety and Support Services
Other Committees and meetings considered at:	Health and Safety Group 22nd January 2024 Executive Committee 7th February 2024

PURPOSE:

To provide the Delivery and Performance Committee with the Annual Report update from 1 January 2023 to 31 December 2023 in relation to the work of the Corporate Health and Safety Group and the progress that has been made with the 2023/24 work plan and the plans for 2024.

RECOMMENDATION:

The Delivery and Performance Committee is asked to:

- **DISCUSS** and take **ASSURANCE** from the report that the organisation implemented its 2022/23 work plan, and it is implementing the programme for 2024.

Approval/Ratification/Decision[1]	**Discussion**	**Information**
✓	✓	

[1] Equality Impact Assessment (EiA) must be undertaken to support all organisational decision making at a strategic level – **N/A**

EXECUTIVE SUMMARY

Powys Teaching Health Board (PTHB) is committed to ensuring the health, safety and welfare of all our employees, and those who may be affected by our work activities or undertakings.

Furthermore, ensuring that those who are engaged to carry out work on our premises, and/or on our behalf are also committed to ensuring the health and safety of their employees and others.

The Health and Safety Annual Plan is the first to be produced by the Health Board with the intention that it is available for the Board and for the public.

The Annual Report describes the activity of the Health and Safety Group during 2023 and describes its work and that of the Health and Safety Unit across five themes.

The revised Health and Safety Policy Framework implemented in 2022 has strengthened the Health Boards Health and Safety Management System and was given a rating of reasonable assurance by the internal audit team. The improvement in reporting of accidents and incidents and access to training and resources is helping to improve the Health and Safety culture of the organisation.

There is still much work to be done to increase training compliance and reduce areas of accidents and incidents in particular areas, notably in moving and handling and Prevention Management of Violence and Aggression (PMVA).

The work plan now established by the Health and Safety Group will continue this work into 2024 to ensure that a positive Health and Safety culture continues to develop.

BACKGROUND AND ASSESSMENT:

This is the first ever Health and Safety Annual Report to be developed for the Board with the intention for sharing in the public domain. The current arrangements are for the Annual Report to be presented via the Delivery and Performance Committee. From April 2024 Health and Safety Group will return to a quarterly meeting and will receive a formal quarterly report. To reflect the key role of workforce and culture within delivering successful Health and Safety the Health and Safety Group report will be taken via the Workforce and Culture Committee on a quarterly basis and the Board will receive an Annual Report. Also**,** from February 2024 to ensure there is collective governance between Health and Safety and Clinical Safety the Assistant Director of Quality and Safety will attend HSG and The Assistant Director of Health and Safety and Support Services will attend the Patient Experience Committee (PECS). The HSG quarterly report will also be taken to PECS.
The Annual Report describes the activity of the Health and Safety Group during 2023 and describes its work and that of the Health and Safety Unit across five themes which are:

1. Assurance and Reporting Arrangements
2. Achieving Health and Safety excellence in reporting incidents and learning
3. Developing a Health and Safety Culture by Training and Development
4. Achieving Excellence in Training Compliance
5. Strengthen Inspection.

Key areas of note in the report are:

- Interim changes to Executive Portfolio as they relate to the work of the Health and Safety Group.
- The review undertaken by Internal Audit gave a rating of reasonable assurance for the way the policy framework was being delivered. An action plan has been agreed and will be taken forwards in 2024.
- Policy development and maintenance has been maintained.
- There have been no HSE enforcement activity in 2023.
- Significant work has been completed in developing improved Activity and Incident monitoring data. There is further work planned in 2024 to improve the quality of the data.

- There has been an improvement in reporting rates for areas associated with violence and aggression and an overall improvement in the confidence in using the Datix system.
- Activity and Incident data is overall reasonable. However there has been an increase in physical assaults to staff which remains a concern to the Health and Safety team and the Service Directorates.
- A letter sent to all health Boards in April 2023 outlining the findings of the national HSE review into NHS management of Prevention Management of Violence and Aggression (PMVA) identified universal issues experience by NHS organisations. The Health and Safety Unit worked with ABUHB on a new model for training to improve attendance rates and deliver a more efficient model. A service level Agreement has been agreed and this training will commence in January 2024.
- Despite training spaces being available for PMVA and Moving and Handling, training compliance is below accepted levels and reflects a known issue of M&S compliance within the Health Board. The Health and Safety Unit continues to work with service Directorates and WOD to improve attendance rates.
- There has been a reduction in RIDDOR reported incidents to HSE against the previous three years.
- There were no recorded Health and Safety risks escalated to the corporate risk register by the Health and Safety Group. With risk management being managed by the Service and Administrative Directorates.

The Health and Safety Group Workplan for 2024 will continue with the five themes and is building on a continuous improvement cycle reporting back to the Health and Safety Group and the Executive Committee.

The report notes that there is still much work to be done to increase training compliance and reduce areas of accidents and incidents in particular areas, notably in moving and handling and PMVA training, to complete the action plan resulting from the Internal Audit and maintain the continuous improvement cycle to strengthen occupational health and Safety.

THE PAPER IS ALIGNED TO THE DELIVERY OF THE FOLLOWING STRATEGIC OBJECTIVE(S) AND HEALTH AND CARE STANDARD(S):		
Strategic Objectives:	1. Focus on Wellbeing	✓
	2. Provide Early Help and Support	✓
	3. Tackle the Big Four	×
	4. Enable Joined up Care	×
	5. Develop Workforce Futures	✓
	6. Promote Innovative Environments	✓
	7. Put Digital First	×
	8. Transforming in Partnership	×
Health and Care Standards:	1. Staying Healthy	✓
	2. Safe Care	✓
	3. Effective Care	✓
	4. Dignified Care	×
	5. Timely Care	×
	6. Individual Care	✓
	7. Staff and Resources	✓
	8. Governance, Leadership & Accountability	✓

The following Impact Assessment must be completed for all reports requesting Approval, Ratification or Decision, in-line with the Health Board's Equality Impact Assessment Policy (HR075):

IMPACT ASSESSMENT					
Equality Act 2010, Protected Characteristics:					
	No impact	**Adverse**	**Differential**	**Positive**	**Statement** **This cover paper and the associated Health and Safety annual Report supportive of the Equality Act 2010.**
Age	✓				
Disability	✓				
Gender reassignment	✓				

Pregnancy and maternity	✓				
Race	✓				
Religion/ Belief	✓				
Sex	✓				
Sexual Orientation	✓				
Marriage and civil partnership	✓				
Welsh Language	✓				

Risk Assessment:

	Level of risk identified				
	None	**Low**	**Moderate**	**High**	**Statement** **This cover paper and the associated Health and Safety annual Report supportive of the Equality Act 2010.**
Clinical		✓			
Financial		✓			
Corporate		✓			
Operational		✓			
Reputational		✓			

Powys Teaching Health Board
Health and Safety Group
Annual Report
2023

HEALTH AND SAFETY GROUP (HSG)

The Health and Safety Group is the principle overarching strategic management meeting for the organisation. The groups' purpose, in line with the terms of reference is to

- *"Review and monitor health and safety matters to comply with the Health & Safety at Work Act 1974*
- *Provide the leadership for the development of health & safety within the Health Board."*

The Focus of the Group is Primarily Occupational Health and Safety.

Statutory Compliance Requirements are reported via the Innovative Environments Group, these include, but are not limited to, individual policies for:

- Water Safety
- Piped Medical Gases
- Asbestos
- Fire Safety
- Electrical Safety
- Gas Safety
- Lifts, Lifting Equipment and component parts
- Medical Devices
- Radiation
- Work Equipment

Following organisational change in April 2023 the group has been chaired on an interim basis by the Director of Therapies and Health Sciences (DoTHS) and meets bi-monthly.

Directorate/service group representation has been strong since the changes to the reporting and membership were implemented. The standardisation of the Highlight Reports has provided an improved focus from Service Groups and Directorates and further work has now begun to develop the reporting format further, so that it strengthens the following areas:

- RIDDOR reported incidents from each area.
- Oversight of unmanaged incidents
- Learning from incidents.
- How learning has been disseminated
- Mandatory and Statutory Training compliance.

As well as the specific representatives from across the Organisation, the Group continues to have good attendance from Health and Safety Officers, Medical Devices Manager, Infection Prevention and Control Practitioners, as well as staff side.

Several groups which formally underpin and support the work of the Health and Safety Group, namely Fire Safety Group and Security Oversight Group continue to report via this group. Following the organisational change, the former group is now chaired by the DoTHS, and the latter is chaired by the Assistant Director of Health and Safety and Support Services. Each group has a standardised agenda and a standing reporting item for escalation to the Health & Safety Group (HSG) as required.

Additionally, the HSG receives an update from the Site Co-ordination Forum, which is now chaired on an interim basis by the Assistant Director of Health and Safety and Support Services. Previously this group was chaired by the Director of Environment role which has been removed from the Health Board Management Structure.

Interim Changes to the Chairing of Assurance Groups

Group	**Previous Chair**	**Current Chair**	**Group Reports to**
Health and Safety Group	Director of Environment	Executive Director of Therapies and Health Sciences	Executive Committee
Fire Safety Group	Director of Environment	Executive Director of Therapies and Health Sciences	Health and Safety Group
Security Group	Director of Environment	Assistant Director Health and Safety	Health and Safety Group

		and Support Services	
Site Coordination Forum	Director of Environment	Assistant Director Health and Safety and Support Services	Health and Safety Group

The Health and Safety Policy outlines the nominated lead Director roles which were changed in 2023 on an interim basis as outlined below.

Interim Nominated Lead Directors are as follows:

- Fire Safety – Executive Director Therapies and Health sciences (Interim)
- Medical Gases - Associate Director of Capital, Estates and Property
- Asbestos – Associate Director of Capital, Estates and Property
- Electrical Safety - Associate Director of Capital, Estates and Property
- Water Safety – Associate Director of Capital, Estates and Property
- Radiation – Director of Therapies & Health Sciences (no change)
- Civil Contingency & Emergency Planning – Director of Public Health (no change)
- Corporate Risk – Board Secretary (no change)
- Site Co-ordinators - Executive Director Therapies and Health sciences (Interim), delegated to Assistant Director Health and Safety and Support Services.
- Infection Control and Prevention – Executive Nurse of Director (no change)
- ICT equipment, Infrastructure and Maintenance, ensuring that all the equipment meets the current requirements for Health and Safety – Finance Director. (no change)

HEALTH AND SAFETY GROUP WORK PLAN for 2023/24

The HSG work plan 2022/23 followed the fiscal year and was completed and reported to the May meeting. The HSG implemented a new work planning 2023/24 to focus on the core areas designed to provide focus based on risk and assist in targeting the limited resources of the small health and safety unit.

HSG workplan aims provide focus for the work of the Group based on the commonly occurring themes arising from field work, training compliance or issues reported to the Group, namely:

- HSG to get assurance through reporting of compliance with Policy and of effectiveness of procedures.
- HSG aims to ensure that the Datix system becomes the primary recording tool for Health and Safety incidents and accidents across the organisation.
- HSG to get assurance that Services develop and maintain departmental training needs analysis, identifying mandatory Health and Safety training for all employees within their area.
- HSG to strengthen the environmental inspection regime across the Health Board.
- Undertake an external baseline assessment of the Health Boards position in relation to the Dangerous Substances and Explosive Atmospheres Regulations 2002.

The annual plan is reviewed formally at each Health and Safety Group meeting and is made up of the following subject areas, with various pieces of work within those categories.

The workplan covered:

1. Assurance and Reporting Arrangements

Assurance and Reporting Arrangements

Internal Audit Review of Health and Safety Arrangements

An Internal audit was conducted in November 2023 and reported back in December 2023.

Purpose: The overall objective of the audit was to review and assess the adequacy of the processes in place within the Health Board to ensure compliance with Health & Safety legislation.

The internal audit provided an overall rating of Reasonable Assurance but identified training as providing limited assurance, due to the challenges in delivering the training as outlined in the Health and Safety Policy, which due to challenges with workforce vacancies may be unsustainable.

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

	Objectives	Assurance
1	The Health Board has health and safety policies in place which comply with the requirements of health and safety legislation. The policies are accessible to staff	Substantial
2	Training requirements and needs have been identified for staff. Training is undertaken and up to date	Limited
3	The health board has an appropriate structure to manage health and safety responsibilities and governance arrangements are in place for the regular monitoring and reporting of health and safety matters	Reasonable
4	Health & Safety risks are appropriately assessed and there is an up-to-date health and safety risk register in place	Substantial

The matters requiring management attention include:

- Improving the processes in place for the identification of health and safety training requirements to ensure that all staff receive appropriate training.
- Establish a training matrix for Health and Safety training.
- Clarifying the Committee reporting structure for the Health & Safety Group.
- Formalising the monitoring and reporting arrangements for Health & Safety Training.
- The Health and Safety Unit have been tasked to review the organisations Health and Safety Training requirements and will use the Health and Safety Executive Five Step Approach and report back in June 2024.

The Health and Safety Executive five-step approach:

- Decide what training your organisation needs.
- Decide your training priorities.
- Choose your training methods and resources.
- Deliver the training.

- Check that the training has worked.

Policy Development

During 2023 a new Personal Protective Equipment Policy was developed to strengthen the existing Health and Safety Policies which are detailed below.

Number	**Policy Title**	**Status**
PTHB HSP001	Health & Safety Policy	Current
PTHB HSP002	Health and Safety Local Implementation Procedure	Current
PTHB HSP003	Manual Handling Policy	Current
PTHB HSP004	Hand Arm Vibration	Current
PTHB HSP005	Violence and Aggression Policy	Current
PTHB HSP006	Lone Working Policy & Procedure	Current
PTHB HSP007	Display Screen Equipment Policy (DSE)	Current
PTHB HSP008	Management of Contractors	Current
PTHB HSP010	New and Expectant Mothers Policy and Procedure	Current
PTHB HSP011	Stress Management Policy (Wellbeing in the Workplace)	Current
PTHB HSP012	The Control of Risks at Work to Young Persons Policy and Procedure	Current
PTHB HSP013	Control of Substances Hazardous to Health (COSHH) Policy & Procedure	Current
PTHB HSP019	First Aid at Work Policy	Current
PTHB HSP021	Reducing False Alarms Procedure & Guidance	Current
PTHB HSP022	Fire Risk Assessment Procedures and Guidance	Current
PTHB HSP023	Arson Prevention Procedures	Current
PTHB HSP024	Emergency Evacuation of Disabled Persons	Current
PTHB FTP 005	Security Protective Measures Policy	Current

Health and Safety Executive Activity

The Health and Safety Executive (HSE) is Britain's national regulator for workplace health and safety. They aim to influence change and help organisations manage risks at work. These include:

- providing advice, information and guidance
- raising awareness in workplaces by influencing and engaging
- operating permissions and licensing activities in major hazard industries
- conducting targeted inspections and investigations
- taking enforcement action to prevent harm and hold those who break the law to account.

There was no enforcement by HSE activity in 2023.

In 2023 there were no FFI received. The Fee For Intervention (FFI) in 2023 was £166.00 and is applied to the organisation if HSE identify a material breach of health and safety law because of a direct inspection or as a separate findings during a routine visit or inspection.

Enforcement Record

Type of HSE Enforcement Action	2019	2020	2021	2022	2023
Prosecution					
Prohibition Notice					
Improvement Notice					
Fee for Intervention (FFI)					

Previous HSE Enforcement

HSE Activity	Reason	Action Completed

2019	FFI Manual Handling	Revision of the Manual Handling training and reporting arrangements. Improved reporting instigated with compliance rates reported by each service via the Health and Safety Group.
2019	Legionella Improvement Notice	Action plan implemented with oversight from the Executive Committee. New documentation, systems and compliance audits put into place. Water Safety Group monitors activity regarding legionella assessments. Live Water Safety Plan created. Annual Compliance Report reviewed via the Delivery and Performance Committee.
2021	Hand Arm Vibration Syndrome (HAVS) Improvement Notice	Revisions to the Occupational Health Assessment and Management. New HAVS Policy created and implemented. Removal of machinery which have a high HAVS risk. All relevant equipment checked for HAVS risks. New Training requirements for roles and tasks created. HAVS compliance is monitored via Health and Safety Group.
2022	Hand Arm Vibration Syndrome (HAVS) Prosecution	

<u>Ionising Radiation</u>

The Powys Teaching Health Board (PTHB) Radiology service operates in collaboration with Radiation Protection Adviser's (RPA) and Medical Physics Expert's (MPE) who are appointed in writing from the Director of Therapies and Health Science (DOTHS) as per the Ionising Radiation safety policy Rad 002. The MPEs/RPA from Velindre Medical Physics, Swansea Bay Medical Physics and North Wales Medical Physics support Brecon, LLandrindod Wells, Ystradgynlais, Machynlleth, Welshpool and Newtown, respectively. Each Radiology/Dental/ Theatre department in PTHB has a Radiation Protection Supervisor (RPS) appointed in writing.

Prior to the RPC, the radiation safety and operational policies (RAD 002, RAD 004), local rules and radiation risk assessments are circulated for

comments, reviewed in line with the review dates, then presented to the RPC whereby they are ratified.

Regulatory audits are performed typically in quarter 2 in preparation for the annual Radiation Protection Committee (RPC) which is chaired by the DOTHS. Each RPS presents their report for their specific radiology/ dental/ and theatre department at the RPC, escalating or giving assurance regarding Quality Assurance (QA), service, audit, radiation incidents/ monitoring/ compliance.

The local radiology risk register is maintained in a timely manner, is in date and any risks identified 9 or above are escalated to the Community Service Group (CSG) risk register. This risk register is also shared with the DOTHS on a quarterly basis. Currently, there is one risk in the red category regarding the lack of a capital financial solution to purchase the essential Digital Radiology equipment associated with the implementation of the Radiology Informatics System Procurement programme when the Fuji contract ends in 2027.

The Personal Dosimetry policy is in place and has recently been reviewed. There are no recorded radiation doses to staff to date, with all staff badge monitors recording 0.00mSv (dose below recording level). There were six reportable radiation incidents pan Powys, relating to patients either being X-rayed on the wrong side or relating to equipment malfunction, none of which exceeded the threshold dose to be externally reportable to Health Inspectorate Wales (HIW), they were reported to the MPE's following PTHB procedure.

The radon report from the meeting of the Estates Compliance Group (ECG) was presented to the RPC, which advised there have been some changes to the radon map, which have now been taken into consideration when conducting the surveys and all sites are now being evaluated for radon. Five sites have mitigation units, and they are all operating correctly.

The governance structure for Radiology is as follows; there are quarterly meetings for radiology governance, and biannual Radiation Images Optimisation Team (RIOT) meetings which report to the RPC. The date of the last RPC was 19th October 2023. The next annual RPC is scheduled for 14th November 2024. The overarching RPC outcome report is presented to the execs in Quarter 4 by the DOTHS.

Asbestos

Asbestos can be found in several products including pipe lagging, wall insulation, false ceiling tiles, sprayed onto steelwork, external roofing material, guttering and down pipes, floor tiles, lining in fire doors, ovens and gaskets, and as textured ceiling coatings (Artex). The supply and use of asbestos was prohibited in 1999, therefore any buildings built after this period should not contain asbestos. But buildings built before 1999 (particularly between 1950 and 1970) will probably contain asbestos. Powys Health Board has a significant proportion of older estate which will have asbestos integrated into the buildings. Asbestos compliance is managed via the Estates team and reported to Board on an annual basis as part of a dedicated Asbestos Annual Report.

PTHB undertakes asbestos inspections on an annual basis. All relevant PTHB buildings have been surveyed to identify, where reasonably practicable, the presence, extent and condition of asbestos containing materials. The surveys are undertaken and reported by an accredited consultant, in accordance with HSE guidance.

The Health and Safety Unit are active members of the Asbestos Compliance Group which reports to the Estates Compliance Group and have created a dedicated resource page where staff can access the PTHB Guide to Asbestos in the Workplace.

There have been no asbestos related incidents reported to the Health and Safety Unit in 2023. The current Asbestos Management Policy which directs the working arrangements was updated in 2022 and will remain in place until 2025.

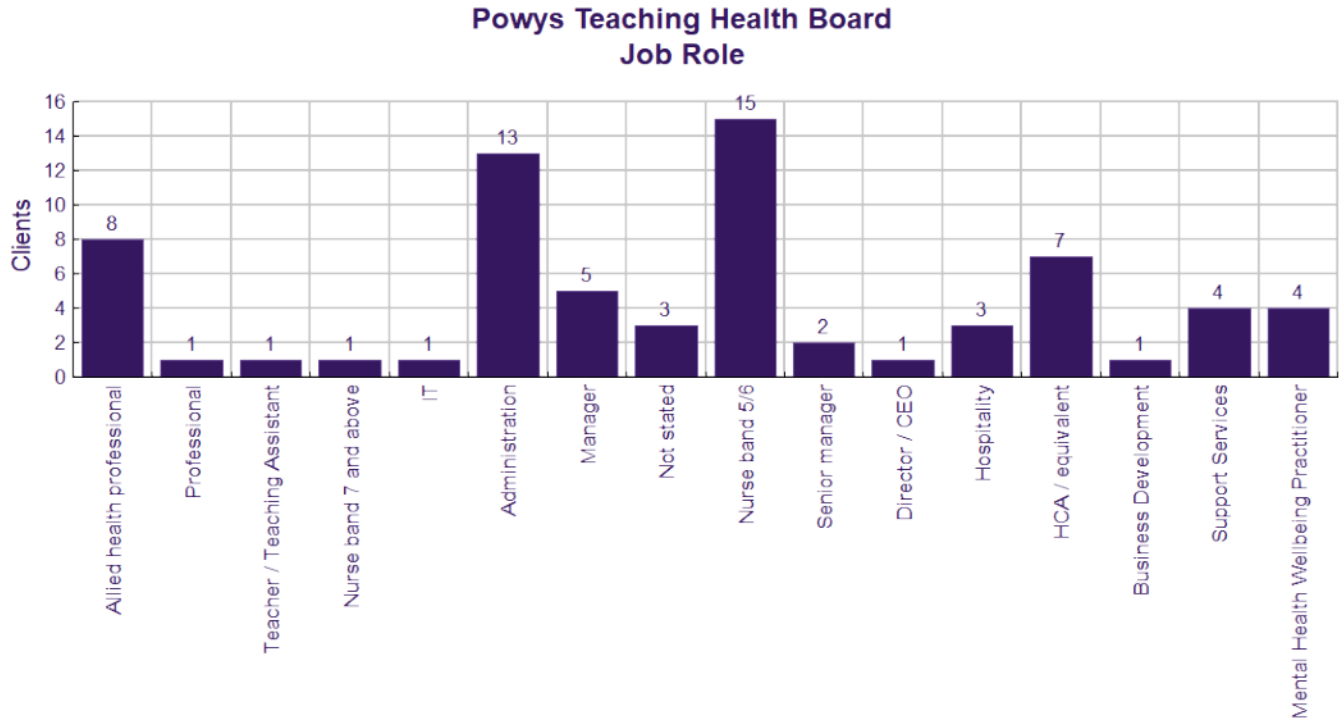
Work Based Stress

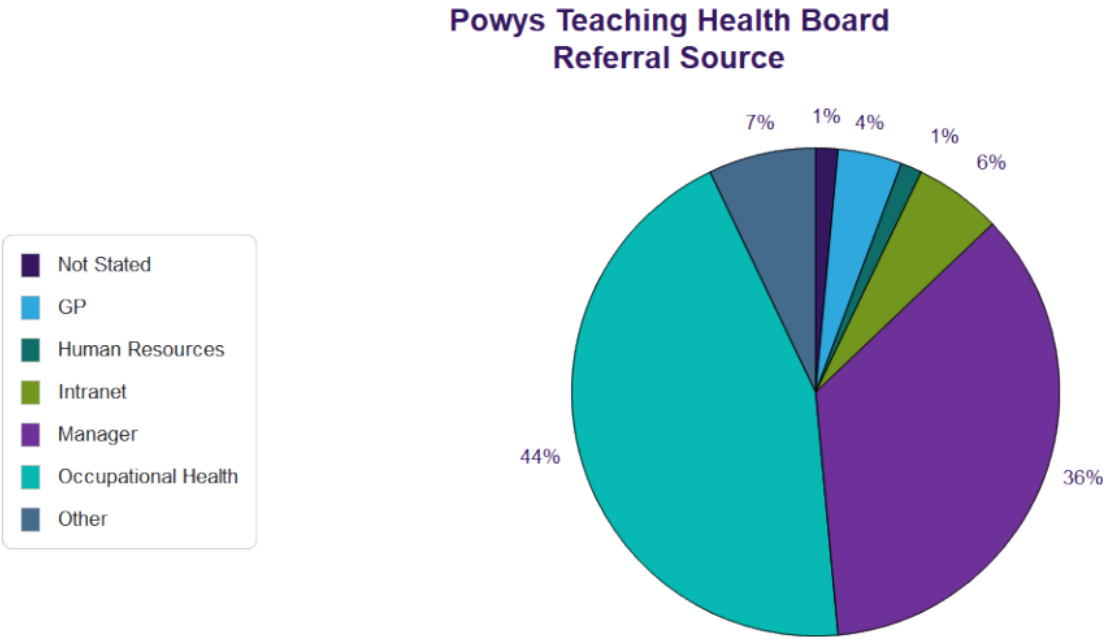
Version nine of the Stress Management and Wellbeing Policy in the Workplace was reviewed in 2022 is in date. Stress and anxiety remain one of the highest reported reasons for staff absence. Workplace stress is attributed to the busy operational environments staff work in. However, some stress has its root in issues and anxieties that fall outside the workspace.

The Occupational Health department provide an update to the Health and Safety Group on the activity and trends reported to them relating to work-based stress and wellbeing through their Employee Assistance Programme. This provides the following:

- 24-hour, 7 day a week, confidential help line 365 days a year.
- Face to face and virtual counselling.
- Self-help books and downloads.
- Podcasts and blogs.
- Debt and utility payment advice
- Domestic abuse
- Benefit advice

Referrals to the Service.





Managers have an important role to play in supporting staff that are experiencing mental health problems. This involves supporting employees in the workplace and supporting them back to work after a period of absence. Managers have shown to have a huge impact on supporting their staff by communicating, listening, being open to adjustments where required and by providing support and signposting as necessary. Line manager training enables managers to initiate conversations with their employees, facilitate reasonable adjustments/return to work meetings and to identify signs of mental health issues to signpost them into the EAP service.

2. Achieving H&S excellence in reporting incidents and learning

Achieving H&S Excellence in Reporting Incidents and Learning

Accidents and Incidents

A fundamental role of the HSG is to monitor and review learning from accidents and incidents. A summary report is provided at each meeting with details of incidents at departmental level. Work has been undertaken during the year to improve the data quality in the Datix reporting system.

Discussion at HSG focuses on ensuring robust review at departmental level of the incidents and ensuring closure and learning. Review of data output from Datix is also assisting in improving the quality of the data input.

The Health and Safety Group monitor several Occupational Health and Safety Incident Types.

The data is taken from the new Once for Wales Datix system which can now provide two full years of consistent data.

Accident or Injury comparison table 2022 and 2023

Stay the Same or improved ✓ Deteriorated ✗

Description	Group	2022	2023	Position
Burns or scalds.	Patient/Service User	10	4	✓
	Public/Visitors	0	0	✓
	Staff / Contractors	3	8	✗
Contact with or exposure to hazardous substance.	Patient/Service User	0	2	✗
	Public/Visitors	0	0	✓
	Staff / Contractors	1	1	✓
	Patient/Service User	1	2	✗

Contact with Needles or Medical Sharpes	Public/Visitors	1	0	✓
	Staff / Contractors	18	12	✓
Entrapment / Drawn in.	Patient/Service User	1	2	✗
	Public/Visitors	0	0	✓
	Staff / Contractors	6	0	✓
Environmental hazards / issues.	Patient/Service User	8	7	✓
	Public/Visitors	1	1	✓
	Staff / Contractors	13	9	✓
Manual Handling - Non patient/service user handling.	Patient/Service User	0	1	✗
	Public/Visitors	0	0	✓
	Staff / Contractors	9	8	✓
Manual Handling - Patient/service user handling.	Patient/Service User	7	13	✗
	Public/Visitors	0	0	✓
	Staff / Contractors	9	5	✓
Non-medical equipment.	Patient/Service User	0	0	✓
	Public/Visitors	0	0	✓
	Staff / Contractors	1	4	✗
Personal protective equipment (PPE)	Patient/Service User	0	0	✓
	Public/Visitors	0	0	✓
	Staff / Contractors	0	0	✓
Road Traffic Collisions.	Patient/Service User	2	2	✓
	Public/Visitors	4	0	✓
	Staff / Contractors	6	2	✓

Slips/Trips/Falls.	Patient/Service User	441	445	✗
	Public/Visitors	6	2	✓
	Staff / Contractors	29	15	✓
Struck against or by an object.	Patient/Service User	5	10	✗
	Public/Visitors	2	3	✗
	Staff / Contractors	12	13	✗

Threatening and Non-Threatening Behaviours Associated Report

Comparison Table 2022 and 2023

Stay the Same or improved ✓ Deteriorated ✗

Description	Group	2022	2023	
Absconding or missing service user	Patient/Service User	31	12	✓
	Public/Visitors	0	0	✓
	Staff / Contractors	0	0	✓
Aggressive/threatening behaviour	Patient/Service User	61	38	✓
	Public/Visitors	3	2	✓
	Staff / Contractors	61	59	✓
Harassment	Patient/Service User	8	1	✓
	Public/Visitors	0	0	✓
	Staff / Contractors	0	4	
Patient clinically challenging behaviour	Patient/Service User	3	2	✓
	Public/Visitors	0	0	✓
	Staff / Contractors	4	10	✗
	Patient/Service User	30	41	✗

Physical assault (physical contact)	Public/Visitors	0	4	✗
	Staff / Contractors	30	70	✗
Verbal Assault (All types)	Patient/Service User	1	2	✗
	Public/Visitors	1	0	✓
	Staff / Contractors	1	18	✗
Self-Harm Injurious Behaviours	Patient/Service User	45	61	✗
	Public/Visitors	0	0	✓
	Staff / Contractors	0	0	✓

Reporting of Injuries, Diseases Occurrences Regulations (RIDDOR)

Resources are provided for managers on the Health and Safety Resource pages relating to Accidents, Incidents and Reporting of Injuries, Diseases Occurrences Regulations 2013 - (RIDDOR). In Powys, all reports are entered by services via Datix, and these are then reviewed by the Health and Safety Unit for action and investigation. Where the incident meets the requirements for reporting to the Health and Safety Executive, they are then termed a RIDDOR.

Numbers for Powys are low and consistent with the type of services we provide and small staff, patient, visitor and contractor numbers.

Reported Date

Cause of RIDDOR	2019	2020	2021	2022	2023	Totals
Slip, Trip, Fall	2	1	3	3	0	**9**
Fall from Height	1	0	0	2	0	**3**
Manual Handling	0	2	2	1	1	**6**
Injury at Work	0	1	1	1	1	**4**
Physical Assault	1	0	0	1	3	**5**
Repetitive Strain	0	0	1	0	0	**1**
Hand Arm Vibration	0	4	2	2	0	**8**
Electrocution	0	0	0	1	0	**1**
Chemical Incident	0	0	0	0	1	**1**
Road Traffic Collision	0	0	0	0	1	**1**
Total	**4**	**8**	**9**	**11**	**7**	

Trends and Themes from the Accident and Incident data

Several key themes have been identified and are being managed by the Health and Safety Group which are summarised in the table below:

- Increase in reports of physical assault with physical contact.
- Trend of attempted self-harm using same types of clothing which has been subject to a spotlight review.
- Training and attendance rates
- Quality of Datix reports and closure of incidents.

Spotlight Review

When a recurring theme is identified a formal Spotlight review is undertaken. This is a new process introduced for this year.

A Spotlight Review is provided by the Powys Health and Safety Unit working with managers, clinicians, teams with the following aims:

- look at an issue from the perspective of risk management, prevention and improvement.
- raise awareness and share learning.
- explore ways to prevent harm.
- Create local action plans.

The focus for a Spotlight presentation is triggered by:

- An increase in Datix or RIDDOR reports which fall under an area of enforcement by the Health and Safety Executive
- In response to a published enforcement or a change in regulation.
- In response to an inspection by the Health and Safety Executive.
- In response to audit results.

Prevention Management of Violence and Aggression (PMVA)

HSE wrote to each Health Board and NHS Trust in March 2023 outlining the findings of their thematic review into prevention and management of violence and aggression.

The common feature identified by the HSE review where contraventions were identified were failings of the management systems and relate to the following four categories:

- Risk Assessment
- Training
- Roles and Responsibilities
- Monitoring and Review

The Health and Safety Team consider the PMVA as an area of continuous improvement activity due to the changing nature of the pressures on the system and legislation.

Current Work being undertaken to improve PMVA.

Following a review with stakeholders across the organisation following priority areas have been identified in 2023 for PMVA training.

Staff Group	Training Type
MH Inpatient ward staff	Module D
Community Mental Health Teams	Module D
CAMHS	Module D
MH Bank Staff	Module D
LD Teams	Breakaway
MH Medical staff	Breakaway
Domestics working in MH inpatient wards	Breakaway
Porters working in MH Inpatient Wards	Breakaway
MIU	Breakaway
District Nurses	Breakaway
As per risk assessment for remaining groups	Breakaway

It is recognised that the current training model of 4 foundation and 10 refresher training sessions for the mandatory Module D should meet the training requirements of staff.

However, a further review undertaken in partnership with the Mental Health and learning Disabilities Service has identified that the current model is not

effective in providing training, as the operational teams cannot be released in the numbers required to make the courses viable and there is a reliance agency staff to back fill training, which increases risks for patient care and is very expensive.
In 2023 Powys Teaching Health Board and Aneurin Bevan University Health Board (ABUHB) started to explore options to provide more flexible training provision for the service in partnership. The aim was to improve access for operational services with a more flexible training model. The model for training has been agreed and will commence in January 2024.

The review also identified that the Health Board should work with stakeholders to review the roles and responsibilities for PMVA and how these are referenced in the polices**.**
In line with the Welsh Government guidance 'Reducing restrictive practices framework 2022' a further revision of the policy framework is being undertaken, to strengthen this area for staff working within the Health Board.

The Prevention Management of Violence and Aggression advisory role undertaken by the Health and Safety Unit monitors activity trends and acts as a key liaison role between staff, social service and the police.
The Health and Safety Dashboard has been developed in the Datix system to provide improved data and direct access for RIDDOR Reporting and PMVA activity.

<u>Hand Arm Vibration Syndrome</u>

Hand Arm Vibration Syndrome (HAVS) is a reportable work-related disease, caused by excessive exposure to vibration over time, whilst using handheld or guided vibratory work equipment, causing damage to the nerve, vascular systems in the hands and arms along with muscular skeletal effects of the disease.

In May 2020, the Health & Safety Unit were informed that during routine health surveillance one of the Estates Operatives had been diagnosed with HAVS due to exposure to vibration at work over several years. This diagnosis was reported to the Health and Safety Executive (HSE), as an Occupational Disease, in line with RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) processes. There have been additional members of staff diagnosed with HAVS since the initial numbers and as of January 2023, a total of 8 members of staff have been diagnosed with HAVS and reported to HSE.

An updated HAVS training strategy was developed and implemented in 2023, including a new policy and training. The current training approach has ensured all relevant staff are now trained and none are due for renewal until 2024.

3. Creating H&S culture by Training and Development

Creating Health and Safety Culture by Training and Development

During 2023 the organisation provided a range of training relating to Health and Safety

Health and Safety Training Delivered:

- IOSH Leading Safely,
- IOSH Working Safely, one day courses IOSH Working Safely as part of ILM level 5 Leadership and Management Course.
- Mandatory Level 1 Health and Safety e-learning package for all staff

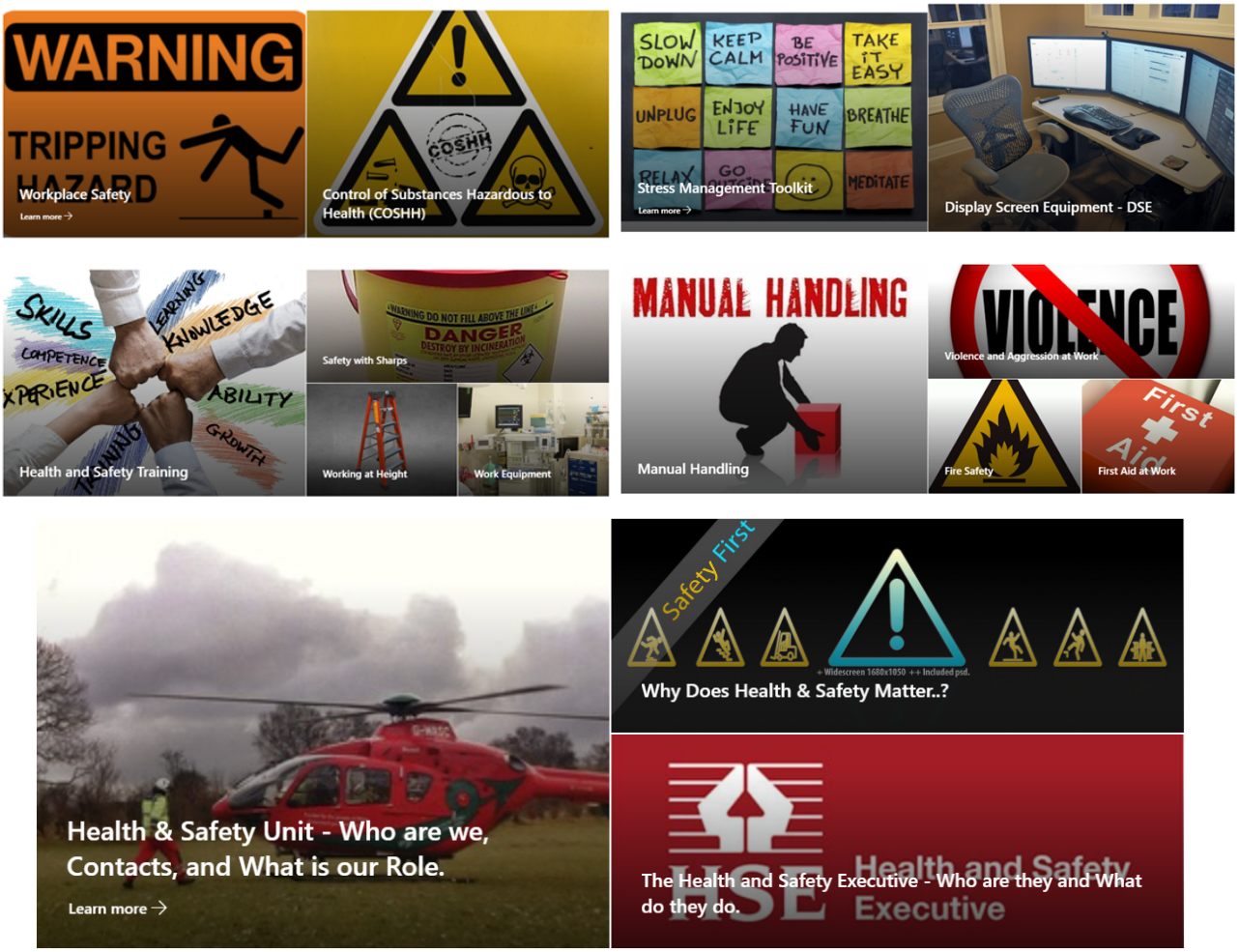
In 2023 services across the organisation provided training in specific subjects to promote and maintain health and safety within the workforce.

- Corporate Induction - Health and safety forms part of the corporate induction day. A 30-minute H&S awareness session is being delivered, covering the following areas: H&S Responsibilities, V&A, Manual Handling, Fire Safety, Lone working, Driving for work, DSE assessments and Datix reporting.
- Specialist training for 'Authorised and Responsible' staff with prescribed roles, under requirements set out under Health Technical Memorandums
- Patient Handling and Object Handling
- Manual Handling for Managers
- Fire Safety courses
- Fire Warden and Fire Incident Coordinator Training
- Toolbox talks are short talks or presentations on specific Health and Safety subject or task.
- Datix Manager Training
- How to submit an incident on Datix training
- Personal Protective Equipment - COVID 19 Training
- Specific training on identified equipment such as the robotic mower.
- Investigation and Root Cause Analysis Training

Health and Safety – Corporate Web Page and Move to SharePoint

A key element of the role of the health and safety function is to support the understanding and awareness of health and safety issues, but most importantly, how local teams can manage such matters. A completely new website has been constructed, implemented and promoted in 2023. This is updated continually as Health and Safety evolves and contains advice, guidance on several health and safety subjects along with easy-to-follow videos on risk assessment and lone working. All H&S template documents are available through the web site and SharePoint. This site acts as a one stop shop resource page for leaders, managers and staff.

Example from the Health Board Health and Safety Resource Pages



4. Achieving Excellence in Training Compliance

Achieving Excellence in Training Compliance

<u>The main Health and Safety Training Compliance Risks</u>

The Health and Safety Group redesigned its Directorate Report template in 2023 to include a standardised report for monitoring Statutory and Mandatory Training Rates.

Training compliance rates are reported through several Groups and Committees within the Health Board. The key challenge reported in the early part of 2023 was the ability of departments to release staff to catch up with training after the pandemic.

Health and Safety Statutory and Mandatory Training rates

Competency Name	Assignment Count	Required	Achieved	Compliance %
Manual Handling for Managers - No Renewal	236	236	172	72.88%
Moving and Handling - Level 1 - 2 Years	819	819	688	84.00%
Moving and Handling - Level 2 - 2 Years	1555	1555	1192	76.66%
Violence and Aggression (Wales) - Module B - 3 Years	2120	2120	1984	93.58%
Violence & Aggression Module D - 1 Year	74	74	40	54.05%

Health and Safety Unit

The Health and Safety Team is led by the Assistant Director of Health and Safety and Support Services and consists of two full time Health and Safety Officers who are Chartered Members of the Institution of Occupational Safety and Health (IOSH) the chartered body for health and safety professionals. The two officers are supported by the Prevention Management of Violence and Aggression (PMVA) and Manual Handing trainer/advisers and part time administration support.

As part of the work to strengthen the Health Boards awareness of Health and Safety, its role has been re defined during 2023 and the team are now referred to as the Health and Safety Unit.

The Health and Safety Unit provides a corporate function and is currently hosted by the Directorate of Therapies and Health Sciences.

The role of the Health and Safety Unit is to:

- Provide impartial expert and specialist advice on all health and safety matters across the Health Board.

- Provide guidance and advice on health & safety management, professional and technical advice along with support at all levels within the organisation.

- Provide professional guidance and technical support to assist managers in their duties of implementing PTHB's health & safety policies at a directorate and service level.

- Provide advice and support in relation to risk assessments.

- Undertake audits and inspections as part of the assurance and compliance monitoring arrangements of the Health Board.

- Conduct and assist in incident/accident investigations, where appropriate.

- Representing PTHB at the All Wales NHS Health & Safety Managers group and subgroups.

- Consulting and liaising directly with the enforcement authorities on behalf of PTHB.

- Contributing to the development of a positive health and safety culture for the organisation.

- Where work practices have been identified as dangerous and placing persons at risk of harm, to intervene and control the risk to ensure persons are protected; and then to report and escalate the issue to the relevant Manager or Director.

Health and Safety Unit Budget

All Health and Safety posts were fully funded for the fiscal year 2023/24. The Health and Safety Training budget was increased from £6000 to £25,000 for the year 2023, which covered most of the training costs.

Specialist Training delivered by the Health and Safety Officers

Staff Group	Face Fit Testing Type 1 (2 Years)	Face Fit Testing Type 2 (2 Years)	Face Fit Testing- Non-licensed Asbestos Management (2 Years)	HAVS Awareness Training - Level 3 (3 Years)	HAVS Management Essentials Training (3 Years)	Medical Gas Safety for Porters (1 Year)
Scientific and Technical Group	4	10				
Additional Clinical Services	65	68				
Administrative and Clerical	3	3		3	10	1
Allied Health Professionals	12	6				
Estates and Ancillary		19	19	158	15	37
Healthcare Scientists	2					
Medical and Dental	4	10				
Nursing and Midwifery	76	93				
Total	**166**	**209**	**19**	**161**	**25**	**38**

Toolbox Talks

In addition to the Statutory and Mandatory training, both Estates and Support Services provide competency training via 'toolbox talks.' Toolbox talks are informal group discussions that focus safety issues. Use of toolbox talks help to promote department safety culture and start health and safety discussions within the team.

There are 62 separate general toolbox talks in use and 10 bespoke ones which are delivered on an annual basis to staff according to their job role and requirements.

Manual Handling Training

To support the ongoing local management and compliance for staff relating to manual handling, the work for 2023/24 has included a specific focus on manual handling involving the introduction and training of manual handling link workers as identified in a Health and Safety Executive (HSE) Notification of Contravention in 2019. To date nine link workers have been trained and are directly supporting their work environment.

The training is delivered in line with the All-Wales NHS Passport scheme and the standards contained therein, this is currently version 3, 2020.

The All-Wales NHS Manual Handling Training Passport and Information Scheme (Passport Scheme) was developed by the All-Wales NHS Manual Handling Group. It was originally launched in 2003 with endorsement from the Welsh Government, NHS Wales and the Health and Safety Executive. After several minor reviews in the intervening years, a comprehensive review was undertaken in 2013-2014 to consider changes to the structure of the NHS in Wales: to ensure learning objectives are relevant, measurable, and achievable; so that the revised Passport Scheme continues to reflect best practice and meets the requirements of NHS organisations in Wales.

The Moving and Handling training aims to plan training on a six-month basis to meet the needs within the organisation and can add more moving and handling courses that may be required. There have been some limitations on training during 2023 due to access to training rooms on the Bronllys and Llanidloes Sites. The Health Board is opening much needed additional training venues in Llandrindod in 2024, which is expected to improve the availability for training spaces.

Moving and Handling Training delivered in 2023.

Moving & Handling Courses Breakdown - 1st January - 31st December 2023		
Course	**Number of courses**	**Number attended**
1 Day Refresher	43	245

2 Day Foundation	35	210
Object/Load	56	296
Managers Module G	17	17
Totals	**151**	**768**

Prevention Management of Violence & Aggression Training

As noted above an update on the challenges in delivering PMVA training was received by the Health and Safety group during the year with compliance rates dropping to 45 % by the end of 2023. This was in part due to due to the difficulties in releasing staff to attend the training dates provided, the loss of the training room for refurbishment and the delay in securing an out of county Health Board provider.

During 2023 the training for prevention and management of violence and aggression was provided by external training contractors to cover the planned leave of the dedicated trainer. Work has been ongoing with Aneurin Bevan University Health Board since the Summer and has been finalised by the end of 2023 with both Health Boards collaborating to provide PMVA training in 2024.

Training delivered in 2023.

PMVA Courses Breakdown - 1st January - 31st December 2023		
Course	**Number of courses**	**Number attended**
4 Day Foundation	3	13
2 Day Refresher	10	61
1 Day Breakaway	13	78
Totals	**26**	**152**

5. Strengthen Inspection

Strengthen Inspection

Risk Assessments & Audits

Assessing and managing risks within departments is one of the most fundamental elements of health and safety. In 2022 the Health and Safety Unit commenced a programme of auditing twenty teams across various departments in Support Services, Estates, Workforce and OD, Women and Childrens Service Group and Community Services Group. Where deficiencies/non compliances were identified, a written report was provided to each service and a local action plan developed. The findings of the audits were reviewed by the Health and Safety Group which accepted the key learning which was in the areas itemised below.

The modules audited.

- Driving for Work
- Lone Working
- Display Screen Equipment
- Violence and Aggression
- Manual Handling
- Workplace Stress

During 2023 the services have worked on their local improvement plans as part of a continuous improvement cycle.

7 Module Audit key learning

Key Learning	Action Implemented
Gain assurance from those departments not audited, that they have the necessary audits in place.	On going - All Directorates are required to provide an update and assurance to Health and Safety Group on their compliance.
Improve access to information and awareness of the relevant H&S advice and policies for each module.	Develop dedicated resource pages on the Health and Safety Resource Site. This has been completed and pages can be accessed here, Health and Safety (sharepoint.com)
Strengthen knowledge and practical skills in risk assessment.	Improved information available for teams via the Health and Safety resources pages

Strengthen managers awareness of their responsibilities in the Health and Safety Policy.	Health and Safety Unit strengthen awareness and advice to managers, promoting the use of site support and access to the online resource pages.
Enable departments to undertake their own audits and report these back to their Directorate Management teams.	Health and Safety Unit are developing audit tools which departments can use to check their compliance on a range of Health and Safety responsibilities.

CORPORATE HEALTH AND SAFETY RISKS

In 2023 There were no Health and Safety Risks escalated to the Corporate Risk Register.

Risks held on local Directorate Risk Registers are reviewed by the Directorate Management teams on a regular basis and escalated to the Health and Safety Group as required.

LOOKING AHEAD 2024/25

The Health and Safety group Workplan for 2024 will maintain five themes and the continuous improvement cycle reporting back to the Health and Safety Group and the Executive Committee.

A dedicated work programme for the Health and Safety Unit has been drawn up which continues the focus on the themes of the previous year with the addition of:

- Scoping a dedicated system to enable risk assessments to be created and stored and audits to be completed by departments. The aim of this system is to dramatically improve the oversight and reporting of compliance and risk in respect to health and safety issues across the organisation.
- Develop an App to enable staff to access the Health and Safety Resources pages via their mobile phone when working in the community.
- Strengthening the safety culture of the organisation by promoting more resources, awareness sessions and support to managers.

- Piloting the IOSH Managing Safely, three-day course to senior managers directly involved with responsibilities of the Health and Safety function.

CONCLUSION

Powys Teaching Health Board is committed to ensuring the health, safety and welfare of all our employees, and those who may be affected by our work activities or undertakings. Furthermore, ensuring that those who are engaged to carry out work on our premises, and/or on our behalf are also committed to ensuring the health and safety of their employees and others. The revised Health and Safety Policy Framework implemented in 2022 has strengthened the Health Boards Health and Safety Management System and was given a rating of reasonable assurance by the internal audit team. The improvement in reporting of accidents and incidents and access to training and resources is helping to improve the Health and Safety Culture of the organisation.

There is still much work to be done to increase training compliance and reduce areas of accidents and incidents in particular areas, notably in moving and handling and PMVA.

The work plan now established by the Health and Safety Group will continue this work into 2024 to ensure that a positive Health and Safety culture continues to develop.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 2.10

DELIVERY & PERFORMANCE COMMITTEE	**Date of Meeting: 29 February 2024**
Subject :	**Estates Compliance**
Approved and Presented by:	Wayne Tannahill, Associate Director Capital, Estates and Property
Prepared by:	Wayne Tannahill, Associate Director Capital, Estates and Property
Other Committees and meetings considered at:	Estates Compliance Group: 15 February 2024 Executive Committee: 21 February 2024

PURPOSE:

This paper provides information which sets out the principles of Estates Compliance and the approach to 'assurance' in Powys Teaching Health Board in the context of an aging estate. A presentation has been prepared to compliment the paper.

RECOMMENDATION(S):

The Committee is asked to:

- **RECEIVE** the report on the approach to Estates Compliance taking **ASSURANCE** an appropriate system is in place.

Approval/Ratification/Decision[1]	**Discussion**	**Information**
✖	✓	✓

1 Equality Impact Assessment (EiA) must be undertaken to support all organisational decision making at a strategic level

THE PAPER IS ALIGNED TO THE DELIVERY OF THE FOLLOWING STRATEGIC OBJECTIVE(S) AND HEALTH AND CARE STANDARD(S):		
Strategic Objectives:	1. Focus on Wellbeing	×
	2. Provide Early Help and Support	×
	3. Tackle the Big Four	×
	4. Enable Joined up Care	×
	5. Develop Workforce Futures	✓
	6. Promote Innovative Environments	✓
	7. Put Digital First	×
	8. Transforming in Partnership	✓
Health and Care Standards:	1. Staying Healthy	×
	2. Safe Care	×
	3. Effective Care	×
	4. Dignified Care	×
	5. Timely Care	×
	6. Individual Care	×
	7. Staff and Resources	✓
	8. Governance, Leadership & Accountability	✓

EXECUTIVE SUMMARY:

Estates Compliance describes a range of activities related to the use, occupation and maintenance of land and buildings, which are governed by legislative requirements.

The paper (and associated slide deck/presentation) identifies the statutory and regulatory requirements which apply to all premises, but also those which apply specifically to 'healthcare' and how these additional obligations are supported and monitored by NHS Wales Shared Services Partnership – Specialist Estates Services (NWSSP-SES).

'Compliance' is a principle which provides assurance in respect of health and safety and the legislation is largely driven by The Health and Safety at Work etc. Act 1974 and Management of Health and Safety at Work Regulations 1999. This means that enforcement is enacted by the Health and Safety Executive but also by Regulatory bodies for other industry specific areas of activity.

The paper and presentation outlines the various tiers of internal and external checks, audits and structured meetings which, together, provide an assurance framework for estates compliance, which extends beyond owned properties to a 'duty of care' for staff in leased premises.

Executive Committee feedback from 21 February 2024 meeting asked that future update could consider the relationship between compliance and the condition of the estate with patient safety and patient experience. This was a topical issue as a current FOI request to NHS England had indicated circa 2,500 events related to the poor condition of the estate (circa £12Bn backlog maintenance in England) with issues including sewage leaks, water ingress though ceiling affecting clinic sessions, etc.

DETAILED BACKGROUND AND ASSESSMENT:

Introduction

A slide deck/presentation accompanies the paper which covers:

- What does 'compliance' mean in relation to the estates function?
- How does compliance relate to 'health and safety' obligations?
- What are the specific / extra compliance obligations in relation to healthcare?
- What role do NHS Wales Shared Services Partnership-Specialist Estates Services undertake?
- Describe the monitoring approach including audit arrangements (owned and leased properties)
- Describe the compliance management / meeting / escalation structure in PTHB
- Identify risks and challenges along with opportunities and improvements
- Summary of presentation

Further assurance on individual compliance topics can be provided.

Summary

- Estates Compliance is a complex, technical and ever-increasing range of activities with significant health and safety implications and obligations

- There are several tiers of compliance from Statutory, Regulatory, Healthcare (HTM) related through to 'good practice' maintenance
- Competent and qualified specialist contractors work alongside the internal Estates team to deliver safe and effective services with management and monitoring undertaken by the Estates management team. This is supplemented by independent review and assessment carried out by NWSSP-SES, Internal Audit, Fire and Rescue Services, etc.
- Risks exist which reflect the challenges of maintaining an aging estate and these are reflected through the highlight reports, risk registers and audit findings. The recent all Wales 'Limited Assurance' draft audit finding for 'Estates Condition' reflects the challenges in maintaining a compliant estate where a suitable level of funding is not readily available.

NEXT STEPS

- Continue to manage, monitor and report on Estates Compliance matters, defining and escalating risks as appropriate.
- Maintain appropriate levels of knowledge and identify and plan for legislation changes as required.
- Maintain collaborative working relationships with NWSSP-SES, internal audit and other regulatory bodies as required.

The following Impact Assessment must be completed for all reports requesting Approval, Ratification or Decision, in-line with the Health Board's Equality Impact Assessment Policy (HR075):

IMPACT ASSESSMENT					
Equality Act 2010, Protected Characteristics:					
	No impact	**Adverse**	**Differential**	**Positive**	**Statement** ***Please provide supporting narrative for any adverse, differential or positive impact that may arise from a decision being taken*** The paper sets out the broad principles applied to estates compliance.
Age	x				
Disability	x				
Gender reassignment	x				
Pregnancy and maternity	x				
Race	x				
Religion/ Belief	x				
Sex	x				
Sexual Orientation	x				
Marriage and civil partnership	x				
Welsh Language	x				
Risk Assessment:					
	Level of risk identified				**Statement** Whilst the paper sets out a compliance framework which has matured considerably in the last 7-8 years, this is against a background of limited revenue and capital funding and an aging estate which gives rise to a level 16 corporate risk describing the challenges of ensuring the estate meets compliance standards and is fully 'fit for purpose'.
	None	**Low**	**Moderate**	**High**	
Clinical			x		

Financial			x		
Corporate			x		
Operational			x		
Reputational			x		

Delivery & Performance Committee:
29 February 2024

Estates Compliance

INNOVATIVE ENVIRONMENTS

Estates Compliance

Capital, Estates & Property Department

Purpose of the presentation:

- What does ‘compliance’ mean in relation to the estates function?
- How does compliance relate to ‘health and safety’ obligations?
- What are the specific / extra compliance obligations in relation to healthcare?
- What role do NHS Wales Shared Services Partnership-Specialist Estates Services undertake?
- Describe the monitoring approach including audit arrangements (owned and leased properties)
- Describe the compliance management / meeting / escalation structure in PTHB
- Identify risks and challenges along with opportunities and improvements
- Summary of presentation

Estates Compliance

Definition of ‘Compliance’ related to Estates Management:

There is a range of legislation which governs the use, occupation and maintenance of land and buildings.

You should make sure that you comply with the legislative requirements to protect the building fabric, systems and users - this is often referred to as ‘statutory compliance’ in buildings. It should be noted that whilst statutory requirements are consistently applied by the government and enforced by law, there are also regulatory requirements which differ dependant on the type of organisation and services delivered – these are enforced by the industry regulators and can result in fines, legal action and revocation of licenses to operate.

Failure to comply with health and safety legislation may result in action, either under health and safety legislation or other regulatory framework.

Items of plant and equipment are likely to be present in most estates. You will need to have information about these items and hold certification to show that they have been maintained.

INNOVATIVE ENVIRONMENTS

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board
Capital, Estates & Property Department

Mills Belinda
28/02/2024 15:10:16

Estates Compliance

Capital, Estates & Property Department

Health and safety law and maintenance of the estate.

What does the law say:

The basis of UK health and safety law is the Health and Safety at Work etc. Act 1974 (HSWA). The regulator is the Health and Safety Executive.

The Health and Safety at Work Act places overall responsibility for health and safety of employees and places of work with the employer, although other persons also have duties under the HSWA. For example, persons who have control of non-domestic premises have certain duties towards individuals who are not their employees and who use those premises.

The HSWA sets out the broad principles for managing health and safety in most workplaces.

Estates Compliance

Capital, Estates & Property Department

The Health and Safety at Work Act requires employers to:

- ensure, so far as reasonably practicable, the health, safety and welfare of employees
- conduct their undertaking in a way that does not expose non-employees to risks to their health and safety

Maintenance plays an important part in complying with health and safety law. As an employer, duties include the:

- safe provision and maintenance of plant and systems of work associated with them
- provision of information, instruction, training and supervision to ensure the health and safety at work of employees
- maintenance of a safe place of work including access and a safe working environment

HSWA duties cannot be delegated, however, delegation for the performance of specific functions is permissible, but that does not release an employer from a legal duty.

Estates Compliance

For example:

As an employer, you may appoint a **competent person** to carry out risk assessments, but you will still have ultimate responsibility for health and safety.

In most businesses, health and safety responsibilities are likely to be delegated. The designated person should ensure that:

- the business meets statutory compliance
- competent persons are engaged to assist with the various compliance areas

The general duties imposed by the HSWA are supported by a number of regulations. Of particular relevance is the Management of Health and Safety at Work Regulations 1999 (MHSWR).

The MHSWR prefer employers to appoint a competent person who is already employed by their organisation.

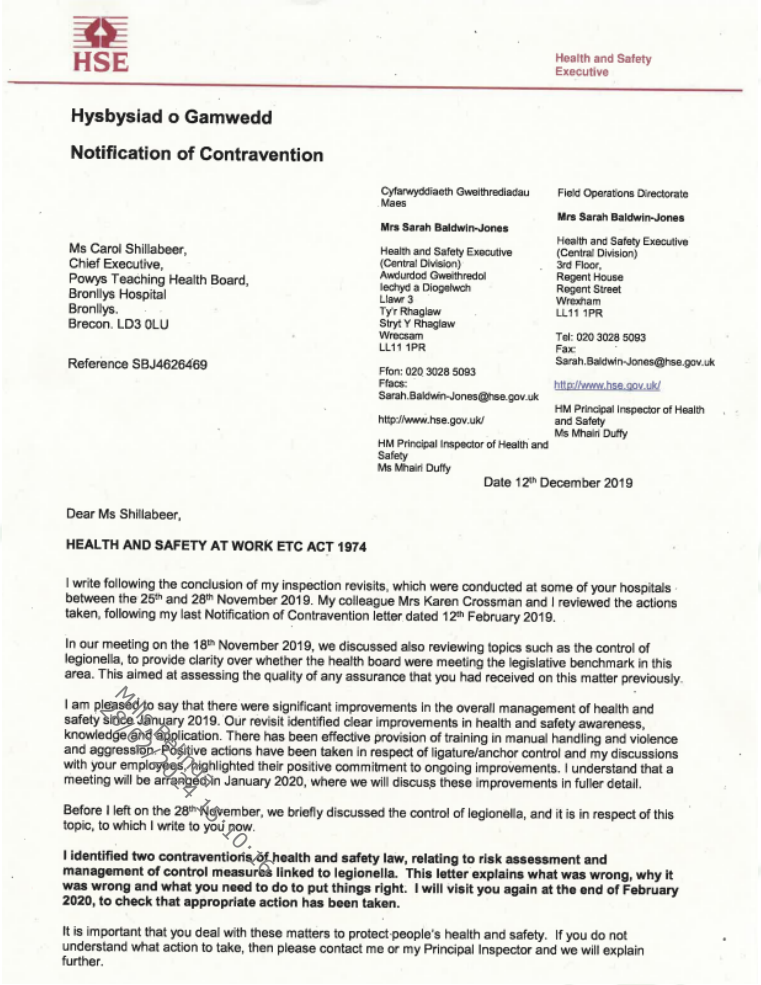
A competent person should have:

- a core knowledge of the subject
- sufficient training
- the experience to apply that knowledge correctly
- the personal qualities needed to undertake functions effectively

Estates Compliance

Capital, Estates & Property Department

Health and Safety Executive:



HSE

Health and Safety Executive

Hysbysiad o Gamwedd

Notification of Contravention

Cyfarwyddiaeth Gweithrediadau Maes

Mrs Sarah Baldwin-Jones

Health and Safety Executive
(Central Division)
Awdurdod Gweithredol
Iechyd a Diogelwch
Llawr 3
Tŷr Rhaglaw
Stryt Y Rhaglaw
Wrecsam
LL11 1PR

Ffon: 020 3028 5093
Ffacs:
Sarah.Baldwin-Jones@hse.gov.uk

http://www.hse.gov.uk/

HM Principal Inspector of Health and Safety
Ms Mhairi Duffy

Field Operations Directorate

Mrs Sarah Baldwin-Jones

Health and Safety Executive
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3rd Floor,
Regent House
Regent Street
Wrexham
LL11 1PR

Tel: 020 3028 5093
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http://www.hse.gov.uk/

HM Principal Inspector of Health and Safety
Ms Mhairi Duffy

Ms Carol Shillabeer,
Chief Executive,
Powys Teaching Health Board,
Bronllys Hospital
Bronllys.
Brecon. LD3 0LU

Reference SBJ4626469

Date 12th December 2019

Dear Ms Shillabeer,

HEALTH AND SAFETY AT WORK ETC ACT 1974

I write following the conclusion of my inspection revisits, which were conducted at some of your hospitals between the 25th and 28th November 2019. My colleague Mrs Karen Crossman and I reviewed the actions taken, following my last Notification of Contravention letter dated 12th February 2019.

In our meeting on the 18th November 2019, we discussed also reviewing topics such as the control of legionella, to provide clarity over whether the health board were meeting the legislative benchmark in this area. This aimed at assessing the quality of any assurance that you had received on this matter previously.

I am pleased to say that there were significant improvements in the overall management of health and safety since January 2019. Our revisit identified clear improvements in health and safety awareness, knowledge and application. There has been effective provision of training in manual handling and violence and aggression. Positive actions have been taken in respect of ligature/anchor control and my discussions with your employees, highlighted their positive commitment to ongoing improvements. I understand that a meeting will be arranged in January 2020, where we will discuss these improvements in fuller detail.

Before I left on the 28th November, we briefly discussed the control of legionella, and it is in respect of this topic, to which I write to you now.

I identified two contraventions of health and safety law, relating to risk assessment and management of control measures linked to legionella. This letter explains what was wrong, why it was wrong and what you need to do to put things right. I will visit you again at the end of February 2020, to check that appropriate action has been taken.

It is important that you deal with these matters to protect people's health and safety. If you do not understand what action to take, then please contact me or my Principal Inspector and we will explain further.

In December 2019, the health board received a Notification of Contravention under the Health and Safety at Work Etc. Act 1974, identifying 2 water hygiene, legionella related matters:

1. The suitability and sufficiency of water risk assessments and their timely production following changes to the estate / project activity

2. The quality and clarity of record keeping and documentation used to record water temperature testing

HSE

Health and Safety Executive

When a health and safety inspector calls

What to expect when we visit your business

About this leaflet

This leaflet tells you what can happen when one of our inspectors visits your workplace.

Before we start

Our job is to keep people safe and healthy at work. We visit thousands of locations every year as part of that job. Your visit is one of many that we do every day.

We may have arrived without warning. This isn't unusual. We don't always tell people we're coming and the law lets us visit at any reasonable time.

Although we have the powers to come into your workplace, our inspectors still have to follow the government's code of practice on entering homes or businesses.

You can complain if you think our inspector hasn't followed the code.

See the 'Complaints' section at the end of this leaflet, or the information at www.gov.uk/guidance/powers-of-entry.

During the visit

The inspector will look at how you keep your workers, and anyone who may be affected by your work, healthy and safe. They may also give you advice on health and safety or make sure you are providing suitable welfare facilities, such as running hot and cold water and toilets.

While the inspector is with you, they may:

- ask you about your workers and what they do;
- look at any possible health risks arising from the work you are doing;
- look at any machinery or other equipment that you have;
- ask to see records or other documents; and
- take photographs.

When a health and safety inspector calls — Page 1 of 6

Estates Compliance

Capital, Estates & Property Department

Compliance in a healthcare setting:

Health Technical Memoranda (HTMs) give **comprehensive advice and guidance** on the design, installation and operation of specialised building and engineering technology used in the delivery of healthcare.

Healthcare providers have a **duty of care to ensure that appropriate governance arrangements are in place and are managed effectively**. The Health Technical Memorandum series provides best practice engineering standards and policy to enable management of this duty of care.

Healthcare-specific technical engineering guidance is a vital tool in the safe and efficient operation of healthcare facilities. **Health Technical Memorandum guidance is the main source of specific healthcare-related guidance for estates and facilities professionals**.

Department of Health

Health Technical Memorandum 00
Policies and principles of healthcare engineering

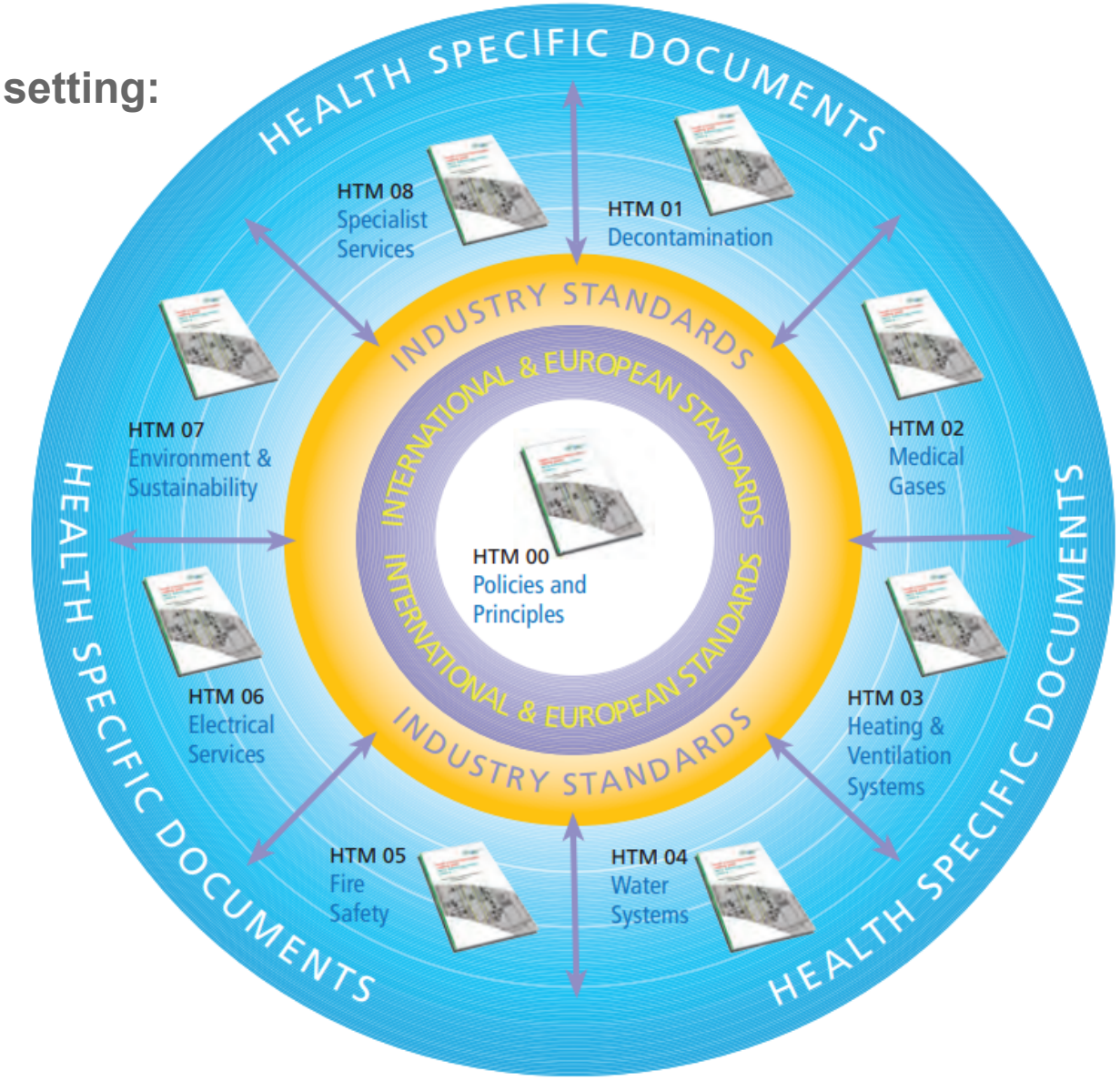
2014 edition

Estates Compliance

Capital, Estates & Property Department

Compliance in a Healthcare setting:

The Health Technical Memoranda are supported by NWSSP - Specialist Estates Services technical guidance and advice offered via Authorising Engineer support for the defined disciplines



- Decontamination
- Medical Gases
- Heating and Ventilation Systems

- Water Systems
- Fire Safety
- Electrical Services
- Environment & Sustainability
- Specialist Services (bedhead services, lifts, acoustics, etc.)

Estates Compliance

Capital, Estates & Property Department

The role of NHS Wales Shared Services Partnership – Specialist Estates Services:

A centralised specialist Estates function funded by the Health Boards supporting key disciplines

WHTM 01 Decontamination	HTM 02 Medical Gases	HTM 03 Heating & Ventilation Systems	WHTM 04 Water Systems	WHTM 05 Fire Safety	HTM 06 Electrical Services
Wayne Tannahill *Associate Director Estates and Property*	Wayne Tannahill *Associate Director Estates and Property*	Wayne Tannahill *Associate Director Estates and Property*	Wayne Tannahill *Associate Director Estates and Property*	Claire Madsen *Executive Director Of Therapies & Health Science, Corporate Services*	Wayne Tannahill *Associate Director Estates and Property*
Appointed Person S L *Estates Officer Specialist Services*	**Lead Appointed Person** G J *Estates Officer Specialist Services* **Appointed Person** S L *Estates Officer Specialist Services*	**Lead Appointed Person** S L *Estates Officer Specialist Services* **Appointed Person** S W *Estates Officer Specialist Services*	**Responsible Person** S W *Estates Officer Specialist Services* **Deputy Responsible Person** S L *Estates Officer Specialist Services*	**Fire Safety Managers Operational** J C *AD Support Services* **Infrastructure** W T *AD Estates, Capital & Property*	**Lead Appointed Person** S W *Estates Officer Specialist Services* **Appointed Person** J A *Capital Project Manager*
Competent Person Approved Contractors	**Competent Person** HAC Approved Contractor	**Competent Person** C W PTHB Estates Team	**Competent Person** PTHB Works Approved Contractors	**Competent Person** S F P Ltd Approved Contractor	**Competent Person** PTHB Electricians Approved Contractors
NWSSP : Authorising Engineer J P	**NWSSP : Authorising Engineer** C E	**NWSSP : Authorising Engineer** D M	**NWSSP : Authorising Engineer** R B	**NWSSP: Authorising Engineer** A P	**NWSSP : Authorising Engineer** N B LV

Estates Compliance

The role of NHS Wales Shared Services Partnership

Authorising Engineer (AE) Annual Reports and audits and NWSSP Specialist Services Unit audit:

1.0 EXECUTIVE SUMMARY

1.1 Generally, the operational management of the Medical Gas Pipe Line Systems (MGPS) in Powys Teaching Health Board has continued to improve during the period since the last report.

1.2 The health board has continued its good progress, with a functioning Medical Gas Pipe Line Systems (MGPS) committee and policy in place.

1.3 There are two Authorised Persons (APs') appointed for the health board. High level non-conformities are listed in section 6, and further non-conformities can be found in the sites annual report issued under separate cover.

1.4 No MGPS yearly site audits were completed for the health board during the 2022 calendar year.

1.5 Compliance audits are carried out in a five-year cycle unless the health board requests a shorter interval.

1.6 Overall the Authorising Engineer (AE (MGPS)) has deemed the compliance rating to be Yellow (reasonable assurance) as shown below in figure 1. This rating is an improved assurance rating to that given in the 2021 calendar year AE Report.

2021	2022
	
Policy ratified. Two appointed APs'. No Procedures approved. Improved governance arrangements. Limited Action plans. No trained DNOs' Risks identified with limited action. Improved MGPS group.	Policy ratified. Two appointed APs'. Procedures being developed. Improved governance arrangements. Limited Action plans. DNO training in progress Risks identified with limited action. Improved MGPS group.
Yellow	Yellow

Figure 1 Overall Compliance Rating

2.0 BACKGROUND

2.1 The following report is a compliance review undertaken by the Authorising Engineer for Medical Gas Pipe Line Systems (AE (MGPS)) appointed by the Powys Teaching Health Board (PTHB).

2.2 This report is in accordance with the guidance set out in Welsh Health Technical Memorandum 00 - which stipulates the requirement for the Authorising

Example AE **Medical Gas Pipeline Systems** audit

Executive Summary

Purpose

The NHS in Wales faces unprecedented challenges balancing the management of the current estate condition against other competing priorities and within existing funding constraints – whilst also developing a deliverable estate strategy for the future.

The backlog maintenance figures for NHS Wales recently exceeded £1bn (the substantial element being High and Significant risks) and is likely to increase further due to the aging estate in Wales.

The latest nationally reported data (2021/22) for the THB confirmed a total backlog maintenance requirement of £52m- although the capital investment requirement to clear the backlog is likely to be materially higher.

The audit sought to evaluate the arrangements put in place by the THB to identify and manage key risks associated with the existing estate and the implementation of resulting strategies to manage/mitigate the risk.

Overview

Key to understanding the challenge is the quality of the baseline data. The THB's current estates condition baseline data was developed from a 2018 six facet condition survey which had been updated annually by desktop review. At the time of reporting the THB were awaiting the results of a six-facet survey undertaken in early 2023 in order to establish an updated baseline during 2023/24. Experience of other NHS organisations suggests that this update is likely to result in an increase in the reported data. Further concerns have been raised on the comparability of the data, given the significantly varied methods of computation by each NHS organisation.

In the short to medium term, the THB uses a combination of all Wales capital

Report Classification

Limited — More significant matters require management attention.

Moderate impact on residual risk exposure until resolved.

Assurance summary[1]

Assurance objectives	Assurance
1 Governance	Reasonable
2 Baseline Information	Reasonable
3 Estates Strategy	Reasonable
4 Funding Strategy	Limited
5 Monitoring & Reporting	Reasonable
6 Risk Management	Reasonable

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

Key Matters Arising	Assurance Objective	Priority
1 Establishment of internal procedures surrounding the annual backlog appraisal/costings; to inform the Estates Facilities Performance Management System.	2	Medium
2 The Health Board should as a priority look to develop an Estates focused service strategy for the medium and long term, to be informed by the up to date Six Facet Estate Condition Survey.	3	High
3 The Board should receive increased assurance as to	4	High

Example draft NWSSP-SSU audit on **Estates Condition** recognising age of estate across NHS Wales

Estates Compliance

Capital, Estates & Property Department

Monitoring Compliance – roles and checks regime

- **Planned Preventative Maintenance**
  - Internal Estates PPM with Maintenance Officer and Estates Manager checks
  - External Specialist Maintenance Provider with Contract Manager (Estates Manager) oversight
- **Estates Compliance Sub-Groups** – assessment of risk and hence compliance, with reporting to Estates Compliance Group
- **NWSSP Specialist Estates Services** – Authorising Engineer (AE) annual audits/reports
- **NWSSP Specialist Services Unit** – cyclical topic related audits of compliance activity
- **PTHB Safety Groups** (Water, Ventilation, Medical Gas, Electrical (tba), etc.)
- **Datix and Health and Safety Executive (HSE)** – Datix root cause analysis and HSE inspections
- **Fire and Rescue Service Audit Inspections** – annual audits of sites

Estates Compliance

Capital, Estates & Property Department

Monitoring Compliance: Estates Compliance PPM weekly reporting and sub-group highlight reports

SOUTH POWYS ESTATES	
Week Commencing	21.01.2024 (Week 4)
Week Ending	28.01.2024

Building	PPM Jobs	Completed PPM Jobs	Incomplete PPM Jobs	Delivery Of Service
Bronllys Hospital	12	11	1	92%
Brecon Hospital	18	16	2	89%
Glan Irfon	1	1	0	100%
Hazels/Merlins Terrace	4	4	0	100%
Knighton Hospital & Clinic	3	3	0	100%
Llandrindod Crown Building	3	3	0	100%
Llanwrtyd Wells	1	1	0	100%
Llandrindod Wells Hospital	9	9	0	100%
Ty-Illtyd	4	3	1	75%
Ystradgynlais Hospital	4	4	0	100%
TOTALS	59	**55**	**4**	**93%**

V1.2 - 8.2.2019

Mills Belinda 28/02/2024 15:10:16

Maintenance Officers/Chargehands - Please insert IFM jobes codes for PPM/Reactive, a brief des available ir

PPM EXCEPTION REPORT

IFM Job Code	Task Description	Reason for not completing
a46001	Showers 51-01-3M	<<Insert Reason>>
a46011	RO Weekly Check	<<Insert Reason>>
a46046	POWYS 008 12M Lightshade Cleaning	<<Insert Reason>>
a46013	POWYS 008 12M Lightshade Cleaning	<<Insert Reason>>
		<<Insert Reason>>

Overall Performance Result | South Powys | North Powys

GIG CYMRU NHS WALES — Bwrdd Iechyd Addysgu Powys — Powys Teaching Health Board

COMPLIANCE HIGHLIGHT REPORT — 8th December 2022

Compliance Activity	Electrical	Author	Steve Watkins- Electrical Authorised Person (Low Voltage)

	Very Low 1-3			Low 4-8				Moderate 9-12			High 15-25				
	1	2	3	4	5	6	8	9	10	12	15	16	20	25	Risk Matrix.d
Current Assessment	☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☐	☐	☐	☐	
Target Risk Level	☐	☐	☐	☐	☐	☐	☒	☐	☐	☐	☐	☐	☐	☐	

Date of last electrical sub-group meeting: 11th October 2022

Date of next electrical sub-group meeting: 13th December 2022

What's Changed Since Last Report:

- **Item 1 - 8.12.22** – Good progress with Llandrindod scheme, metering is installed, works being planned to lift new generator over boiler house into position and swap existing electrical circuits to new switchgear.
- **Item 3 - 8.12.22** – External electrical resource in place to support where required as an interim measure.
- **Item 5 - 8.12.22** – Despite works being undertaken, electrical audit as come back for Brecon as limited assurance. Existing old switchgear requires attention – Estates working through audit report.
- **Item 8 - 8.12.22** – Information has been shared with Donna Bale, discussions ongoing whether to use old fuel/polish old fuel and top up with new fuel (at a cost) – CERTAS are contracted to provide fuel to Powys as part of an all Wales contract, assurances have been provided that the hospitals in PTHB are on the priority list for fuel deliveries.

	Risk Describe the risk – top 5 only	Mitigating action What measures will address the risk identified?	Current Risk Rating Score: Likelihood x Impact = Risk			Indicative Cost £	Current actions	Target Date
1.	The main power supplies and standby generators in Welshpool, Brecon & Llandrindod may not be large enough to accommodate the new AHU for COVID-19.	This is being reviewed currently by Estates and design teams. Mitigating measures will be temporary generators for AHU plant.	3	4	12	ALL COSTS TBC	• **20.5.21** – Current situation is Welshpool Hospital & Llandrindod Hospital have temporary generators feeding new AHU plant – existing electrical incoming supply is too small. Currently there is a capital scheme in design stage for Llandrindod to replace incoming switchgear, transformer, generator to enable Phase 2 works and support Llandod site • **21.10.21** – Llandrindod power supply is currently out to tender and will be completed by March 22. Welshpool funding has been made available and will also be undertaken by March 22.	March-Aug 22

Estates Compliance

Capital, Estates & Property Department

Monitoring Compliance: a compliance (**duty of care**) responsibility extends to staff who are based in **leased premises** which are not owned or managed by the health board. This involves checks to ensure landlord's responsibilities are met.

Property ID	Lease Name	Property	Leased Area	Landlord	Use	FRA 2023 (2 years)	Asbestos 2022	Water Risk Assessment (2 Years)	Fixed Wire Test (5 Years)	PAT Test	Gas Safety (Annual)	Air Con (5 Years)	REQUESTED	CHASE
52	Brecon GP Surgery	Brecon Medical Group Practice, Ty Henry Vaughan, Bridge St, Brecon, Powys	HV room & DN room. Use of clinic rooms	PC -Brecon Medical Group Practice	Health visitors x 1 office & 1 clinic. District nurses x1 office and use of clinic room	No copy found	Asbestos Survey Dated 2009. copy on file.	Dated : January 2024 Next Due: January 2026	Dated: March 2023 Next Due: March 2028	No copy found	Dated: Dec 2023 Next Due: Dec 2024	N/A No Air Conditioning	Denise Mcnamara 03/02/2020	Denise Mcnamara 30/04/2021 11/05/2022 31/10/2022 18/08/2023 27/12/2023
57	Crickhowell Health Centre	Crickhowell War Memorial Health Centre, Crickhowell, Powys, NP8 1AG	Physio, District Nursing and HV rooms		HV shared space, DN office, possible MH office	Dated: February 2021 Next Due: February 2022	Asbestos survey completed May 2012. Copy on file.	Dated: March 2023 Next Due: March 2024	Dated: April 2017 Next Due: April 2022	Next Due: July 2024	Dated: February 2021 Next Due: February 2022	Next Due: November 2021	Julie Chouhan 03/02/2020	Julie Chouhan 05/05/2021 18/08/2023
58	Talgarth Surgery	Haygarth Practice, The Surgery, Talgarth, Powys	2 rooms + 1 store	PC -Haygarth Practice	DN Office, 1 HV room (pre covid)	Dated: August 2020 Next Due: August 2021	PM claims Landlords have provided confirmation that no asbestos was used in construction	Dated: July 2020 Next Due: July 2022	Dated: December 2018 Next Due December 2023 Now Marked Unsatisfactory - more info requested	No copy found	Dated: June 2019 Next Due: September 2020	N/A No Air Conditioning	Dawn Price 10/02/2020	Dawn Price 30/04/2021 Dawn Price 13/09/2021 14/09/2023
59	Hay Surgery	Haygarth Doctors, The Medical Centre, Forest Road, Hay on Wye, Hereford, HR3 5DS	1 physiotherapy Room, 1 HV & SN room, 1 clinic room	PC -Haygarth Doctors	1 office for SN and HV. Baby clinic room.	Dated: August 2020 Next Due: August 2021	PM claims Landlords have provided confirmation that no asbestos was used in construction	Dated: July 2020 Next Due: July 2022	Dated: February 2019 Next Due: February 2024	Next Due: September 2021	Dated: September 2023 Next Due: September 2024	Dated: September 2021 Next Due: September 2026	Dawn Price 10/02/2020	Dawn Price 30/04/2021 Dawn Price 13/09/2021 14/09/2023
35	Antur Gwyr - Builth Wells	Antyr Gwy, Park Road, Builth Wells, Powys, LD2 3BA	2 rooms (A05 and A06)	Powys County Council	CAMHS - 1 office plus one large bookable consulting room.	PCC FRA Completed 11.05.22 Next Due 11.05.24. PTHB FRA 9th December 2022 Next Due: December 2025	Asbestos monitoring doc saved in file dated 07/06/2022	Dated: October 2022 Next Due: Sept 2024	Dated: Sept 2020 Next Due: Sept 2025	Dated: October 2022	Dated: Nov 2022 Next Due: Nov 2023	Dated: October 2022 Next Due: Oct 27	Garet Richards 23/02/3031 Angela Protheroe / PCC Compliance	Angela Protheroe 04/05/2021 Paul Barnes 08/07/2021 Wendy Davies 24/02/22 chased David Warhurst 02/06/23 for Gas Safety Certificate
110	Flying Start - Llandrindod Wells	Trefonnen C in W School, Tremont Road, Llandrindod Wells, LD1 5EB		Powys County Council / school	Flying start HV scheme	PCC FRA Completed 10.07.22 Next Due 10.07.24	N/A. Post 1999 Build no asbestos used in construction	Dated: May 2021 Next Due: May 2023	Dated: June 2021 Next Due: June 2026	Dated June 2022	Dated: October 2022 Next Due: October 2023	Dated: January 2016 Next Due: January 2021	Garet Richards 23/02/3031 Angela Protheroe / PCC Compliance	Angela Protheroe 04/05/2021 Paul Barnes 08/07/2021 Wendy Davies 24/02/22
68	Rhayader Surgery	The Surgery, Rhayader, Caeherbert Lane, Powys, LD65 5ED	1 DN room Use by Podiatry	PC -Rhayader GP Practice	1 DN Room. Use of a room on a weekly basis by Podiatry	Dated: March 2017 Next Due March 2018	Landlord completed June 2012, no copy on our files	"No water tank so no WRA required" Andrew Mason notes - Check with SW	Dated: September 2013 Next Due: September 2018	No copy found	N/A No Gas installation	N/A No Air Conditioning	Jane Jones 10/02/2020	Jane Jones 30/04/2021 Jane Jones 13/09/2021
113	Antyr Gwyr - Builth Wells	Builth Health Annex, Park Road, Builth Wells, Powys, LD2 3BA	First Floor Offices	Powys County Council	Office base for W&C and MH Primary care	PCC FRA Completed 11.05.22 Next Due 11.05.24. PTHB FRA 9th December 2022 Next Due: December 2025	Held at site. Have requested scanned copies for our files	Dated: October 2022 Next Due: Sept 2024	Dated: Sept 2020 Next Due: Sept 2025	Dated: October 2022	Dated: Nov 2022 Next Due: Nov 2023	Dated: October 2022 Next Due: Oct 27		
116	Glanirfon	Glanirfon, Builth Wells, Powys	Ground floor and part of first floor	Powys County Council	Office and clinical base. DN, Physio, OPD, etc	Dated: 9th December 2022 Next due: 9th December 2024	N/A. Building built post 2000.	Dated: Nov 2024 Next Due: Nov 2025	Dated: 25 Sept 19 Next Due: Sept 2024	Dated: October 2024	Dated: September 2023 Next Due: September 2024	N/A No Air Conditioning	Kelly Harris 15/02/2020	Kelly Harris 30/04/2021 Wendy Davies 24/02/22 David Gatefield 28/10/22 Kelly Harris - 25/01/2024

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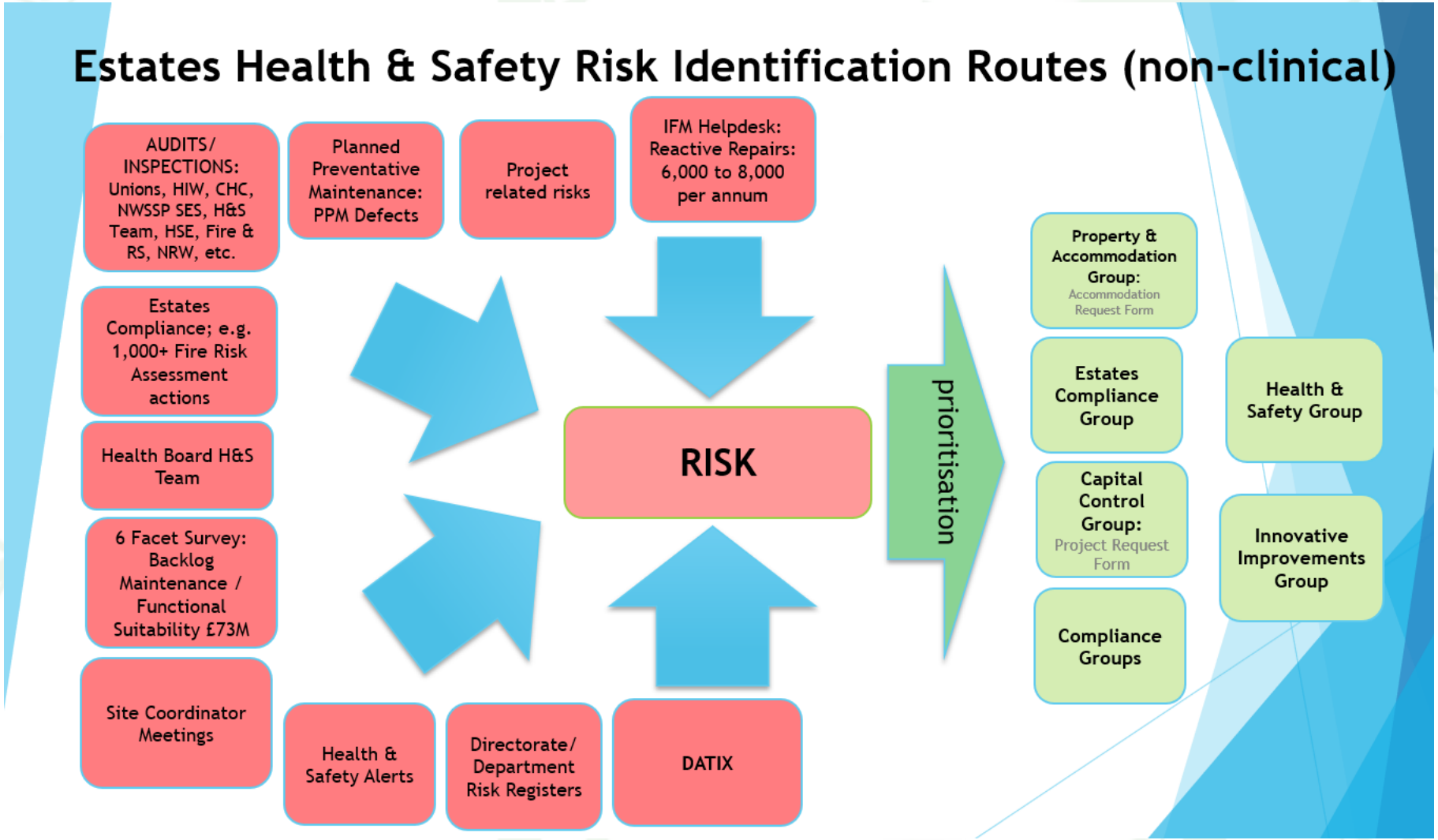
Estates Compliance

Capital, Estates & Property Department

Monitoring Compliance: Health and safety risk-based approach



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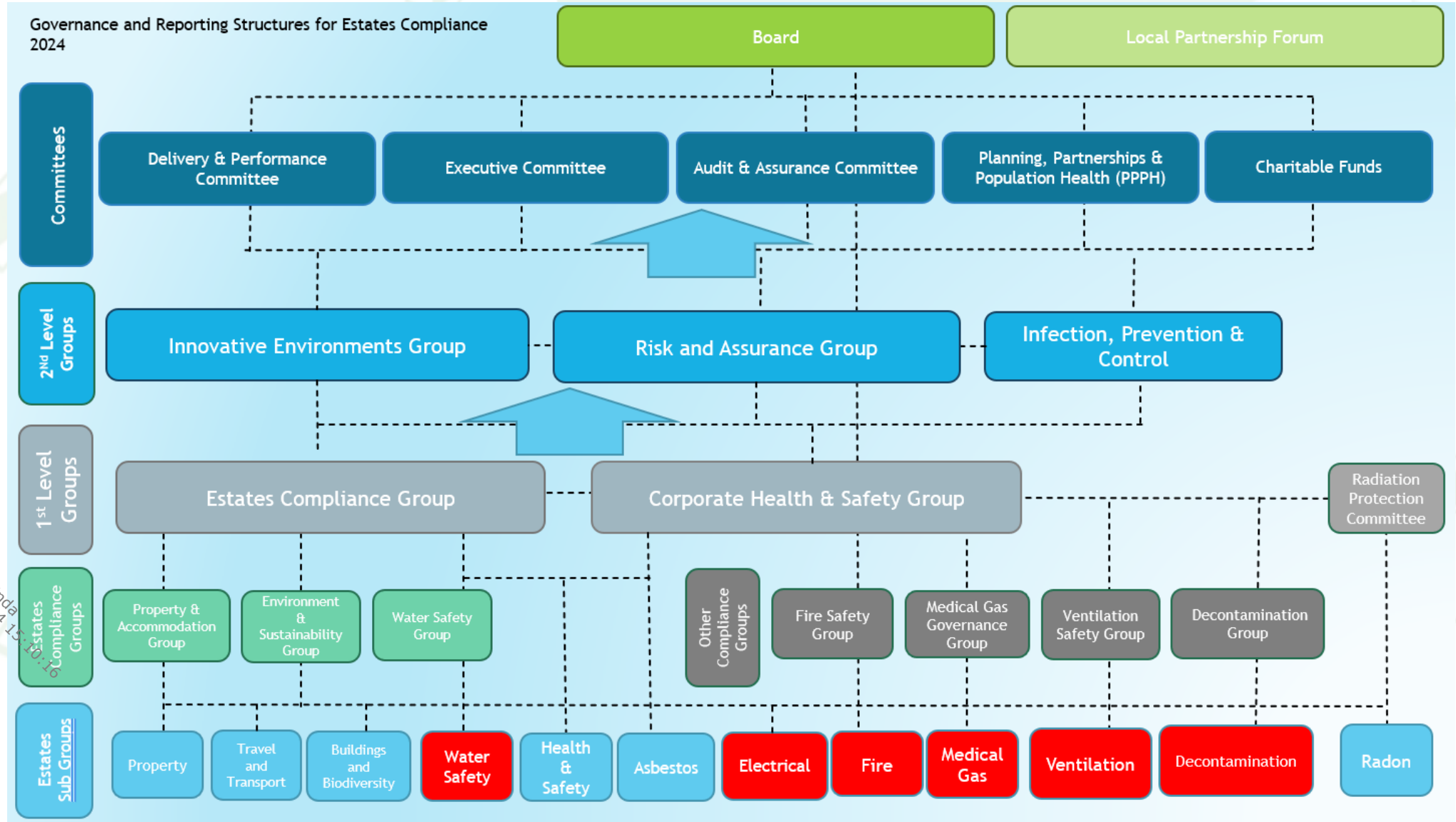
Estates Compliance

Meetings' structure reporting chart (under review):



Estates Compliance

Asbestos Management, for example, is an important area of compliance which is not overseen by NWSSP-SES. It is recognised, therefore, that added assurance is necessary - in addition to the Asbestos Sub Group, an Asbestos Safety Group with wider organisational oversight has been introduced with a new Annual Reporting requirement in 2022 in line with the updated policy. NWSSP-SSU audit in 2018 with Reasonable Assurance with Follow Up audit in 2020

NWSSP-SSU Audit & Review: Reasonable Assurance 2018 and Follow Up Report February 2020

Prior Ref	Priority	Recommendation	Responsibility & Timescale
Asbestos Management – Reasonable Assurance (October 2018)			
1	Medium	The Asbestos register (database) should be updated during and following conclusion of the refurbishment surveys currently being undertaken.	Asbestos Manager September 2019
2	Low	A detailed review of the Asbestos Management Plan should be completed.	Asbestos Manager May 2019
3	Low	The updated Asbestos Policy should be formally ratified.	Asbestos Manager May 2019

PTHB Asbestos Safety Group: Asbestos Annual Report 2022

POWYS TEACHING HEALTH BOARD
ASBESTOS SAFETY GROUP

ASBESTOS ANNUAL REPORT 2022

INNOVATIVE ENVIRONMENTS

Estates Compliance

GIG CYMRU NHS WALES | Bwrdd Iechyd Addysgu Powys | Powys Teaching Health Board

Capital, Estates & Property Department

Risks and Challenges - this describes a sample only:

- **Estates Condition audit:** recent NWSSP-SSU all Wales audit has resulted in Limited Assurance rating for all health boards. This is fundamentally related to the mis-match between available capital funding and the aging NHS estate with over £1Bn of backlog maintenance identified. PTHB estate has backlog maintenance of circa £73M when last assessed and an annual discretionary capital allowance of £1.26M (2023/24).
- **PTHB ageing estate:** 38% of the estate was built pre-1948 whilst the NHS Wales average is 12%. Only 5% of the PTHB estate was built after 2005 whilst the NHS Wales average is 23%. This is the 'oldest' and 'least new' estate in NHS Wales.
- **Estates Workforce**: workforce planning assessments of resource against planned and reactive workload indicated the structure was several staff under the establishment deemed necessary to fully meet compliance needs. The department has also seen recruitment and retention challenges and is investing in 'grow your own' but recognises the pay differential with outside industry and other factors such as rurality, etc. that have an impact.
- **Corporate Risk Register**: CRR 010 identifies the risk around a 'fit for purpose' estate and has a risk rating of 16. This incorporates the wide range of compliance elements and is indicative of the medium to long-term challenge to bring the estate up to a 'satisfactory' standard. The fire compartmentation programme, for example, is making significant improvements but will retain a high-level risk until all of the estate is brought up to standard.

Estates Compliance

Capital, Estates & Property Department

Opportunities and Improvements - this describes a sample only:

- **Maintenance Contracts**: three-year programme nearing completion to formalise 25+ maintenance contracts with strengthened specifications and 3-5 year period which enables contractor relationships to be built. Contracts now incorporate Key Performance Indicators and routine review meetings.
- **Dangerous Substances and Explosive Atmospheres Regulations** (DSEAR): external expert consultant review of estate undertaken with draft report imminent, and although no significant findings, this is a formally documented review providing specialist assurance.
- **Reinforced Autoclaved Aerated Concrete** (RAAC): structured checks have not indicated any presence of RAAC within the PTHB estate or in leased premises where PTHB staff are present. Current checks being undertaken on the Primary and Community Services third party estate with returns to Welsh Government by end February.
- **Capital Programme**: the investment in capital projects such as the recently completed £15M+ Bro Ddyfi hospital, Machynlleth is a means by which significant improvements can be made to the PTHB estate, addressing circa £4M of backlog maintenance and creating more maintainable buildings. Further major investments planned for Llandrindod, Newtown, etc.
- **Senior Management Team** (SMT): in 2019 approval was received to strengthen the senior department team with the subsequent appointments in 2020 of a Head of Estates, Head of Technical Services (Fire, Environment and Property) and Business Manager - this has provided the resource to implement measures such as the maintenance contract programme.

Estates Compliance

Capital, Estates & Property Department

Summary:

- Estates Compliance is a complex, technical and ever-increasing range of activities with significant health and safety implications and obligations

- There are several tiers of compliance from Statutory, Regulatory, Healthcare (HTM) related through to 'good practice' maintenance

- Competent and qualified specialist contractors work alongside the internal Estates team to deliver safe and effective services with management and monitoring undertaken by the Estates management team. This is supplemented by independent review and assessment carried out by NWSSP-SES, Internal Audit, Fire and Rescue Services, etc.

- Risks exist which reflect the challenges of maintaining an aging estate and these are reflected through the highlight reports, risk registers and audit findings. The recent all Wales 'Limited Assurance' draft audit finding for 'Estates Condition' reflects the challenges in maintaining a compliant estate where a suitable level of funding is not readily available

- Executive Committee feedback 21 February: recognises the breadth of the topic with future update to explore impact of compliance on patient safety and experience

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item:2.11

Delivery & Performance Committee	**Date of Meeting: 29th February 2024**
Subject :	**Information Governance Key Performance Monitoring Report**
Approved and Presented by:	Pete Hopgood, Director of Finance, Information, and IT
Prepared by:	Vicki Cooper Chief Digital Information Officer Amanda Smart Head of Information Governance, Records and Data Protection Officer
Other Committees and meetings considered at:	Executive Committee - 21 February 2024 who: • Received the report and supported the actions outlined.

PURPOSE:

The purpose of this paper is to provide assurance and to inform the Committee of the Information Governance compliance statistics for the six month period1st July 2023 – 31st December 2023.

RECOMMENDATION(S):

The Delivery and Performance Committee are asked to:

- **RECEIVE** the Compliance statistics and Performance data and take **ASSURANCE** that actions are in place to:
  - Continue improvements aligned to Statutory and Legislative Compliance and Performance
  - Review and improve identified areas of poor compliance (notably poor compliance with IG Mandatory E Learning not being completed within 6 weeks for new starters).
  - Implement Continual Service Improvement and Efficiency measures to ensure increased demands for information is met.

Approval/Ratification/Decision	Discussion	Information
	✓	✓

THE PAPER IS ALIGNED TO THE DELIVERY OF THE FOLLOWING STRATEGIC OBJECTIVE(S) AND HEALTH AND CARE STANDARD(S):

Strategic Objectives:	1. Focus on Wellbeing	x
	2. Provide Early Help and Support	x
	3. Tackle the Big Four	x
	4. Enable Joined up Care	x
	5. Develop Workforce Futures	x
	6. Promote Innovative Environments	x
	7. Put Digital First	x
	8. Transforming in Partnership	✓
Health and Care Standards:	1. Staying Healthy	x
	2. Safe Care	x
	3. Effective Care	x
	4. Dignified Care	x
	5. Timely Care	x
	6. Individual Care	x
	7. Staff and Resources	x
	8. Governance, Leadership & Accountability	✓

EXECUTIVE SUMMARY:

This report provides an assessment against key performance and compliance indicators for information governance (IG).

The reporting period covers Access to Information Requests FY 23/24 Quarters 2 & 3.

Freedom of Information (FOI):

- A total of 248 requests were received with 45 breaches. 82% Compliant
- The Health Board remains slightly below the target compliance of 90%
- The longest breach was 43 days, 23 days over the legislative timeframe of 20 working days.

Subject Access Requests (SARS) for personal information (living and deceased):

- A total of 349 requests were received with 14 breaches.
- Compliance increased to 95% (from 92 %) which remains above the locally set target of 90%.
- There has been an 18% increase of SARS received when compared to same reporting period in 2022.
- A total of 113 disclosures have been made to the NWSSP Medical Examiner (ME) Service.

Requests for records rectification, erasure, and restricting processing (exercising individuals rights):

- Four requests were received (slight increase). =rand(40,50)

IG Mandatory E-Learning Training:

- From Dec 2023 the compliance rate was 88.07% which is an increase from Q1 2023-24 and remains above the national target of 85%.
- However, figures for non-compliance of new starters completing this training within 6 weeks of commencement remains high (97.74% this reporting period).
- The organisation continues to report consistent poor compliance with IG Mandatory E Learning not being completed within 6 weeks for new starters to the organisation.

Datix Incidents (Breach Reporting):

- There were 77 Information Governance related incidents reported.
- 31 incidents were not reported within the UK GDPR regulatory 72 hours, this was due to service delays in reporting.

Complaints – IG related:

- One complaint was received regarding a request for rectification was processed under data protection legislation. Following issue of a response, no further concerns have been raised.

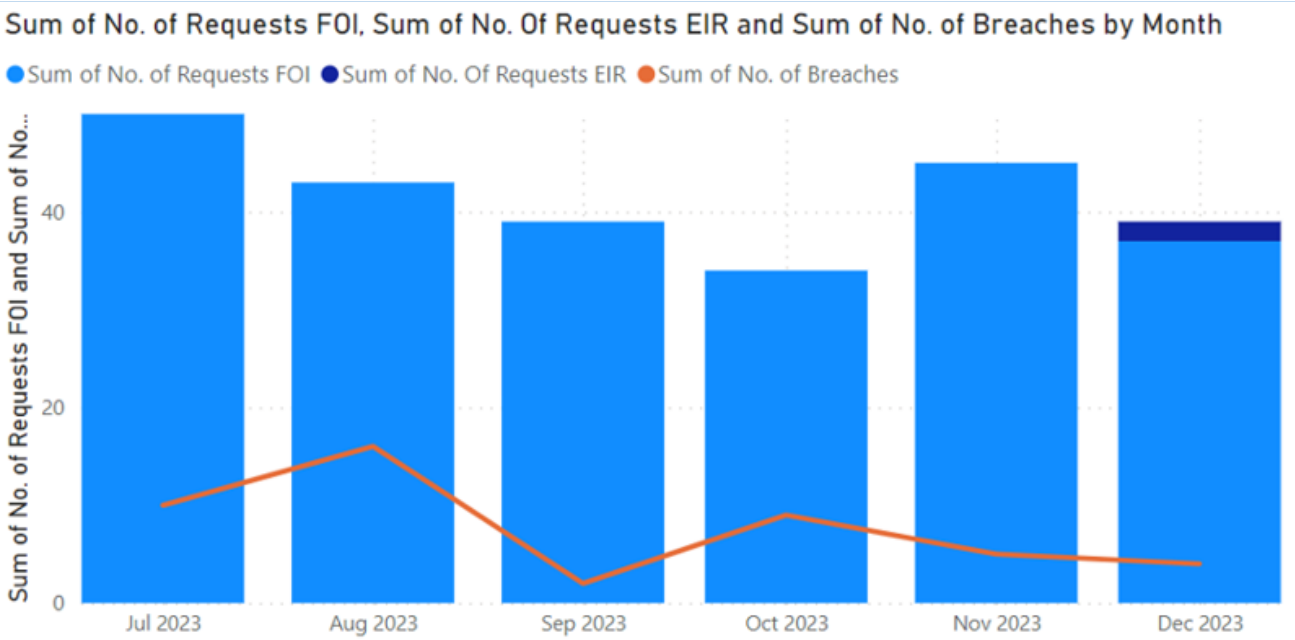
The National Intelligent Integrated Audit Solution (NIIAS):

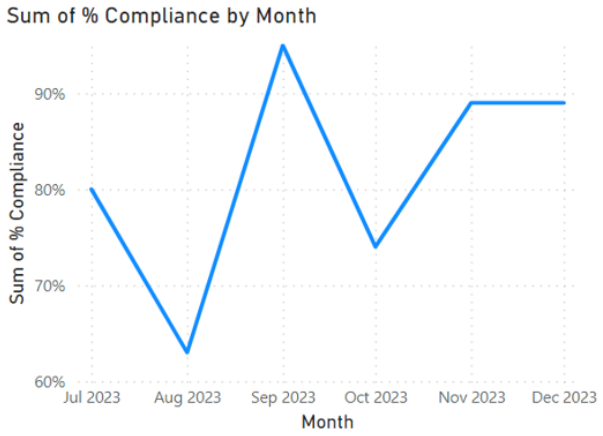
- 22 notifications were reported. None of the notifications were deemed reportable to the ICO following investigation.

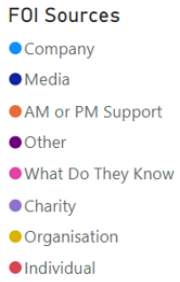
DETAILED BACKGROUND AND ASSESSMENT:

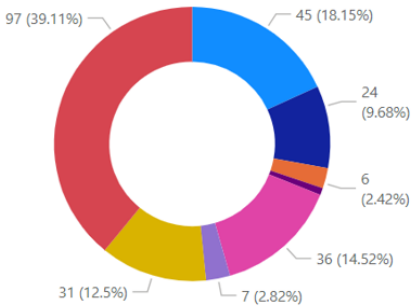
Freedom of Information: There has been a 9.25% increase in the number of requests received compared to the same period in 2022 (227 requests). Five requests for Internal Reviews were received.

During this reporting period, overall, 32 Exemptions were applied.









The main causes for the forty-five breaches during this reporting period were:

- Service delays in providing responses within the timeframe.
- Staff absence due to annual leave.
- Increased number of complex requests.

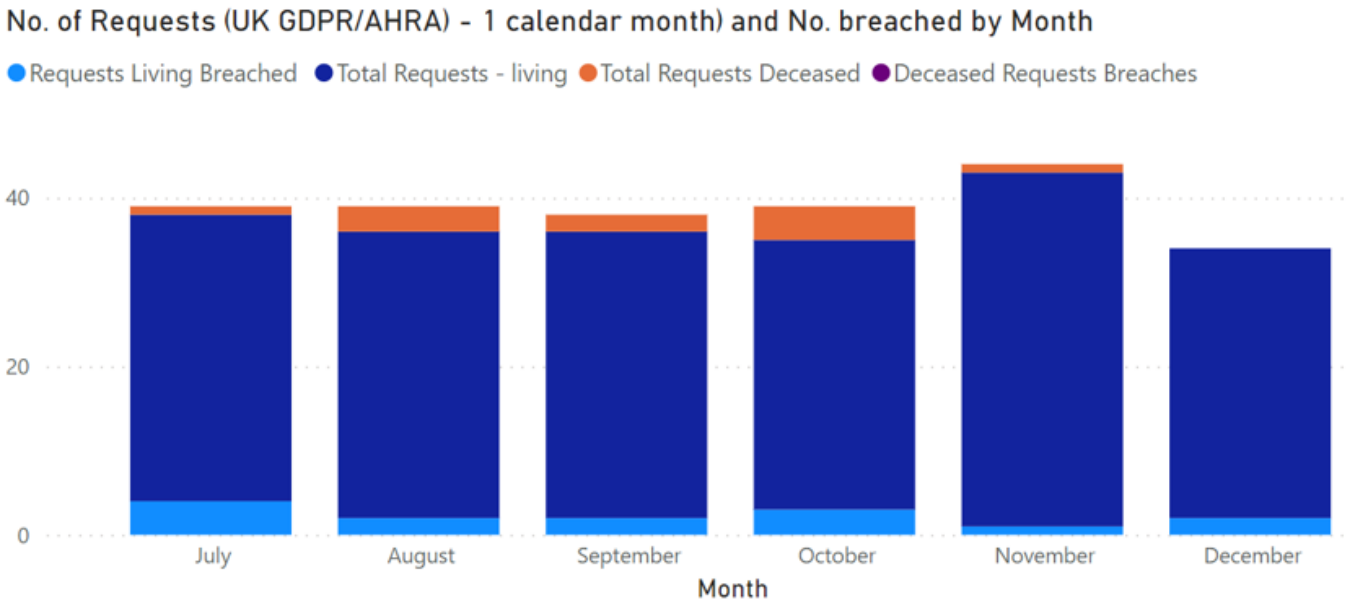
The top four FOIA Exemptions used:

- Section 12 - Costs of complying with request will exceed the cost limit.
- Section 40(2) - Data Protection and Personal Information.
- S43 - Trade secrets and Prejudice to Commercial Interests.
- S21 - Information is accessible by other means.

Requests for Personal Information (living and deceased):

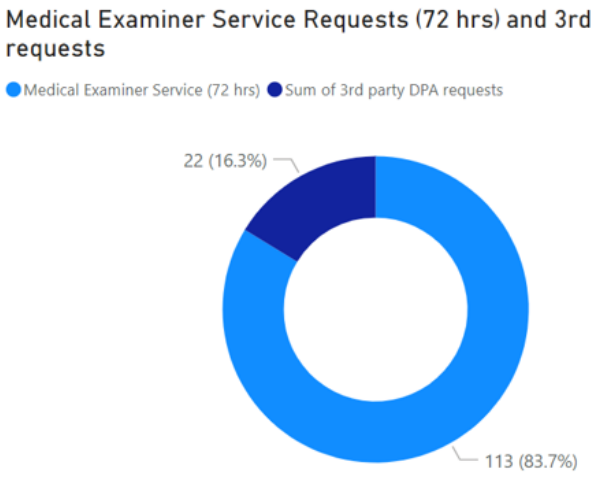
The total number of requests received this reporting period has increased by 18% against the same reporting period for the 2022. Delays are due to:

- Staffing issues within service areas resulted in the records not being supplied in time.
- Complex requests requiring extra resources which included requests for email searches.



Medical Examiner Service:

- Two disclosures exceeded the 72-hour expected timeframe by 1 day. These late disclosures were caused by a delay in receiving notes from the ward.



IG Training:

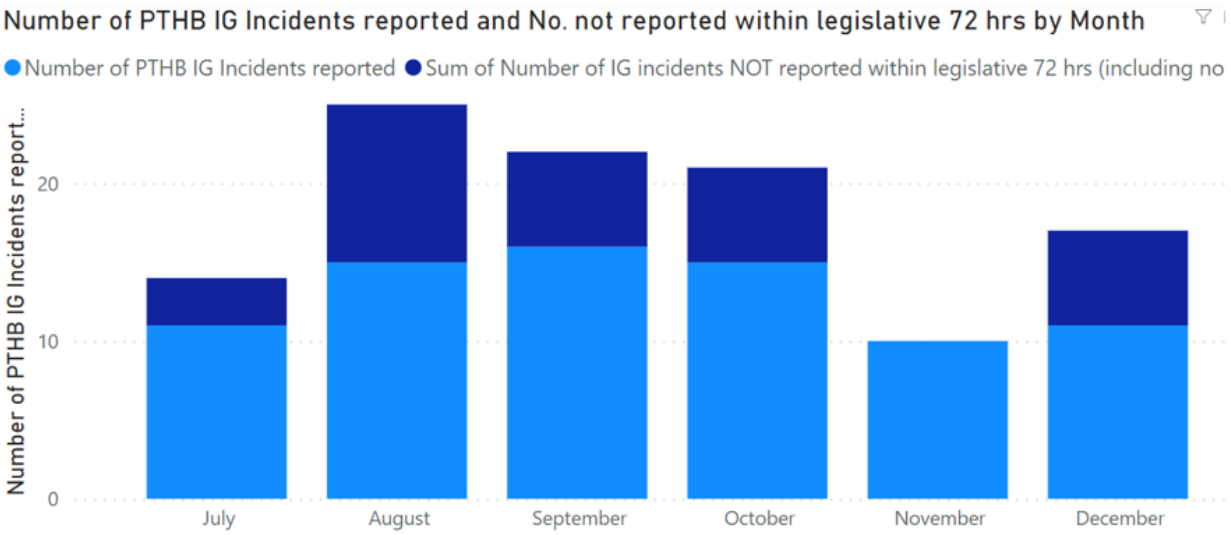
New Starters:

Welsh Government requires all mandatory training be undertaken within 6 weeks of commencing employment. This remains a consistent issue each quarter.

Should there be an incident the Information Commissioner's Office will investigate that staff have not undertaken this training.

- Bi-annual reminders are issued by the IG Team targeting non-compliant staff.
- One bespoke session was delivered by the IG Team to the Estates Team away day.

IG Related Datix Incidents

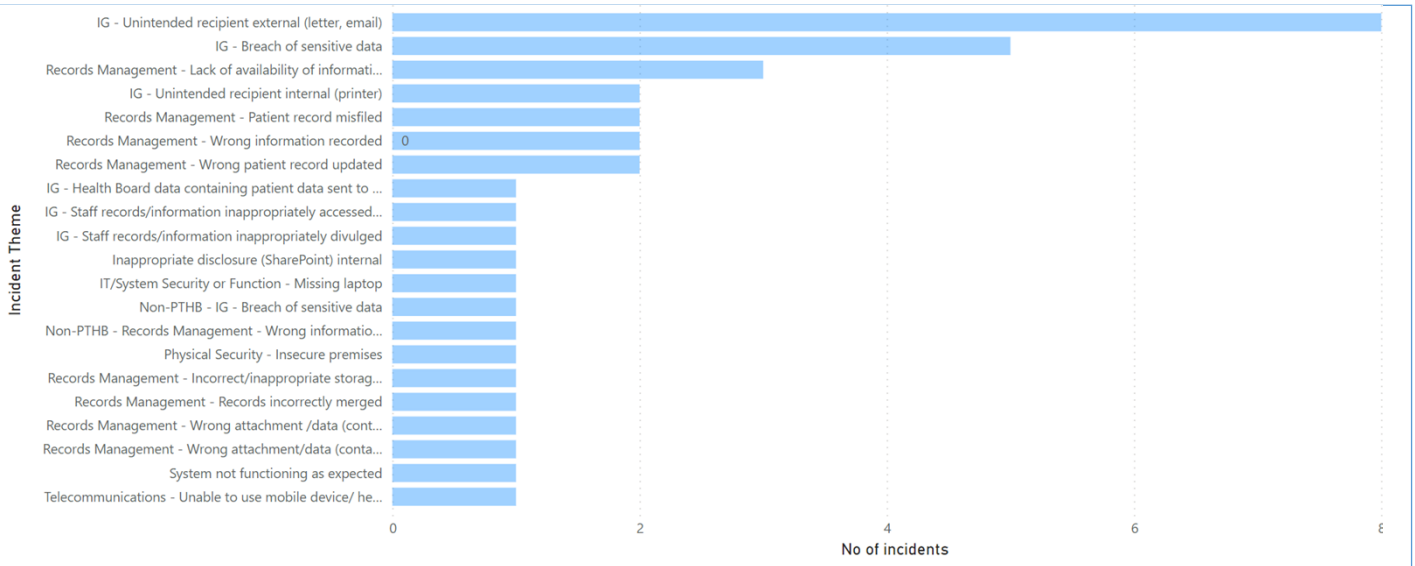


None of the incidents reported were deemed reportable to the ICO. The volume of IG incidents logged has increased which could be due to awareness raising.

The top four themes identified during this reporting period were:

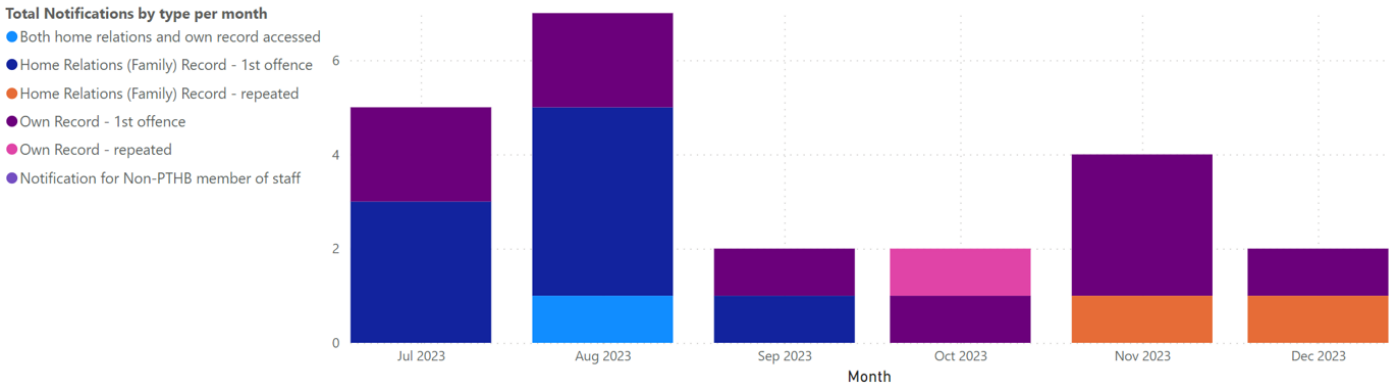
- Records Management - Missing records/documentation – 7 incidents
- Records management – Wrong information recorded – 4 incidents.
- IG - Unintended recipient external (letter, email) – 19 incidents
- IT - Unintended recipient internal (printer) – 4 incidents

Overview of themes are below:



The National Intelligent Integrated Audit Solution (NIIAS)

To streamline internal processes the IG Team have collaborated with IG colleagues from Hywel Dda University Health Board. One meaningful change to local process is that should staff offend, a Datix is logged**,** and the member of staff is asked to re-complete the mandatory IG E-Learning training especially when staff are found to be non-compliant.



NEXT STEPS:

Action plan in place for the continued improvement of PTHB IG performance and continued awareness with use of training tools.

IG related incidents – Explore ways of working with service areas to reduce the number of incidents.

IG training compliance – a reminder will be issued to non-compliant staff during Q1 2024/2025. Establish robust processes in partnership with Workforce and OD to improve compliance of new starters.

Continued assurance reports will be submitted to the Committee quarterly.

Information Governance
Final Internal Audit Report

November 2023

Powys Teaching Health Board

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

GIG CYMRU NHS WALES
Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Contents

Review reference:	PTHB-2324-09
Report status:	Final
Fieldwork commencement:	19 May 2023
Fieldwork completion:	29 June 2023
Debrief meeting:	05 July 2023
Draft report issued:	14 September 2023
Management response received:	07 November 2023
Final report issued:	07 November 2023
Auditors:	Ian Virgil (Head of Internal Audit), Martyn Lewis (Senior IM&T Audit Manager), Sian Harries (IM&T Audit Manager)
Executive sign-off:	Pete Hopgood (Executive Director of Finance, Information & IT Services)
Distribution:	Vicki Cooper (Assistant Director – Digital Transformation and Informatics), Amanda Smart (Head of Information Governance, Records & Data Protection Officer)
Committee:	Audit Risk & Assurance Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Acknowledgement
NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Executive Summary

Purpose

The overall objective of the audit is to review the adequacy of the resourcing, capacity, and resilience of the Information Governance structures to achieve compliance with UK GDPR and FoI requirements, and completion of the IG Toolkit.

Overview

We have issued **limited** assurance on this area. The significant matters which require management attention include:

- insufficient resourcing to undertake all IG duties;
- lack of wider IG structure within the Health Board to engage IG and support the IG team;
- information asset owners not identified in all service areas, and information asset register only partially progressed; and
- inadequate frequency of reporting arrangements.

Report Opinion

		Trend
Limited 	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.	N/A

Assurance summary[1]

Objectives		Assurance
1	Sufficient resources to undertake IG function	Limited
2	Appropriate structure to engage and comply with all areas of IG	Limited
3	Appropriate governance structure	Reasonable

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	IG Team Resources	1	Design	High
2	IG Structure	2	Design	High
3	Information Asset Register	2	Design	Medium
4	IG Reporting Arrangements	3	Operation	Medium

1. Introduction

1.1 In line with the 2023/24 Internal Audit Plan for the Powys Teaching Health Board (the Health Board), a review of the management of Information Governance was undertaken.

1.2 Information Governance (IG) is the framework for handling information in a secure and confidential manner that allows organisations and individuals to manage patient, personal and sensitive information legally, securely, efficiently, and effectively, in order to deliver the best possible healthcare and services.

1.3 Key legislative requirements related to IG are identified within:

- UK Data Protection Act 2018 (DPA) and the UK General Data Protection Regulation (UK GDPR); and
- Freedom of Information Act (FoIA).

1.4 The relevant lead director for the review is the Executive Director of Finance, Information & IT Services.

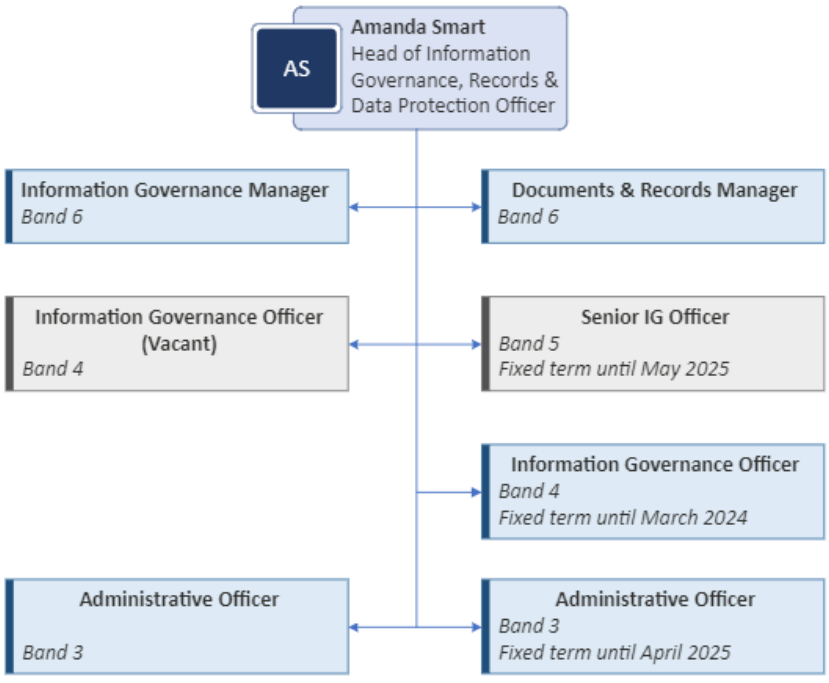
1.5 The potential risk considered in the review is as follows:

- Non-compliance with legislation.

2. Detailed Audit Findings

Objective 1: There are sufficient resources in place to enable all IG duties to be undertaken effectively.

2.1 At the time of this review, the Health Board's IG structure is depicted as below:



2.2 In line with UK GDPR, the Head of IG and Records (HoIGR) is the appointed Data Protection Officer (DPO) and is responsible for ensuring the Health Board meets its legislative and statutory duties through the governance of both IG and Records Management functions. Whilst operational responsibility for corporate and clinical records sits with services, the strategic development of the Health Board's approach to Record Management comes under the remit of the HoIGR. This includes the Records Management Improvement Plan (RMIP), created, and adopted by the Health Board's Audit, Risk and Assurance Committee in November 2019 in response to the 'No Assurance' Internal Audit Report of the same year (PTHB-1920-17 Records Management).

2.3 We note that the Health Board has recognised the importance of Information Governance and the staffing of the function has been increased to reflect this. However, as discussed below, the Health Board has been subject to increasing numbers and complexity of requests for information which has eroded the effect of the additional resource provided.

2.4 We reviewed the IG team structure and documented roles and responsibilities of team members, which highlighted substantial workloads. We note that the HoIGR currently has managerial responsibilities for all team members, and positive steps have been taken to explore the opportunity to delegate the responsibility of junior staff to the Senior Officer and Managers. We consider the current structure, inclusive of fixed term contracts and one vacancy, to offer little resilience in the service. Whilst resourcing has increased since the beginning of the pandemic, 50% of the IG team are on fixed-term contracts, which presents a continuous challenge to build a cohesive team and places further demand on the team to re-recruit and re-train new staff in the immediate future. We understand that due to the knowledge required to undertake IG roles, it can take upwards of six months to successfully embed into the team.

2.5 The HoIGR is a member of the NHS Wales Information Governance Management & Advisory Group (IGMAG), and the IG team are involved in all national and local programmes and projects involving personal data as evidenced by their programmes of work register, to ensure that potential incident risks to the Health Board are identified and resolved. It is important to note that numerous tasks within the IG team's remit are received on an ad-hoc basis, are time-limited and time-consuming, with the potential for substantial penalties if breached. Whilst not exhaustive, we have outlined below some of the more significant tasks undertaken by the IG team in addition to Access to Information requests, which are covered in detail under sections 2.14-2.24.

- investigating personal data breaches and reporting above-threshold incidents to the Information Commissioner's Office (ICO) within 72 hours;
- processing Medical Examiner Service requests within 72 hours of a death occurring;
- processing requests for Erasure or Rectification within one calendar month;
- processing Access to Information requests within 20 – 40 days;
- processing Court orders;

- completing Data Protection Impact Assessments (DPIA) for any project requiring the processing of personal data;
- completing Data Sharing Agreements;
- creating and delivering bespoke training for Health Board services; and
- NHS Wales Information Governance Toolkit for Health boards and Trusts.

2.6 The IG Team has a workplan in place. This sets out the foundational activities and work needed to develop the structures and processes within the Health Board to enable compliance with legislation and ensure good information governance is maintained going forward.

2.7 Our assessment of the IG team's current and forecasted workplan identified that resource levels are not sufficient to meet all demands from the service. We note that the workplan captures improvement and development actions which, whilst not being a legislative requirement, are actions that seek to improve information governance within the organisation. The workplan is RAG rated to demonstrate progress against duties and we observed that 11.5% of tasks are being achieved, 50% are barely being achieved and 38.5% have not been started and/or are not being achieved, which include the following:

- Policy and procedure review;
- Records Management Improvement Plan;
- Destruction of Records project;
- Digitisation of Records project;
- Information Asset Register;
- Privacy Notice for Children;
- Account Control 3 Audits;
- Record of Processing Activities (ROPA) Register;
- Auditing;
- General Information Governance and Records related guidance; and
- Professional Development.

2.8 We noted that team capacity is cited as one of the main reasons for not achieving progress with the above tasks, although we note that funding is also a constraining factor for some, e.g., the Digitisation of Records project. Capacity has also been identified as a risk to respond to requests within legislative timescales and included on the Digital Transformation Risk Register. Risk IG02, which has a current high risk rating of 9, was added to the register in June 2021. The mitigating action against risk IG02 is to undertake a review to identify additional resources required, however, we note that the risk has not been updated since August 2022. Whilst the IG team have an active workplan, it does not capture the complexity nor the time it takes to complete each task, therefore, there is a continued risk that resources required to undertake the IG function effectively, have not been fully quantified.

2.9 As observed in other Health Boards, whilst the pandemic promoted the importance of good information governance, a surge in demand of the IG team ensued as they received high volumes of requests for support to mitigate issues and risks arising from the rapid enactment of new digital ways of working, which included DPIAs,

Information Sharing Protocols (ISPs) and supplementary Privacy Notices. The IG team also received an increased number of requests for information exercising their rights from both the public and staff. We note from IG Key Performance Indicators (KPIs) regularly presented to the Delivery and Performance Committee (DPC) that the IG team continue to receive high volumes of requests, however, they do not portray the upward trend of receiving increasingly complex requests, the length of time required to resolve or level of resource available to handle them.

2.10 Factors adding to the complexity of a request may include:

- technical difficulties in retrieving information – for example if data is electronically archived.
- applying an exemption that involves large volumes of particularly sensitive information.
- clarifying potential issues around disclosing information about a child to a legal guardian.
- any specialist work involved in obtaining and/or redacting information or communicating it in an intelligible form.
- coordinating/meeting with service leads in a timely manner.
- reading and understanding current legislation and how it can be applied to complex requests.

2.11 The absence of this detail provides an inadequate representation of the IG team's current and future capacity. A full assessment of the resources available to undertake all IG-related duties is required to enable effective gap analysis, upon which capacity and resilience can be measured. We acknowledge from our meeting with the HoIGR, that recording time against duties is challenging due to already demanding workloads and options are currently being explored with the Digital Transformation Team to find a way forward. **See Matter Arising 1 at Appendix A.**

2.12 The recently appointed Documents and Records Manager was recruited to play a key role in coordinating the ongoing design and delivery of a robust Records Management Framework by progressing the Records Management Improvement Plan (RMIP). However, we noted that they are also greatly involved in supporting other statutory duties such as FOI requests and SARs, therefore, advancement of the framework has been hindered. Our review of the RMIP update report provided to the DPC on 23 June 2023, highlights significant progress is still to be made against the plan as indicated below:

Recommendation	Progress %	RAG Status	Start Date	End Date
Accountability, leadership, and coordination of records management	100			
Strategies, Policies and Procedures	50		May-22	Dec-22
Identification and Tracking of Records	40		Mar-22	Mar-23
Security of Records	30		Mar-22	Dec-22
Storage of Records	30		Mar-22	Dec-22
Risk Management	60		May-22	Dec-22

2.13 The current IG structure and present ways of working provide a challenge to maintain conformance with legislative responsibilities across multiple areas, including Access to Information requests, and to progress programs of work such as the Information Asset Register (IAR) (See Objective 2). This has impacted upon the Health Board's ability to meet strategic requirements to develop, implement and embed robust arrangements to effectively manage and protect its information assets.

Freedom of Information Act (FoIA)

2.14 Anyone has a right to request information from a public authority. Organisations have two separate duties and up to 20 working days when responding to these requests:

- to tell the applicant whether they hold any information falling within the scope of their request; and
- to provide that information.

2.15 Organisations responding to fewer than 90% of requests within 20 working days, are classed as 'unsatisfactory' by the Information Commissioner's Office (ICO). Whilst there are currently no monetary penalties for breaching FoIA, in 2022 the ICO announced that it would be delivering more systematic enforcement action against public authorities with consistent poor performance in responding to FoI requests. From our review of figures presented to the DPC, which are included in the below table, the Health Board is at risk of ICO monitoring and possible remedial action.

	Number of FOI Requests	Number of FOI breaches	% FOI Compliance
2021			
Qtr2	77	29	62
Qtr3	86	8	91
Qtr4	84	25	70
2022			
Qtr1	82	25	70
Qtr2	83	22	73
Qtr3	124	42	66
Qtr4	102	15	85
2023			
Qtr1	113	18	84
Grand Total	**751**	**184**	**75**

Subject Access Requests (SARs)

2.16 Patients, staff and third parties have the right to ask the Health Board whether they are storing personal data, what information is held, how they are using it, who are they sharing it with, where the data was obtained from, and to receive

copies of all relevant data. The request can legally be received by any member of the Health Board at any time, and can be in writing, verbally or through social media. The request does not need to include any reference to the phrase SAR or to data protection legislation.

2.17 The Health Board must respond to requests within one month. This can be extended to a maximum of three months if several requests have been made and/or the request is complex, provided a clear explanation is given to the requestor.

2.18 Data protection legislation is regulated by the ICO and stipulates several actions that need to be adhered to when responding to a SAR, including searching for relevant information and redaction. Personal data is increasingly kept electronically as well as on paper, therefore searches need to be conducted across many sources, including e-mails, Microsoft Teams, WhatsApp, SMS, clinical systems, health records, hard drives (work and home), tablets, portable memory sticks, voice recordings, social media posts and CCTV files. Once all the information has been identified, data protection legislation requires appropriate clinical / healthcare professional scrutiny, redaction, and approval prior to its release.

2.19 The IG team is responsible for managing SARs in their entirety a well as other third-party requests such as police requests, including communicating with requestors and liaising with service representatives to supply the requested information and coordinate the responses. Redactions may be necessary to avoid the disclosure of third-party information from an individual's record. It is the responsibility of the reviewing clinician or service lead to identify information for redaction to the IG team as part of the internal process, however, we learned from our meeting with the HoIGR that the IG team are increasingly having to double-check clinical / healthcare input and redaction work prior to its release due to a lack of attentiveness, which is putting further strain on the team. This is of particular concern as redaction failings and/or erroneous disclosure of information are reportable ICO breaches. A serious breach of this nature recently occurred in another NHS Wales organisation, whereby one SAR disclosure included personal information pertaining to 7 other data subjects, which was subsequently reported in the press. The repercussions of these failings were significant and led to patient and wider family distress, patient safety concerns, financial compensation, formal complaints, ICO investigation and damage to the organisation's reputation.

2.20 The ICO has the power to issue an enforcement notice or monetary penalty should a UK GDPR breach occur. The higher maximum amount is £17.5 million or 4% of the total annual worldwide turnover in the preceding financial year, whichever is higher, or the standard maximum will apply if there is an infringement of other provisions, such as administrative requirements of the legislation, which is £8.7 million or 2% of the total annual worldwide turnover in the preceding financial year, whichever is higher.

2.21 The below table and graph capture the number of SARs received and breached over the last three years. We note that overall compliance has declined year on year, which exposes the Health Board to potential ICO scrutiny.

Year	Requests	Breaches	Compliance
2020/21	422	42	90%
2021/22	369	63	83%
2022/23*	465	38	81%

**Figures up to 29 March 2023 due to reporting cycle.*

2.22 Whilst none of the breaches were reportable to the ICO on this occasion, the Health Board should ensure that internal delays in responding and/or approving requests for information are addressed and improved.

Conclusion:

2.23 Whilst the pandemic promoted the importance of good information governance, it resulted in the IG Team receiving sustained high numbers of often complex and time-consuming statutory requests, which has created a significant challenge to adequately manage all requirements of the IG function. We acknowledge that resourcing has been strengthened over the last few years, however, building a cohesive team of fixed-term staff capable of managing the rise in number and complexities of statutory requests to satisfactory levels is challenging. Newly appointed staff require thorough training whilst the team as a whole must maintain conformance with duties. There is a mounting challenge to adequately manage responsibilities across areas such as FoI and SARs, as evidenced by below-threshold compliance rates, as well as maintain progress with non-core functions and meet strategic requirements to develop IG arrangements. Furthermore, there is a potential risk to the wellbeing of the IG team if the time-pressured demand is sustained with current capacity. Consequently, we have concluded **Limited** assurance for this objective.

Objective 2: There is an appropriate structure within the organisation to ensure all areas are engaged and comply with IG.

2.24 NHS Wales has a national IG Policy, with which the Health Board is generally compliant. Our review of the local IG structure confirmed that the key roles defined within the policy have been appropriately assigned as below:

Chief Information Officer	Chief Clinical Information Officer
Senior Information Risk Owner	Executive Director of Finance, ICT and Information Services
Caldicott Guardian	Executive Medical Director
Data Protection Officer	Head of Information Governance and Records

2.25 The Health Board has an IG Strategy and Implementation Plan, however, it is outdated, covering the period of 2015 – 2018 and has not been reviewed since June 2018. We note that it has been on the IG workplan since 2019, however, due to capacity challenges (linked to Matter Arising 1), this work has not been progressed.

2.26 The Health Board has an Information Asset Register (IAR) that was developed and deployed to support the launch of the UK GDPR in 2018/19. However due to the IG team at that time consisting of only two part-time members of staff, Information Asset Owners (IAO) and Information Asset Administrators (IAA) were not adequately identified in all areas of the organisation, and the launch was taken through the IG Champions Group which has since been stood down. Whilst the IAR template has recently been modernised to be hosted on Microsoft SharePoint and some areas within the Health Board are engaged with updating their information, the content has not been fully reviewed by the IG team due to the level of demand to perform other IG duties.

2.27 IAO should be responsible for ensuring that all information held by their service area is used and managed effectively, efficiently, securely, responsibly, and legally, regardless of format. To do this, IAO responsibility needs to be formally assigned in all areas of the Health Board. **See Matter Arising 2 at Appendix A**.

2.28 As required under the UK GDPR, organisations must protect their information assets. In order to effectively do this, they need to know what information they hold, if it's correct and up to date, who it's shared with and how it's processed. The IAR should be reviewed and progressed by each service area as a tool to track this information and not only show what information is held where, but to also map out the information flows to ensure there are appropriate security measures and controls in place based on how information moves around. **See Matter Arising 3 at Appendix A**.

2.29 We positively note that the HoIGR is currently engaged with the Health Board's Business Intelligence Team to ascertain whether the IAR could be moved into an O365 application and subsequently link in with the Systems Asset Register.

Conclusion:

2.30 Whilst the Health Board has mechanisms for engaging its employees with IG, the absence of IG Leads / Champions within the organisation places demand on the IG team to perform tasks that could be delegated, such as raising awareness of data protection legislation and chasing services for information to a FoI or SAR. We note that some areas have formally assigned IAO and IAA and a progressed IAR, however, not all areas of the Health Board are engaged, therefore, there is no complete record of what information the organisation holds, if it's correct and up to date, who it's shared with and how it's processed, which not only adds additional pressure on the IG team but is also non-compliant with UK GDPR requirements. This poses a risk of ICO scrutiny and potential formal enforcement notices as detailed under objective 1. Consequently, we have concluded **Limited** assurance for this objective.

Objective 3: An appropriate reporting framework is in place.

2.31 The IG team sits within the Digital Transformation Directorate, and in-line with Standing Orders and the Board's Scheme of Delegation and Reservation of Powers, the Health Board's Delivery and Performance Committee (DPC) oversees and seeks assurance that information management and governance are sufficient, effective, and robust. In addition, the Health Board has established a Digital Governance Board (DGB), to ensure the effective, efficient, lawful and safe use of information and technologies, including services provided by Powys County Council under the section 33 agreement.

2.32 As noted under objective 1, we observed that the IG Annual Report and regular reporting of IG performance and RMIP updates are received by the DPC, which is inclusive of appropriate Executive-level members, Directors, and several Independent Members. However, from our review of IG team meeting minutes from March 2023, we noted that the business cycle of the DPC was to be modified and IG and RMIP reports are no longer to be submitted quarterly, but instead bi-annually. We understand from the HoIGR that the change has now been agreed. As the Health Board's IG compliance rates are below ICO thresholds and targets as evidenced under objective 1, we would expect to see quarterly reporting as a minimum considering the potential heavy penalties that could be imposed for failing to adequately undertake IG duties. **See Matter Arising 4 at Appendix A**.

2.33 We established that the local IG team have regular meetings with an ongoing action log. IG policies and procedures are reviewed and ratified at the DGB, and operational IG issues (including records management) are raised directly at operational service led meetings.

2.34 IG risks reside on the Digital Transformation Risk Register, which feeds into the Directorate Risk Register (Finance and IT) on an escalation basis and is overseen by the Risk and Assurance Group (RAG). We noted that the risks pertaining to IG are not included on the Directorate Risk Register, despite the residual scores being high, and further observed that RAG have not met since August 2022. As the risk governance structure is non-compliant with its own procedures, this leads to IG risks not being effectively overseen.

2.35 We have previously raised a matter arising around the operation of the RAG as part of our 2022/23 audit of Risk Management (PTHB-2223-01) and a management action to address the issue was agreed with the Director of Corporate Governance.

Conclusion:

2.36 Whilst we observed regular reporting of IG performance to appropriate committees, we have noted the risk of reducing the IG reporting cycle to the DPC to bi-annually. Less frequent formal disclosure could result in less transparency and, in effect, data going unreported for a longer period of time, which in the Health Board's current position of non-compliance with legislative requirements, could hinder the Executive Team in making informed decisions to avoid potential enforcement notices and financial penalties for failing to meet ICO thresholds and targets. Consequently, we have concluded **Reasonable** assurance for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Information Governance Team Resources (Design)	**Impact**
Our review highlighted substantial demand on the IG function. The sustained high number and growing trend of more complex statutory requests and requirements has created a reactive rather than proactive way of working. There is a mounting challenge to adequately manage legislative responsibilities across areas such as FoI and SARs, as evidenced by below-threshold compliance rates, as well as maintain progress with non-core functions and meet strategic requirements to develop IG arrangements. KPI reporting is against the number of requests received without measurement against the level of resources available to handle them. This does not provide an adequate representation of the IG team's current or future capacity, as there is no detail of the time and resources required to resolve requests.	Potential risk of: • non-compliance with legislation

	Recommendations	**Priority**
1.1	The Health Board should ensure that a full assessment of needs and resources is undertaken to identify gaps and risk areas upon which capacity and resilience can be appropriately measured, including but not limited to the following: • all current and upcoming legislative duties, tasks, and strategic developments segregated into corresponding areas such as Records Management or IG; • approximate average time to resolve requests based on level of complexity (until a more suitable solution can be achieved with the Digital Transformation Team); • resource utilisation metrics e.g., total 'billable' hours / total available working hours x 100	**High**
1.2	As part of the recommended assessment, the Health Board should consider re-assigning managerial responsibility of junior staff to the Senior Officer and Managers within the IG team to allow the HoIGR to invest time in their role as DPO, ensuring that any amendments are updated in respective job descriptions.	**Medium**

Agreed Management Action	**Target Date**	**Responsible Officer**

1.1	Accept: Work is being undertaken to identify and deploy a suitable digital solution that the IG team can use which will capture all information required to support a full needs analysis.	30/5/2024	**Head of Information Governance, Records and DPO**
1.2	Accept: Job Descriptions of both the Documents and Records Manager and Information Governance Manager have been updated to include managerial responsibility and these have been through Consistency Panel. Request has been made through ESR to reflect these changes and delegate managerial responsibility.	COMPLETE	**Head of Information Governance, Records and DPO**

Matter Arising 2: IG Structure (Design)	**Impact**
Information Asset Owners (IAO) and Information Asset Administrators (IAA) have been assigned in some but not all areas of the Health Board. Information Asset Owners should be responsible for ensuring that all information held by their directorate/service area is used and managed effectively, efficiently, securely, responsibly, and legally, regardless of format. To do this, IAO responsibility needs to be formally assigned in all areas. Whilst the Health Board has key defined roles and mechanisms of engaging its employees with IG through policies, guidance, training and IG alerts for example, we identified that it does not have service-level IG Leads / Champions as observed in other NHS Wales organisations. IG Leads / Champions support the IG function by channelling information on data protection within their respective areas and ensure tasks are completed for the IG team. We understand from the HoIGR that due to the unique way the Health Board is structured that identifying staff who are operational, and the correct level of seniority to be IG Leads / Champions has proved difficult in the past, however, this should be revisited in conjunction with identifying appropriate IAO and IAA, with the purpose of assisting the IG team in discharging its duties.	Potential risk of: • non-compliance with legislation

Recommendations		**Priority**
2.1	The Health Board should ensure that IAO and IAA responsibilities are assigned to appropriate individuals with required seniority and authority to oversee the controls on the information assets and how they are used, within all areas of the organisation.	**High**
2.2	The Health Board should ensure that appropriate IG Leads / Champions are identified within the Health Board to support the IG team by promoting good information governance practice.	**Medium**

Agreed Management Action	**Target Date**	**Responsible Officer**

2.1	Accept: Work is underway to engage with Service Leads to identify key staff within their services to take on the role of IAO and IAA and these roles will be supported by the Information Governance Team. Once roles have been assigned, training will be provided to support these staff to understand their roles as IAO or IAA. Ongoing review and reporting on the IAR will be undertaken by the Information Governance Team, IAO and IAA, where risks/issues will be discussed and where necessary reported via the Risk and Assurance Committee for consideration.	**28/2/24**	**Head of Information Governance, Records and DPO**
2.2	Accept: Work is underway to engage with Service Leads to identify key staff within their services to take on this role. Once identified work will take place led by the IG Team to utilise these roles to support the IG/Records Workplans to promote good information governance practices in both health and corporate areas. A PTHB Information Governance Advisory Group will be set up to meet bi-annually, to discuss progress the Information Asset Register agenda and promotion of good Information Governance practices across the organisation.	**31/3/24**	**Head of Information Governance, Records and DPO**

Matter Arising 3: Information Asset Register (IAR) (Design)	**Impact**
The Health Board has been unable to review and progress the content of the IAR since its development in 2018/19. It is imperative that organisations know what information they hold, if it's correct and up to date, who it's shared with and how it's processed. An IAR should be developed as a tool to track this information and not only show what information is held where, but to also map out the information flows to ensure there are appropriate security measures and controls in place based on how information moves around. Linked to matter arising 2, the IAO and IAA should be responsible for progressing the IAR within their respective areas.	Potential risk of: • non-compliance with legislation

Recommendations			Priority
3.1	The Health Board should ensure that the IAR is progressed by the Information Asset Owners and Information Asset Administrators identified under recommendation 2.1.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
3.1	Accept: The existing Information Asset Register is due to move to a new platform in Power BI which will enhance monitoring for completeness and data quality providing better tools for the IG Team, IAO and IAA to ensure all assets are entered in a timely manner and are correct.	**31/3/24**	**Head of Information Governance, Records and DPO**

Matter Arising 4: IG Reporting Arrangements (Operation)			**Impact**
We note that the business cycle of the Delivery and Performance Committee has been modified and IG performance reports are no longer to be submitted quarterly, but instead bi-annually. As the Health Board's IG compliance rates are below ICO thresholds and targets, we would expect to see quarterly reporting as a minimum considering the potential heavy penalties that could be imposed for failing to adequately undertake IG duties.			Potential risk of: • non-compliance with legislation.
Recommendations			**Priority**
4.1	The Health Board should consider re-establishing submission of quarterly IG performance and Records Management Improvement Plan reports to the Executive Team and Delivery and Performance Committee.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
4.1	Accept: For 23/24 IG Performance report submission will be increased with a submission to the Delivery and Performance Committee in December 2023 and IG annual report submission in April 2024. 24/25 business cycle for IG and Records Management reporting will be agreed ahead of March 2024.	**1/3/24**	**Director of Corporate Governance**

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**Unsatisfactory assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

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Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 6.1

Delivery and Performance Committee	**Date of Meeting: 29 February 2024**
Subject:	**COMMITTEE BASED RISKS ON THE CORPORATE RISK REGISTER**
Approved and Presented by:	Director of Corporate Governance
Prepared by:	Interim Head of Corporate Governance
Other Committees and meetings considered at:	n/a

PURPOSE:

The purpose of this paper is to provide the Committee with the December 2023 version of the Committee Risk Register for information.

RECOMMENDATION(S):

It is recommended that the Committee CONSIDERS the December 2023 version of the Committee Risk Register, which reflects the risks identified as requiring oversight by this Lead Committee. This iteration of the Committee Risk Register is based upon the Corporate Risk Register (CRR) considered by the Board on 31 January 2024.

Approval/Ratification/Decision	Discussion	Information
✖	✓	✓

THE PAPER IS ALIGNED TO THE DELIVERY OF THE FOLLOWING STRATEGIC OBJECTIVE(S) AND HEALTH AND CARE STANDARD(S):

Strategic Objectives:	1. Focus on Wellbeing	
	2. Provide Early Help and Support	
	3. Tackle the Big Four	
	4. Enable Joined up Care	
	5. Develop Workforce Futures	

	6. Promote Innovative Environments	
	7. Put Digital First	
	8. Transforming in Partnership	✓
Health and Care Standards:	1. Staying Healthy	
	2. Safe Care	
	3. Effective Care	
	4. Dignified Care	
	5. Timely Care	
	6. Individual Care	
	7. Staff and Resources	
	8. Governance, Leadership & Accountability	✓

EXECUTIVE SUMMARY:

The purpose of the Committee Risk Register is to draw together relevant risks for the Committee from the Corporate Risk Register (CRR), to provide a summary of the significant risks to delivery of the health board's strategic objectives.

BACKGROUND AND ASSESSMENT:

The CRR provides a summary of the significant risks to the delivery of the health board's strategic objectives. Corporate risks also include risks that are widespread beyond the local area, and risks for which the cost of control is significantly beyond the scope of the local budget holder. The CRR is reviewed by the Executive Committee on a bi-monthly basis and is noted by the Board.

The Committee is asked to DISCUSS the risks relating to Delivery and Performance Committee and the risk targets within the Committee Risk Register, and to CONSIDER whether the targets identified are achievable and realistic.

The full Committee Risk Register is attached at **Appendix A.**

NEXT STEPS:

The development of Committee risk registers will be progressed in order to provide greater oversight of the more detailed aspects of the risks, controls and mitigating actions within the Corporate Risk Register.

Delivery & Performance Committee
(29th February 2024)
Committee Based Risk Register

CORPORATE RISK HEAT MAP

There is a risk that...

In-Committee Risks (Private)			CRR 009 A cyber-attack results in significant disruption to services and quality of patient care (Risk Score: L4 x I5 = 20)				
Impact	**Catastrophic**	**5**				• The health board fails to manage its financial resources in line with statutory requirements – current financial year • The urgent and emergency health and social care system fails to deliver a timely response for care for Powys citizens • The health board fails to manage its financial resources in line with statutory requirements – medium term	
	Major	**4**			• A significant public health event/emergency impacts on provision, continuity and sustainability of services	• The health board fails to adequately allocate resources, including transformation capacity, to improve health outcomes/experience and reduce inequalities • The care provided in some areas is compromised due to the health board's estate being not fit for purpose.	• Inequity of access to planned, secondary and specialised care results in poorer outcomes and experience for some Powys citizens
	Moderate	**3**					
	Minor	**2**					
	Negligible	**1**					
			1	**2**	**3**	**4**	**5**
			Rare	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
			Likelihood				

COMMITTEE RISK DASHBOARD

Risk Lead	Risk ID	Main Risk Category	Risk Description There is a risk that:	SCORE (Likelihood x Impact)	Board Risk Appetite	Risk Target	At Target ✓/×	Lead Board Committee	Risk Impacts on
DFIT	CRR 001a	**Financial Sustainability**	The health board fails to manage its financial resources in line with statutory requirements -current financial year	**4 x 5 = 20**	Cautious	8	×	Delivery and Performance	Organisational Priorities underpinning all WBOs
DFIT	CRR 001b	**Financial Sustainability**	The Health board fails to manage its financial resources in line with statutory requirements – medium term	**4 x 5 = 20**	Cautious	8	×	Delivery and Performance	Organisational Priorities underpinning all WBOs
DFIT	CRR 002	**Financial Sustainability**	The health board fails to adequately allocate resources, including transformation capacity, to improve health outcomes/experience and reduce inequalities	**4 x 4 = 16**	Cautious	8	×	Delivery and Performance	Organisational Priorities underpinning all WBOs
D Ops	CRR 004	**Safety**	The urgent and emergency health and social care system fails to deliver a timely response for care for Powys citizens	**4 x 5 = 20**	Averse	12	×	Delivery and Performance	Organisational Priorities Underpinning WBO 1 to 4

Risk Lead	Risk ID	Main Risk Category	Risk Description There is a risk that:	SCORE (Likelihood x Impact)	Board Risk Appetite	Risk Target	At Target ✓/×	Lead Board Committee	Risk Impacts on
DP&C	CRR 005	**Quality**	Inequity of access to planned, secondary and specialised care results in poorer outcomes and experience for some Powys citizens	**5 x 4 = 20**	Minimal	12	×	Delivery and Performance	Organisational Priorities Underpinning WBO 1 to 4
ADoEP	CRR 010	**Quality**	The care provided in some areas is compromised due to the health board's estate being not fit for purpose	**4 x 4 =16**	Minimal	9	×	Delivery and Performance	Organisational Priorities Underpinning WBO 1 to 4
DPH	CRR 011	**Performance and Service Sustainability**	A significant public health event/emergency impacts on provision, continuity and sustainability of services	**3 x 4 = 12**	Cautious	12	✓	Delivery and Performance	Health and wellbeing of the population

KEY

Risk Appetite Descriptors and Categories

Risk Appetite	Description
Averse	Avoidance of risk and uncertainty in achievement of key deliverables or initiatives is key objective. Activities undertaken will only be those considered to carry virtually no inherent risk.
Minimal	Preference for very safe business delivery options that have a low degree of inherent risk with the potential for benefit/return not a key driver. Activities will only be undertaken where they have a low degree of inherent risk.
Cautious	Preference for safe options that have low degree of inherent risk and only limited potential for benefit. Willing to tolerate a degree of risk in selecting which activities to undertake to achieve key deliverables or initiatives, where we have identified scope to achieve significant benefit and/or realise an opportunity. Activities undertaken may carry a high degree of inherent risk that is deemed controllable to a large extent.
Open	Willing to consider all options and choose one most likely to result in successful delivery while providing an acceptable level of benefit. Seek to achieve a balance between a high likelihood of successful delivery and a high degree of benefit and value for money. Activities themselves may potentially carry, or contribute to, a high degree of residual risk.
Eager	Eager to be innovative and to choose options based on maximising opportunities and potential higher benefit even if those activities carry a very high residual risk.

Executive Lead:	
CEO	Chief Executive
DFIT	Director of Finance, Information and IT
D Ops	Director of Operations/Director of Community and Mental Health
DoNM	Director of Nursing and Midwifery
MD	Medical Director
DPH	Director of Public Health
DWOD	Director of Workforce & Organisational Development
DoTHS	Director of Therapies & Health Sciences
DP&C	Director of Performance and Commissioning
ADoEP	Associate Director of Estates and Property
DCG	Director of Corporate Governance

Risk Scoring

LIKELIHOOD	IMPACT				
	Insignificant 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
Almost Certain 5	5	10	15	20	25
Likely 4	4	8	12	16	20
Possible 3	3	6	9	12	15
Unlikely 2	2	4	6	8	10
Rare 1	1	2	3	4	5

Very Low	1-3	Low	4-8	Moderate	9-12	High	15-25

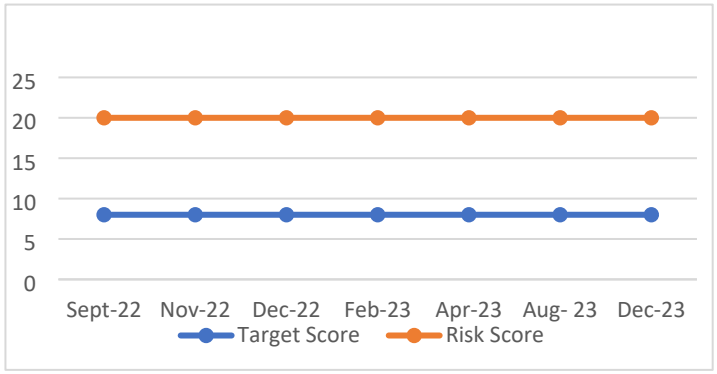
RISK APPETITE	
Category	**Appetite for Risk**
Safety	Averse
Quality	Minimal
Regulation and Compliance	Cautious
Reputation and Public Confidence	Cautious
Performance and Service Sustainability	Cautious
Financial Sustainability	Cautious
Workforce	Cautious
Partnerships	Open
Innovation and Strategic Change	Open

CRR 001a **Risk that:** the health board fails to manage its financial resources in line with statutory requirements – current financial year	**Executive Lead:** Director of Finance, Information and IT **Assuring Committee:** Delivery and Performance
Risk Impacts on: Organisational Priorities underpinning all objectives	**Date last reviewed:** December 2023

Risk Rating

(likelihood x impact):
Inherent: 4 x 5 = 20
Current: 4 x 5 = 20
Target: 2 x 4 = 8

Date added to the risk register
Risk Updated & Split June 2023



Rationale for current score:

- Financial planning for 2023/24 has identified that the THB will have a significant deficit.
- The Plan submitted to WG in March 2023 was for a deficit of £33.5m in 2023/24 with a planned underlying deficit carried forward into 2024/25 of £33.5m.
- Following the receipt of £18.3m funding in October and the setting of a target control total of £12m deficit by WG, the Health Board instigated actions and approved a revised Financial Plan of £12m deficit.
- The THB forecasts that it can manage its capital expenditure within the capital allocation.

Controls (What are we currently doing about the risk?)

- Clear Financial Plan included in IMTP Submission with recurrent mitigating actions of £7.5m.
- Additional control - Finance and Performance Group established as sub-group of Executive Committee is monitoring the achievement of the mitigating actions.
- Financial Control Procedures and Standing Orders and Standing Financial Instructions and Budgetary Control Framework, Budgetary Control Audit rated as substantial assurance.
- Risks and Opportunities – focus and action to maximise opportunities and minimise / mitigate risks.
- Service Reviews / Performance reviews to strengthen financial monitoring of performance and longer-term impact on financial plan (support better decision making).
- Contracting Framework to monitor and forecast the impact of arrangements in 2023/24 and going forward.

Mitigating actions (What more will we do?)

Action	Lead	Deadline
The capacity, capability and sustainability of the Finance Team is being re-assessed given the step change in the financial challenges facing the organisation and the increased external scrutiny.	DFIIT	March 2024
Revisit the assessment of cost pressures in the Financial Plan for 2023/24.	DFIIT	Completed
Consider whether saving schemes can achieve more in 2023/24.	DFIIT	Completed
Increase focus on longer term efficiency and sustainability (value) and balance with in year delivery as needed for plan. Value Based	DFIIT / MD	Established

▪ Task and Finish Groups established for CHC, Variable Pay and Contracting with identified leads and clear expectation re delivery, these groups will have a short and longer-term focus for delivery. ▪ Investment Benefits Group to increase its focus on benefits realisation alongside supporting the VBHC approach. ▪ Regular communication and reporting to Welsh Government and Financial Planning and Delivery Directorate regarding the impact of pressures and impact on Financial Plan and underlying position. ▪ Value Programme Board supporting a series of Getting it Right First Time Reviews and Planned Care Programme Board implementing the findings to improve outcomes and use of resources. ▪ Revised Financial Plan approved in November 2023, including clear mitigating actions targeting a £3.2m stretch improvement.	Healthcare and Sustainable Model Programme Boards established.		
Current Risk Rating	**Update including impact of actions to date on current risk score**		
4 x 5 = 20	Finance and Performance Group is focussing on delivery of recurrent £7.5m mitigating actions targeted for 2023/24. Recent exercise focused on financial improvement has helped to inform actions being taken to manage and off-set emerging cost pressures. Clear, risk rated mitigating actions targeting a £3.2m stretch improvement.		

CRR 001b
Risk that: the health board fails to manage its financial resources in line with statutory requirements – medium term

Executive Lead: Director of Finance, Information and IT

Assuring Committee: Delivery and Performance

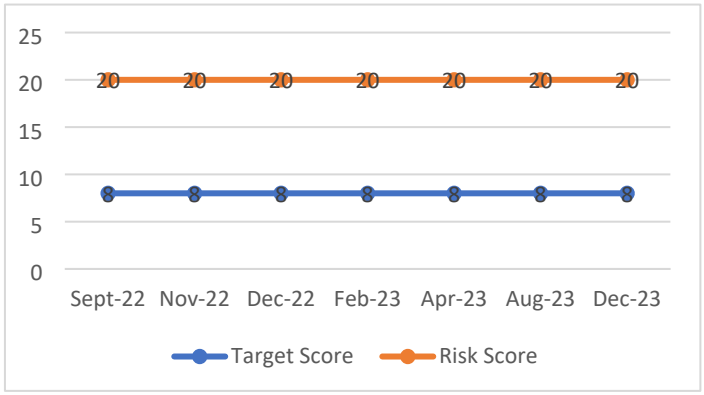
Risk Impacts on: Organisational Priorities underpinning all objectives

Date last reviewed: December 2023

Risk Rating

(likelihood x impact):
Inherent: 4 x 5 = 20
Current: 4 x 5 = 20
Target: 2 x 4 = 8

Date added to the risk register
Risk Updated
September 2022



Rationale for current score:

- Financial planning for 2023/24 has identified that the THB has a significant deficit. The Plan submitted to WG in March 2023, and reconfirmed in May 2023, included an underlying deficit of £33.5m.
- The Health Board received £18.3m additional funding in October 2023. Of this, £14.2m is recurrent conditional on the Health Board progressing towards its 2023/24 £12m deficit control target.
- The Health Board is experiencing greater cost pressures than its recurrent mitigating actions can contain, which is leading to an increase in its underlying deficit.
- The scale of this deficit against annual expenditure of circa £400m makes it probable that the organisation will not be able to comply with its statutory duty to breakeven for some time.

Controls (What are we currently doing about the risk?)

- Clear Financial Plan included in IMTP Submission with recurrent mitigating actions of £7.5m. Plus, non-recurrent stretch actions for a further £2.8m in 2023/24.
- Additional control - Finance and Performance Group established as sub-group of Executive Committee is monitoring the achievement of the mitigating actions.
- Financial Control Procedures and Standing Orders and Standing Financial Instructions and Budgetary Control Framework, Budgetary Control Audit rated as substantial assurance.
- Risks and Opportunities – focus and action to maximise opportunities and minimise / mitigate risks.
- Service Reviews / Performance reviews to strengthen financial monitoring of performance and longer-term impact on financial plan (support better decision making).
- Contracting Framework to monitor and forecast the impact of

Mitigating actions (What more will we do?)

Action	Lead	Deadline
The capacity, capability and sustainability of the Finance Team is being re-assessed given the step change in the financial challenges facing the organisation and the increased external scrutiny.	DFIIT	March 2024
Revisit the assessment of cost pressures in the Financial Plan for 2023/24.	DFIIT	Competed
Increase focus on longer term efficiency and sustainability (value) and balance with in year delivery as needed for plan. Value Based Healthcare and Sustainable Model Programme Boards established.	DFIIT / MD	Established

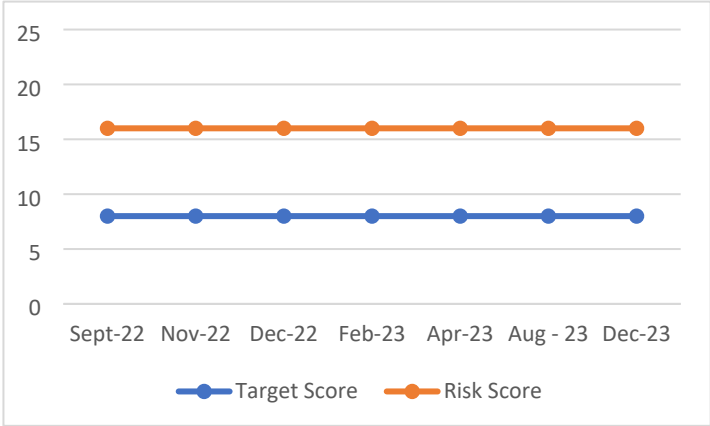
arrangements in 2023/24 and going forward. ▪ Task and Finish Groups established for CHC, Variable Pay and Contracting with identified leads and clear expectation re delivery, these groups will have a short and longer-term focus for delivery. ▪ Investment Benefits Group to increase its focus on benefits realisation alongside supporting the VBHC approach. ▪ Regular communication and reporting to Welsh Government and Financial Planning and Delivery Directorate regarding the impact of pressures and impact on Financial Plan and underlying position. ▪ Value Programme Board supporting a series of Getting It Right First Time Reviews and Sustainable Model Planned Care Programme Board implementing the findings to drive improved outcomes and use of resources. ▪ Following the issue of the 2024/25 Allocation Letter, the financial plan for 2024/25 and underlying deficit is being prepared. ▪ As part of planning for 2024/25, an organisation wide group of AD/DDs has been established to identify actions to achieve recurrent savings.			
Current Risk Rating	**Update including impact of actions to date on current risk score**		
4 x 5 = 20	Finance and Performance Group is focussing on delivery of £7.5m recurrent mitigating actions targeted for 2023/24. As part of planning for 2024/25, an organisation wide group of AD/DDs has been established to identify actions to achieve recurrent savings.		

CRR 002 **Risk that:** the health board fails to adequately allocate resources, including transformation capacity, to improve health outcomes/experience and reduce inequalities	**Executive Lead:** Director of Finance, Information and IT **Assuring Committee:** Delivery and Performance
Risk Impacts on: Organisational Priorities underpinning all WBOs	**Date last reviewed:** December 2023

Risk Rating

(likelihood x impact):
Inherent: 4 x 5 = 20
Current: 4 x 4 = 16
Target: 2 x 4 = 8

Date added to the risk register
September 2022



Rationale for current score:

- Planned deficit of £33.5m for 2023/24 indicates that resources are being consumed above planned and allocated levels. Reconfirmed by revised 2023/24 financial plan with £12m target control total.
- Lack of data re Patient Outcome and Experience to support understanding. Nationally the PROMS and PREMS electronic platforms have been procured separately. The platform for patient experience is in place, but does not have all the necessary functionality for PROMS collection and analysis.
- Value Based Healthcare approach introduced, but not yet embedded into financial plan and budget allocation fully.
- Value Programme Board established and key action is to develop the Health Board approach to PROMs and PREMs (to measure patient experience and outcomes) to inform future resource allocation. Procurement of a national platform is underway.
- PTHB is working with national groups to ensure that dashboards show a resident health board position, including English flows, rather than a Welsh provider position, so that they are reliable for corporate decision making in Powys.
- CEO led Sustainable Model Programme Board in place, embedding a value based health care approach, with supporting executive led programmes for Frailty, Community Urgent Care; Planned Care, Diagnostics and Admission Avoidance; and Mental Health
- Draft design report submitted to PPPH Committee, to be considered as next part of next iteration of long term plan.
- Value Programme Board continuing to support ~~a series of~~ Getting It Right First Time Reviews
- Sustainable Model Planned Care Programme implementing findings from a series of Getting It Right First Time Reviews; and rolling out implementation of value based service developments and clinical techniques.

	▪ Frailty, Community and Urgent care Programme Board; Planned Care Programme Board; and Mental Health Programme Board helping to develop and deliver the sustainable model. ▪ Following the reduction in funding from WG for Recovery and an exercise to reduce expenditure, £500k has been removed from the budget for transformation.

Controls (What are we currently doing about the risk?)	Mitigating actions (What more will we do?)		
	Action	**Lead**	**Deadline**
▪ Value Board established (report via Sustainable Model Executive Committee Programme Board). ▪ Value approach embedded in IMTP focused on outcome, experience and cost. ▪ Organisational position in relation to PROMs and PREMs (to inform resource allocation and actions) approved in principle by Executive Committee, based on EQ5DL for PROMS, overlaid with condition specific outcomes. ▪ CIVICA in place for the collection of patient experience. ▪ PROMS Group established to assist with technical implementation of PROMS. Value Opportunities Group established. ▪ Interventions Not Normally Undertaken Group established. ▪ Information and Data Dashboards under development to inform reporting re outcomes and experiences, with work undertaken to ensure national dashboards are amended to show resident health board position including English patient flows. ▪ Accelerated Sustainable Model Programme in place with Discovery Report completed, embedding value approach, to help guide prioritisation and resource allocation for maximum value impact. ▪ Approach agreed with WOAD and Programme Board to develop and embed organisational understanding of value from induction through to leadership development. ▪ Series of Getting It Right First Time Reviews completed with implementation underway through the Sustainable Model Planned Care Programme Board ▪ Reports for Community Cardiology indicate positive shift underway. First phase roll out in North Powys, at end of December 2023, showed that of 410 patients seen to date only 17 have required onward referral to a DGH	Action as identified in Value Group Workplan including approach to developing PROMs and PREMs.	AD T&V	Ongoing.
	Ongoing Action as per the Value Group Workplan.	AD T&V	Ongoing.
	Continue to progress work on the Accelerated Sustainable Model including Design and Delivery phases, including work on planned care, frailty and mental health.	Execs and ADTV	23/24

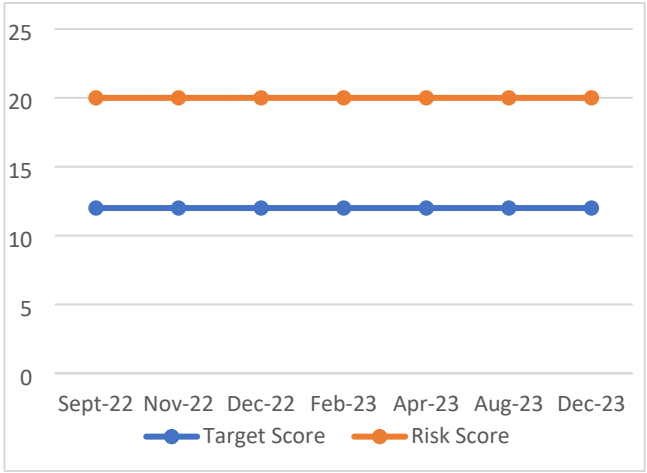
consultant. 333 patients have received an echocardiogram in Powys and 23 an ECG. Treatment plans have been put in place for 230 patients locally ▪ Full Board involvement in development of priorities and financial plans for 2023/24.			
Current Risk Rating	**Update including impact of actions to date on current risk score**		
4 x 4 = 16	N/A		

CRR 004 **Risk that:** the urgent and emergency health and social care system fails to deliver a timely response for care for Powys citizens	**Executive Lead:** Director of Operations/Director of Community and Mental Health **Assuring Committee:** Delivery and Performance Committee
Risk Impacts on: Organisational Priorities underpinning WBO 1 to 4	**Date last reviewed:** December 2023

Risk Rating

(likelihood x impact):
Inherent: 4 x 5 = 20
Current:4 x 5 = 20
Target: 3 x 4 = 12

Date added to the risk register
September 2022



Rationale for current score:

- Fragility and rising demand on the unscheduled care system, including 111, GP In and Out of Hours, WAST response times, delays and pressures within the acute system. This includes delays in discharges and flow from acute and community hospital settings. This leads to an impact/effect on the quality of timely care provided to patients, delays in care and poorer outcomes, increased incidents of a serious nature relating to handover delays at the Emergency departments front door and delayed ambulance response to community emergency calls, increasing pressure on adverse patient experience, reduction in stakeholder confidence and increased scrutiny from regulators.
- Planned industrial action and potential impact on the urgent and emergency health system capacity to meet demand and timely response for care.
- Fragility and gaps in social care assessment, delivery and social care market provision (including both domiciliary care and independent care home sector) resulting in substantial delays and patients being stranded in community hospitals and out of county beds.
- Delays in assessment of complex care cases and inefficient brokering resulting in increased delays and cost.

Controls (What are we currently doing about the risk?)

- Daily management system in place to manage patient flow including multiple daily local and national calls.

Mitigating actions (What more will we do?)

Action	Lead	Deadline
Review of Complex Care arrangements in place to improve system improvements and to reduce delays. Active planning and implementation of new ways of working to create capacity within current	DoO	April 2024

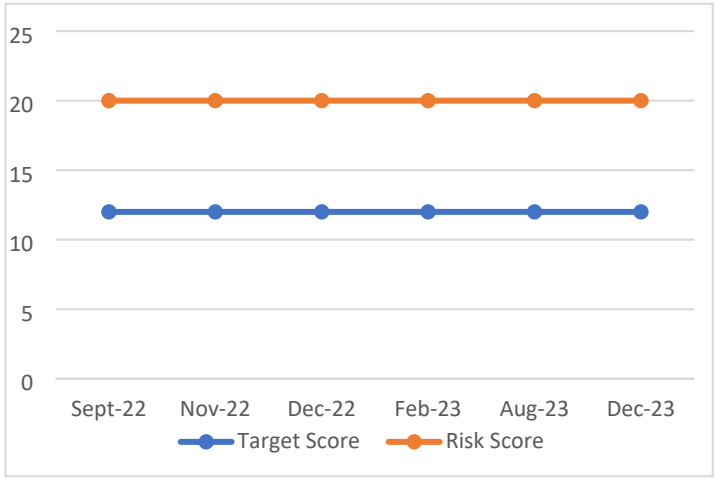
▪ Continuous focus on reducing delays for health and social care reasons including complex care management, fast track cases and implementation of a home first ethos. ▪ Weekly reviews of long stay patients in community hospitals to reduce average length of stay. ▪ Training on discharge and complex care management is provided to ward based staff through the Complex Care and Unscheduled Care Team. ▪ Review of urgent care team arrangements, with agreement to fund a business case for Discharge Liaison officers. ▪ Care coordination in place across all acute hospital sites to facilitate timely repatriation of patients back into Powys. ▪ Care Home risk and escalation plans to support care home capacity. ▪ Reinstatement of Delivery Coordination Group including Senior Social Care attendance. ▪ Winter Plan reviewed to manage whole system pressures. Refresh of escalation options in development between health and social care to increase community care capacity and to reduce delays. ▪ Industrial action command and control structure in place to manage service impact and to minimise disruption to services. ▪ Daily operational management of patient flow. ▪ Refresh of Delivery Coordination Group in place to improve performance and delivery at a system level. ▪ System escalation including senior officer daily review and weekly Gold level oversight. ▪ Urgent escalation plan in development to secure additional system impact to improve community care capacity and flow. ▪ Industrial action management plans in place, coordinated and reporting at bronze, silver and gold levels.	system. Internal Audit have commenced structured audit of Continuing Health Care.		
	Transformational development of urgent care system (6 Goals) including ICAP and focus on handover delays.	DoO	
	Delivery of RPB Plan including additional capacity for Supported Living.		October 2024
	Deliver the Integrated Care Action Plan (ICAP).		2025
	ASM Programme for Frailty and Community Model.		2025
	North Powys Wellbeing Programme.		
Current Risk Rating	**Update including impact of actions to date on current risk score**		
4 x 5 = 20	N/a - new risk September 2022		

CRR 005 **Risk that:** inequity of access to planned, secondary and specialised care results in poorer outcomes and experience for some Powys citizens	**Executive Lead:** Director of Performance and Commissioning **Assuring Committee:** Delivery and Performance
Risk Impacts on: Organisational Priorities underpinning WBO 1 to 4	**Date last reviewed:** December 2023

Risk Rating

(likelihood x impact):
Inherent: 5 x 4 = 20
Current:5 x 4 = 20
Target: 3 x 4 = 12

Date added to the risk register
Risk Updated December 2022



Rationale for current score:
Baseline as at end of September 2022 indicates current aggregated waiting times as follows (including PTHB provided services):
5,194 patients waiting over 36 weeks, of these 2,795 are waiting over 52 weeks of those 668 wait longer than 104 weeks.

Validated position: at end November 2023 in NHS Wales commissioned service providers, 281 Powys residents waiting > 104 weeks; 1155 Powys residents waiting 53-104 weeks.

At end of September 2023 in NHS England commissioned service providers, 11 Powys residents waiting > 104 weeks; 845 Powys residents waiting 53-104 weeks.

A number of patients are not getting treatment within published access standards. There is the potential risk of and harm for patients with excessive treatment waiting times.

If urgent and emergency care pressures lead to the invoking of the NHS Local Options Framework, planned care will be reduced/suspended resulting in further delays to treatment.

Controls (What are we currently doing about the risk?)

- Performance Trajectories and details on harm reviews for Powys residents requested from commissioned service providers in NHS England and NHS Wales to understand year-end position for 2023/24 (with reference to NHS Wales Planning Framework 2023-26 and NHSE access target requirements by March 2024).
- Medinet contract previously extended to offer Powys residents experiencing long waits in commissioned service providers in NHS Wales to be treated in Powys. Work being progressed to issue a tender for insourced provision in 2024/25.

Mitigating actions (What more will we do?)

Action	Lead	Deadline
Secure performance improvement trajectories from providers.	DPP	April 2024

▪ Proposals being developed with Robert Jones and Agnes Hunt to provide increased capacity for high volume low complexity long waiting orthopeadic patients. ▪ Identify key priorities to deliver elective treatments within ministerial access targets. ▪ Implementation of Integrated Performance Framework. Performance Engagement Group established. ▪ Ongoing scrutiny and oversight through CQPR meetings with escalation through Integrated Performance Report. ▪ Ensure Powys residents are included in the activity being sourced through the West Midlands Mutual Aid hub.			
Current Risk Rating	**Update including impact of actions to date on current risk score**		
5 x 4 = 20	Improved performance experienced within NHS England commissioned service providers; same level of improvement not being experienced in NHS Wales commissioned service providers creating inequity of access for Powys residents.		

CRR 010 **Risk that:** the care provided in some areas is compromised due to the health board's estate being not fit for purpose	**Executive Lead:** Associate Director of Capital, Estates and Property **Assuring Committee:** Delivery and Performance
Risk Impacts on: Organisational Priorities underpinning Well-being Objectives 1 to 4	**Date last reviewed:** December 2023

Risk Rating

(likelihood x impact):
Inherent: 4 x 5 = 20
Current: 4 x 4 = 16
Target: 3 x 3 = 9

Date added to the risk register
January 2017

Rationale for current score:

- **Estates Compliance**: 38% of the estate infrastructure was built pre-1948 and only 5% of the estate post-2005. Significant investment and risk-based programmes of work over several years across the compliance disciplines (fire, water hygiene, electric, medical gases, ventilation, etc.) will be required.
- **Capital:** the health board has not had the resource or infrastructure in place in recent times to deliver a significant capital programme and this places pressures on systems, capital resource and the wider organisation to fully support major project activity. Furthermore, Discretionary Capital acts as the safety net for overspend on capital projects for the health boards, and with a very limited discretionary allowance in PTHB this is a significant financial risk. Whilst PTHB is fortunate to receive significant slippage monies from Welsh Government each year, due to financial challenges this may not be possible at the end of this year.
- **Environment & Sustainability**: NHS Wales Decarbonisation Strategic Delivery Plan published in 2021 - challenging targets with limited resource.

Controls (What are we currently doing about the risk?)	Mitigating actions (What more will we do?)		
ESTATES ▪ Specialist sub-groups for each compliance discipline ▪ Risk-based improvement plans introduced ▪ Specialist leads identified ▪ Estates Compliance Group and Capital Control Group established ▪ Medical Gases Group; Fire Safety Group; Water Safety Group; Health & Safety Group and Ventilation Safety Group in place. ▪ Capital Programme developed for compliance and approved capital programme ▪ Capital and Estates set as a specific Organisational Priority in the health board's Annual Plan ▪ Address (on an ongoing basis) maintenance and compliance issues ▪ Address maintenance and compliance improvements to ensure patient environment is safe, appropriate and in line with standards **CAPITAL** ▪ Capital Procedures for project activity ▪ Routine oversight / meetings with NWSSP Procurement ▪ Specialist advice and support from NWSSP Specialist Estates Services ▪ Audit reviews by NWSSP Audit and Assurance ▪ Close liaison with Welsh Government, Capital Function ▪ Reporting routinely to Delivery & Performance Committee ▪ Capital Programme developed and approved ▪ Detailed Strategic, Outline and Full Business Cases defining risk Capital and Estates set as a specific Organisational Priority **ENVIRONMENT** ▪ Retained ISO 14001 accreditation ▪ Environment & Sustainability Group ▪ NWSSP Specialist Estates Services (Environment) support and oversight ▪ Welsh Government support and advice to identify and fund decarbonisation project initiatives Welsh Government Energy Service / Re:fit energy programme of works underway. High Level Appraisal completed, and Investment Grade Proposal (IGP) published to illustrate invest to save projects.	**Action**	**Lead**	**Deadline**
	Implement the Capital Programme and develop the long-term capital programme.	AD Estates & Property	In line with Annual Plan for 2023-24
	Continue to seek WG Capital pipeline programme funding continuity: seek alternative capital funding opportunities to mitigate funding reduction for 2022/23 and develop projects in readiness for any capital slippage with additional £1.1M received. Estates Funding Advisory Board (EFAB) for 2023/24 and 2024/25 secured. Phase 2 project Llandrindod with endorsed PBC and SBAR, with a total cost of £3.4M submitted to WG ~~and~~. BJC cases being developed. Machynlleth £15.2 reconfiguration of front of hospital completed March 2023.	AD Estates & Property	In line with Annual Plan for 2023-24
	Develop capacity and efficiency of the Estates and Capital function	AD Estates & Property	In line with Annual Plan for 2023-24
	Review current structure of capital and estates department – Estates Management and Senior Management Team structure enhancements in place. Second tier of structure review required to address establishment staff numbers in Works Team and recruitment challenges. Resource review undertaken by IEG in 2023 with proposal limited by financial position.	AD Estates & Property	March 2024

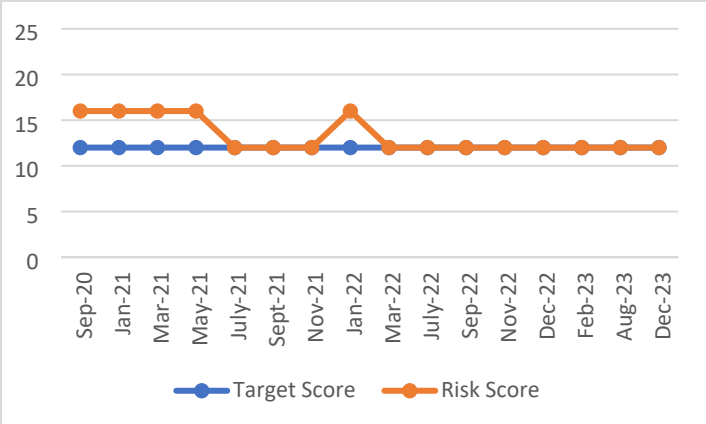
Current Risk Rating	Update including impact of actions to date on current risk score
4 x 4 = 16	**Estates:** Estates compliance – team continues to support core statutory compliance and limited Reactive job requests using risk-based approach due to age of estate. Workforce challenges for recruitment and staff resource establishment level being reviewed at Innovative Environments Group. **Fire:** Work to improve operational fire structure has been positive, but significant infrastructure risks related to compartmentation and physical systems remain. Programmes of work implemented but are dependent on capital funding. **Property:** significant pressure on space with expanding staff numbers alongside implementation of new agile working approach. Rationalisation of space of health board and other public sector bodies underway. **Finance:** significant cost pressures related to fuel and inflation are acting to increase pressure on Estates Revenue and Capital projects outturn costs and material / Supplier availability. Estates related pressure on revenue due to defects identified and scheduled from new Maintenance Contract roll out.

CRR 011 **Risk that:** a significant public health event/emergency impacts on provision, continuity and sustainability of services	**Executive Lead:** Director of Public Health **Assuring Committee:** Delivery and Performance
Risk Impacts on: the health and wellbeing of the population, patients and visitors and on the continuity of a range of NHS systems and services, including workforce, support services and supply chain.	**Date last reviewed:** December 2023

Risk Rating

(likelihood x impact):
Inherent: 4 x 4 = 16
Current: 3 x 4 = 12
Target: 3 x 4 = 12

Date added to the risk register
February 2020



Rationale for current score:

Likelihood: 'Possible'. Vaccination has weakened the link between cases and admissions to hospital and provide good protection against severe disease from variant strains of SARS-CoV2, although protection against infection and mild disease is lower and relatively short lived. Recognising that the (direct) risk of Covid-19 overwhelming the NHS has reduced, the likelihood has been adjusted from 'likely' to 'possible' as of February 2022.

It should be noted there are still risks including uncertainties regarding the size and timing of potential future waves of Covid-19, winter remains the season when the threat from Covid-19 and other respiratory viruses is greatest. The emergence of new variants of concern cannot be discounted due to the unpredictability of virus evolution. During the winter months other respiratory viruses such as influenza virus and respiratory syncytial virus (RSV) co-circulate with Covid-19, and over winter 2022/23 there was an increase in Strep A virus. An overlap in waves of infection due to different respiratory and other infectious viruses would pose increased risks to the health of individuals and to the NHS.

Throughout the pandemic, Covid-19 has disproportionately affected those in older age groups, residents in care homes for older adults, and those with certain underlying health conditions, particularly those who are severely immunosuppressed.

Following vaccination, these same factors continue to identify those persons who are at higher risk of developing severe COVID-19 and it's important that those eligible continue to take up the offer of a vaccine and treatment. The NHS is already operating at near maximum

		capacity. From 1 April 2023 WG has stopped routine testing for respiratory infections, testing decisions are now being clinically led to support antiviral treatment and to manage high risk settings. The risk score will therefore need to be kept under regular review. Impact: 'Major'. COVID-19 presents five harms to the population: - 1. The direct harm arising from the disease itself; 2. The harm caused by an overwhelmed NHS; 3. The harm caused by stopping other non-COVID activity; and 4. The wider harm to wellbeing caused by population level measures in response to COVID-19. 5. Harms rising from exacerbated or new inequalities

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more will we do?)**		
1. Spring (2023) Booster Programme implemented between April - June 2023 for eligible groups in line with JCVI and WG guidance with the primary objective to augment immunity in those at higher risk of COVID-19 and thereby optimise protection against COVID-19, specifically hospitalisation and death. Completed successfully. 2. Delivered Autumn Covid-19 Booster programme to eligible booster cohort between September 2022 and March 2023, with walk ins available at all MVC's and between January & March 2023 offer flu vaccine to eligible population, and non-attendees offered reappointment achieving high uptake rates. Joint management and oversight arrangements remain in place with Powys County Council, including a joint Prevention and Response Strategic Oversight Group, which has widening remit to include oversight of other health protection areas e.g. MPox, Ukrainian refugees. 3. Test, Trace Protect programme transitioned during April – June 2023 to a Health Protection Service in line with '*Together for a Safer Wales'* with significant smaller team in place to carry out testing, contact tracing for covid-19 'stable situation' in line with WG guidance: • WG patient-facing testing framework published 30th March 2023 with approach being test to diagnose to support clinical care and treatment and test to safeguard; • PCR testing will be focused on those in an outbreak situation and those immunocompromised;	**Action**	**Lead**	**Deadline**
	Continued delivery of COVID-19 and flu vaccination planning and delivery for 2023/24 in line with WG funding and directives, and JCVI guidance	MB/SB	31/03/24
	Additional phase (phase 3) of Care Home visits planned to undertake infection control and environment visits.	NB/CW	31/03/24

• Contact tracing will only take place during period of escalation and to manage high risk outbreaks; • Care home cell meeting will continue with ability to stand up in an incident; • Regional response cell meetings stood down but to reconvene if required. 4. Working as part of the wider system in Wales through participation in national planning and response arrangements as these evolve to respond to stage of pandemic and wider health protection issues. 5. Continued delivery of '*Together for a Safer Future*' transition in line with WG policy decisions and national health protection review. 6. Staff IPC measures and protective behaviours (PPE/Social distancing etc) guidance updated regularly in line with WG guidance and local circumstance, overseen by HB Infection Prevention Advisory Group. 7. FFP3 mask usage – decision on 29th December 2021 to continue to follow UK IP&C guidance supporting risk assessed use (this guidance has since been updated, mask usage is kept under review in line with current guidance) 8. Staff testing guidance kept under review in line with WG Guidance and under direction of HB Infection Prevention and Advisory Group. December 2023 no testing of staff for Covid-19 in line with National advice. 9. Surge vaccination plan developed and submitted to WG in January 2023, and exercised in March 2023. 10. Reviewed vaccination plan (workforce and venues) in line with substantially reduced WG funding for 2023/24 (implemented April 2023). 11. Scoping health protection response in line with WG funding and requirements for 2023/24. Significant reduction in funding and local resource available to respond to all health protection 'hazards'. Anticipating further reduction in funding for 2024/25 but still a requirement to respond to all health protection 'hazards'. 12. Preparing for Autumn/Winter Respiratory viruses and preventative preparedness support offered to care homes for older adults, during August/September 2023, including: - delivery of IP&C workbooks. - staff training offered for swab sampling, use of PPE and hand hygiene - sampling processes/pathways - evidence base for vaccinations.			

13. Updated and commenced implementation of plans for 2023/24 winter respiratory vaccination programme in line with national changes to Covid-19 vaccination planning communicated to Health Boards on 30 August 2023. 14. Blended model of delivery for influenza vaccination in place involving GP Practices, Pharmacies, School Nursing Team, Vaccination Service with learning from 2022/23 incorporated into plans. 15. Completion of visits for Care homes for older adults for preparedness support regarding IP&C and training. 16. Covid-19 Vaccination Autumn 2023 programme delivered from 11 September 2023 starting with Care Home Residents. All eligible patients sent an appointment letter by 30 November 2023 and offered an appointment by 17 December 2023 as per WG request. Current phase of programme in 'leave no one behind' and embarking on tasks of recall and reappointing. Programme increased number of Outreach clinics and Pop Up clinics (Community Settings) over course of delivery phase. Programme worked with GP practices to also support delivery with 7 practices taking part and offering co-administration with influenza vaccine, where possible. 17. Targeted scheme offered to primary care to increase uptake of the influenza vaccine in those aged 2-3 years in line with the CMO recommendations. 18. Health Board Staff Flu programme delivered from 09 October 2023 starting with appointments at the 2 x vaccination centres. The centres allowed the offer of co-administration of flu with Covid-19 vaccines. Further delivery has included a Peer Vaccinator model, at Occupational Health appointments, drop-ins at vaccination centres and outreach and vaccinator site walk arounds. 19. GP practices and Pharmacies have delivered the influenza vaccination programme 2023-24			
Current Risk Rating	**Update including impact of actions to date on current risk score**		
3 x 4 = 12			

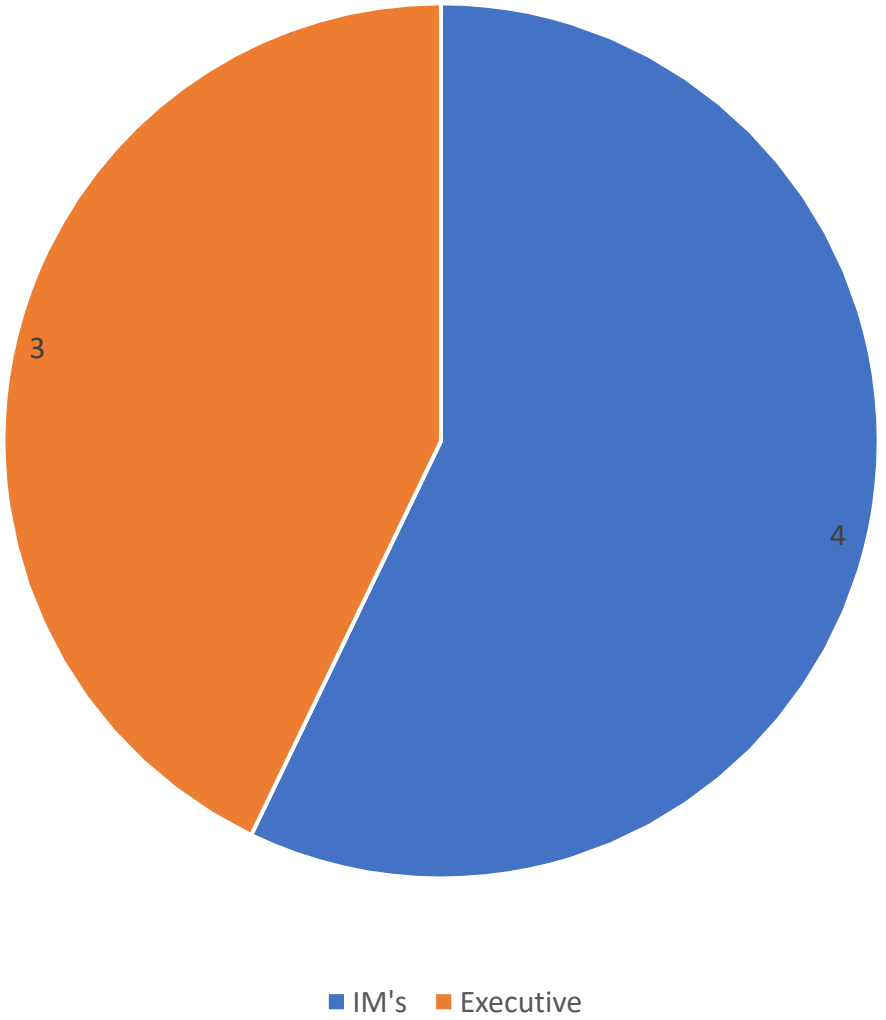
Delivery and Performance Committee 2023-24

Theme	Item Title	Role of Committee	May 02/05/2023	June 27/06/2023	August 31/08/2023 (Agenda reduced - items due to be reviewed)	October 17/10/2023	December 19/12/2023	February 29/02/2024
Governance	Minutes of previous meeting	Approval	✓	✓	✓	✓	✓	✓
Governance	Declaration of Interests	Compliance	✓	✓	✓	✓	✓	✓
Governance	Action Log	Approval	✓	✓	✓	✓	✓	✓
Governance	Committee Risk Register	Assurance	✓	✓	☒	✓	✓	✓
Governance	Annual Work Programme	Recommenda	✓					
Governance	Work Programme (updated through year)	Review		✓	✓	✓	✓	✓
Governance	Annual Assessment of Committee Effectiveness	Review			☒			✓
Governance	Committee Annual Report	Recommenda						☒
Governance	Review of Terms of Reference	Recommenda						✓
Performance	Integrated Performance Report	Assurance	✓	✓	✓	✓	✓	✓
Performance	Annual Delivery Plan Q2 and reset for rest of year							
Finance	Finance Report	Assurance	✓	✓	✓	✓	✓	✓
Finance	Finance Savings Report	Assurance		✓		✓		☒
Finance	Financial Sustainability In-Committee	Assurance	✓	✓	✓	✓	✓	☒
Finance	Six monthly report on Continuing Heath Care costs	Assurance			✓			✓
Annual Reporting	Draft Performance Report (invite ARAC)	Assurance	☒					
Health & Safety and Fire Safety	Compliance with regulations and Standards	Assurance						✓
Health & Safety and Fire Safety	Health and Safety Assurance Update	Assurance			✓			
Health & Safety and Fire Safety	Health and Safety Annual Report (to include asbesto	Assurance						✓
Information Governance	Annual Report	Assurance	✓					
Information Governance	Monitoring Report	Assurance			✓		✓	✓
Information Governance	IG Toolkit (National Audit replaces Caldicott	Assurance					✓	
Records Management	Records Management Improvement Plan	Assurance	✓				✓	
Records Management	Records Management Update	Assurance					✓	
Innovative Environments	Capital Programme Delivery	Assurance					✓	
Innovative Environments	Capital and Estates Compliance Report	Assurance						✓
Innovative Environments	Capital and Estates Strategy	Assurance				☒	☒	✓
Innovative Environments	Capital Pipeline Overview	Assurance			☒			
Innovative Environments	Capital Procedures re authorisation of capital	Assurance				✓		
Primary Care	GMS	Assurance						✓
Primary Care	GDS	Assurance					✓	
Primary Care	Out of Hours	Assurance			☒	✓		
Primary Care	Community Pharmacy	Assurance					☒	✓
Digital First	Annual Plan	Assurance	✓					
Digital First	Monitoring Report	Assurance					✓	
Digital First	IT Infrastructure and Asset Management (update	Assurance		✓	☒	✓	✓	✓
Renewal Portfolio Highlight Reports/ASM	Renewal Portfolio Closure Report	Assurance		✓				
Accelerated Sustainable Model (ASM)		Assurance						
Audit Rec Monitoring	Cyber security - In Committee	Assurance	✓	✓	☒			✓
Escalated Issue	Variable Pay	Assurance			✓			
requested items	IPC - data assurance lessons learned (via HB)	Assurance			☒			✓
	ISO 14001 Report	Assurance			✓			
	Digital Strategic Framework	Assurance					☒	✓

	Audit Wales report - Orthopaedic Services - Tackling the backlog (action)	Assurance				☒	✓	
	Montoring of the Primary Care Prescribing (action)	Assurance					✓	
Key								
Date to be confirmed								
Item to be confirmed								
Item deferred								
Item brought forward								
Going to Board								
Due to Committee								
Find Exec Cttee date								
Added to draft agenda								

Subject:	Committee Effectiveness – Delivery and Performance Committee
Approved and Presented by:	Director of Corporate Governance/Board Secretary
Author:	Director of Corporate Governance/Board Secretary
Purpose:	This presentation provides a summary of the responses received to the Committee Effectiveness questionnaire (D&P); and is provided to stimulate discussion within the Committee to support the identification of what works well, learning and actions for improvement.
Recommendations:	The Committee is asked to: • **DISCUSS** the summary of the Committee Effectiveness survey and any areas for action/improvement.
Executive Summary:	Each Committee of the Board is required to assess its effectiveness at the end of each year and to report its views to the Board on how governance arrangements might be improved. This is a key principle of good corporate governance which demonstrates a committee's understanding of its remit and oversight responsibility and a culture of continuous improvement. The approach for 2023/24 contained a questionnaire and then discussion at the Committee meeting. The Committee effectiveness questionnaire focuses on the critical themes of: (i) composition and establishment, (ii) effective functioning, and (iii) assurance.

Response Overview



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Section 2 – Composition and Establishment

Overview of ratings – Composition and Establishment

Question	Lowest score	Highest score	Score as % of maximum
The Committee understands its role	3	4	93%
The Committee annual work plan covers all the relevant areas in terms of reference.	2	4	86%
The Committee has the membership, authority and resources to perform its role effectively.	3	4	93%
The right people attend meetings of the Committee to enable it to fulfil its role effectively.	3	4	96%
Committee members have the collective skills & experience needed to fulfil the terms of reference and to advise & assure the Board.	3	4	82%

- The role and remit could cover everything the Health Board does. It has the potential for the workload to become unmanageable
- This Committee has a big big task. It is making progress but there is more to be achieved
- Where is primary care? Insufficient attention
- Consider more medical representation and a higher profile for the assistant directors in that area
- The committee works well
    - the agenda is very full
    - there is a balance to achieve between deep dive and details when needed
    - keeping the reports and conversation at the strategic and assurance level as appropriate.

Section 3 – Effective Functioning

Overview of ratings – Effective Functioning

Question	Lowest score	Highest score	Score as % of maximum
Meeting arrangements (frequency, time allocation) allow members individually and collectively to contribute to effective scrutiny and challenge.	3	4	93%
Committee meetings are conducted in a business - like manner and managed effectively with issues getting the time & attention proportionate to importance.	3	4	93%
Committee papers are of good quality and provide sufficient information (detail, presentation, timeliness) to enable the committee to fulfil its role.	3	4	89%
There is good monitoring of matters arising & agreed actions to support the Committee in its role.	3	4	96%

Overview of ratings – Effective Functioning

Question	Lowest score	Highest score	Score as % of maximum
The Committee is briefed on urgent/emerging issues (policy, performance or new legal/regulatory obligations) in a timely and appropriate way.	3	4	96%
The Committee environment is one in which members can provide supportive but critical challenge on key/sensitive issues.	3	4	93%
Reports to the Board cover all key issues discussed at Committee. The Board takes due regard of the Committee's views (i.e. recommendations, issues escalated, sharing of good practice).	3	4	93%
In meetings, we listen to and respect each other's views.	3	4	96%

Effective Functioning – Comments

- We need to achieve a much better balance in the flow of business through the committee
- Sometimes the agenda can be quite full and the amount of information for each item can be quite extensive
- In regard to the lower degree of scrutiny of primary care, it could be argued that views are respected but not acted upon
- Safe environment with appropriate challenge.

Section 4 – Assurance

Overview of ratings – Assurance

Question	Lowest score	Highest score	Score as % of maximum
The Committee receives sufficient and timely reports and advice on key issues that clearly set out the analysis of the situation, the risks and the assurance the Committee can take in order to enable it to discharge its responsibilities.	3	4	89%
The Committee receives timely reports on the work of external regulatory and inspection bodies and other independent sources of assurance.	3	4	86%
The Committee receives regular and sufficient evidence that the organisation is learning and improving.	2	4	79%
Performance reporting is at an appropriate level to enable the Committee to identify areas where it requires further assurance.	3	4	86%
The Committee receives the assurance it needs to fulfil its role effectively.	3	4	89%

Assurance – Comments

- We are well sighted on performance against Welsh Government targets but not all other performance
- We need to get a better handle on all performance reporting
- Secondary services really dominate the agenda.

Section 5 – General Comments

Comments - What areas are going well?

- Integrated performance reports are continuing to develop
- Well chaired
- Covering the agenda but not always in enough detail
- Covers a large remit effectively
- Commissioned secondary care and in-Powys provision
- Understanding the issues, constructive challenge
- Improved reports, use of supporting slides to present items.

Comments – What could be Improved?

- Better balance between focus on performance of primary care / more about primary care
- Highlighted change reports for some items
- Encouraging the Executive to define improvement timescales
- Manage agenda and time to keep focus on key issues.

Comments – What training/other development activity would support the Committee in its role?

- Training for Committee Chairs
- Periodic deep dive presentations into service areas
- A supporting programme of training/ briefing sessions on areas as and when needed for awareness and understanding.

Comments – What areas should the Committee focus on in the future (incl. areas to be looked at more or less frequently)?

- Primary care needs more attention
- More focus on service improvement and value
- What matters most to patients in Powys
- Ensure we deliver all of the aims / objectives of the Structured Assessment
- As per current workplan.

Any Other Comments

- Some improvement here but so much more to do.

Next Steps

Next Steps

Actions	Timescale
1. Share content of the Effectiveness questionnaire with Committee	29 February 2024
2. Receive feedback from the Committee, discuss any actions / improvements	29 February 2024
3. Develop action plan, in partnership with Committee Chair, for Committee oversight based on Committee survey and contributions	Next Committee meeting (May 2024)
4. Committee feedback and key actions will be incorporated into summary report with other Committees' feedback and shared with the Board	By end May 2024
5. Committee forward plan for 2024/25 is in development and will form part of the April Committee meeting (reviewed at each meeting)	Next Committee meeting (May 2024)
6. PTHB Chairs Forum will continue to develop an overarching role in committee focus areas and work plans	Ongoing

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 6.4

Delivery and Performance Committee	**Date of Meeting: 29 February 2024**
Subject :	**Delivery and Performance Committee Terms of Reference**
Approved and Presented by:	Helen Bushell, Director of Corporate Governance and Board Secretary
Prepared by:	Liz Patterson, Interim Head of Corporate Governance
Other Committees and meetings considered at:	N/A

PURPOSE:

The purpose of this paper is for the Committee to consider the Terms of Reference of the Delivery and Performance Committee in order to ensure that they remain fit for purpose.

RECOMMENDATION(S):

The Committee is asked to:

- **IDENTIFY** any suggested amendments to the Committee terms of reference in order to make recommendations to the Board in May 2024.
- **AGREE** that the Chair of the Committee and Director of Corporate Governance finalise any recommendations to the Board.

Approval/Ratification/Decision[1]	**Discussion**	**Information**
✓	✓	

[1] Equality Impact Assessment (EiA) must be undertaken to support all organisational decision making at a strategic level

THE PAPER IS ALIGNED TO THE DELIVERY OF THE FOLLOWING STRATEGIC OBJECTIVE(S) AND HEALTH AND CARE STANDARD(S):		
Strategic Objectives:	1. Focus on Wellbeing	
	2. Provide Early Help and Support	
	3. Tackle the Big Four	
	4. Enable Joined up Care	
	5. Develop Workforce Futures	✓
	6. Promote Innovative Environments	
	7. Put Digital First	
	8. Transforming in Partnership	✓
Health and Care Standards:	1. Staying Healthy	
	2. Safe Care	
	3. Effective Care	
	4. Dignified Care	
	5. Timely Care	
	6. Individual Care	
	7. Staff and Resources	✓
	8. Governance, Leadership & Accountability	✓

EXECUTIVE SUMMARY:

Under the Standing Orders of the Health Board, Board Committees are required to review their Terms of Reference on an annual basis. The existing Terms of Reference (Sept 2021) for the Delivery and Performance Committee are attached as Appendix 1.

Any suggested changes will need to be recommended to the Board for approval.

The Committee is asked to discuss the current terms of reference and identify any suggested amendments. The Chair of the Committee and Director of Corporate Governance will then take forwards any recommendations to the Board in May 2024 to take effect into 2024/25.

It is suggested that the Committee specifically considers:

Section of Terms of Reference	Comment / Suggestions
2 - Purpose	Does this remain accurate and appropriate?

3 - Delegated Powers and Authority	Does this remain accurate and appropriate? It is proposed that *compliance with Health and Safety Regulations and Fire Safety Standards* be moved to Workforce and Culture Committee.
5 - Committee meetings	• The modern practice of holding meetings virtually should be reflected. • The ability to take any decisions via Chair's Action (where appropriate) should be added • Proposed change to wording to be x4 meetings per year instead of no less than quarterly
Tidying up	The document requires some general tidying up to ensure correct job titles are reflected

NEXT STEPS:

The Chair of the Committee and Director of Corporate Governance will take forwards any recommendations to the Board in May 2024 to take effect into 2024/25.

The following Impact Assessment must be completed for all reports requesting Approval, Ratification or Decision, in-line with the Health Board's Equality Impact Assessment Policy (HR075):

IMPACT ASSESSMENT - ASSESSMENT NOT REQUIRED					
Equality Act 2010, Protected Characteristics:					
	No impact	**Adverse**	**Differential**	**Positive**	**Statement** ***Please provide supporting narrative for any adverse, differential or positive impact that may arise from a decision being taken***
Age	x				
Disability	X				
Gender reassignment	X				
Pregnancy and maternity	X				
Race	X				
Religion/ Belief	X				
Sex	X				
Sexual Orientation	X				
Marriage and civil partnership	X				
Welsh Language	X				
Risk Assessment:					
	Level of risk identified				**Statement** ***Please provide supporting narrative for any risks identified that may occur if a decision is taken***
	None	**Low**	**Moderate**	**High**	
Clinical					
Financial					
Corporate					
Operational					
Reputational					

Delivery and Performance Committee

Terms of Reference & Operating Arrangements

September 2021

1. INTRODUCTION

1.1 Section 2 of the Standing Orders of the Powys Teaching Health Board (referred to throughout this document as 'PTHB', the Board' or the 'Health Board') provides that:

"*The Board may and, where directed by the Welsh Government must, appoint Committees of the Health Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of its business extends equally to the work carried out on its behalf by committees*".

1.2 In-line with Standing Orders and the Board's Scheme of Delegation and Reservation of Powers, the Health Board has established a committee to be known as the **Delivery and Performance Committee** (referred to throughout this document as 'the Committee'). The Terms of Reference and operating arrangements set by the Board in respect of this committee are set out below.

1.3 The scope of the Committee extends to the full range of PTHB responsibilities. This encompasses the delivery and performance management of all directly provided and commissioned services.

2. PURPOSE

2.1 The purpose of the Committee is to provide advice and assurance to the Board on the effectiveness of arrangements in place for securing the achievement of the Board's aims and objectives, in accordance with the standards of good governance determined for the NHS in Wales. In doing so, the Committee will seek assurance that there is ongoing development of an improving performance culture which continuously strives for excellence and focuses on improvement in all aspects of the health board's business, in line with the Board's Framework for Improving Performance.

2.2 ADVICE
The Committee will provide accurate, evidence based (where possible) and timely advice to the Board and its committees in respect of the ongoing development of an improving performance culture which continuously strives for excellence and focuses on improvement in all aspects of the health board's business, in line with the Board's Framework for Improving Performance.

2.3 ASSURANCE

In respect of the achievement of the Boards' strategic aims, objectives and priorities, the Committee will seek assurances:

a. on timely and appropriate access to health care services to achieve the best health outcomes within agreed targets, for directly provided and commissioned services;
b. on performance against national and locally set quality and safety measures of care together with compliance to legislative requirements ensuring services are safe, personal, effective and continuously improving;
c. that services are improving efficiency and productivity and financial plans are being delivered;
d. risks are suitably identified, mitigated and residual risks controlled and corrective actions are taken as required to sustain or improve performance.

3. DELEGATED POWERS AND AUTHORITY

3.1 With regard to specific powers delegated to it by the Board, the Committee will play a key role in monitoring the achievement of the Board's strategic aims, objectives and priorities and will:

A. Seek assurance that arrangements for **financial management** and **financial performance** are sufficient, effective and robust, including:

- the allocation of revenue budgets, based on allocation of funding and other forecast income;
- the monitoring of financial performance against revenue budgets and statutory financial duties;
- the monitoring of performance against capital budgets;
- the monitoring of progress against savings plans, cost improvement programmes and implementation of the efficiency framework;
- the monitoring of budget expenditure variance and the corrective actions being taken to improve performance;
- the monitoring of activity and financial information for external contracts to ensure performance within specified contract terms, conditions and quality thresholds;
- the monitoring of arrangements to ensure efficiency, productivity and value for money;
- the monitoring of delivery against the agreed Discretionary Capital Programme; and

- the adequacy of standing financial instructions, including the application of capital and estates controls.

B. Seek assurance that arrangements for the **performance management** and **accountability** of **directly provided** and **commissioned services** are sufficient, effective and robust, including:
    - the ongoing implementation of the Board's Framework for Improving Performance, enabling appropriate action to be taken when performance against set targets deteriorates, and support and promote continuous improvement in service delivery;
    - the monitoring of performance information against the Board's Well-being and Enabling Objectives and associated outcomes;
    - the monitoring of performance information against National Outcome Frameworks, including the NHS Wales Outcomes Framework, the Public Health Outcomes Framework and the Social Services Outcomes Framework, developed in-line with the Wellbeing of Future Generations Act and the Social Services Wellbeing Act;
    - the monitoring of performance information across directly provided services including outpatients, theatres, community and inpatient services, mental health and LD, women and children's services;
    - the monitoring of performance information across commissioned services including Primary Care, outpatients, community and inpatient services, mental health, women and children's services and WHSCC, EASC and NHS Wales Shared Services Partnership;
    - the monitoring of poor performance through effective and comprehensive exception reporting, including trajectories for improved performance; and
    - the review of performance through comparison to best practice and peers and identifying areas for improvement.

C. Seek assurance that arrangements for **compliance with Health and Safety Regulations and Fire Safety Standards** are sufficient, effective and robust, including:
    - the operating practices in respect of: staff health and safety; stress at work; patient health and safety, i.e., patient falls, patient manual handling; violence and aggression; fire safety; risk assessment processes; safe handling of loads; and hazardous substances

D. Seek assurance that arrangements for **information management** are sufficient, effective and robust, including:
   - the monitoring of information related objectives and priorities as set out in the Board's IMTP and Annual Plan;
   - the monitoring of the implementation and application of information related legislation, policies and standards, including GDPR and Freedom of Information;
   - the review of arrangements to protect the integrity of data and information to ensure valid, accurate, complete and timely data and information is available for use within the organisation;
   - the reporting of data breaches, incidents and complaints, ensuring lessons are learned;
   - the recommendations arising from national and local audits and self-assessments, including assessment against the Caldicott Standards; and
   - the monitoring of arrangements to support the continued development of business intelligence and capacity.

E. Seek assurance that arrangements for the **performance management** of **digital and information management and technology (IM&T) systems** are sufficient, effective and robust, including:
   - the monitoring of digital related objectives and priorities as set out in the Board's IMTP and Annual Plan; and
   - the monitoring of the annual business plan for IM&T.

F. Seek assurance that arrangements for the **performance management** of **capital**, **estates and support services related standards and systems** are sufficient, effective and robust, including:
   - the monitoring of capital and estates related objectives and priorities as set out in the Board's IMTP and Annual Plan;
   - the monitoring of compliance with Health Technical Memorandums;
   - the monitoring of progress in delivery Board-approved capital business cases and programmes of work.

3.2 The Committee will consider and recommend to the Board for approval those policies reserved for the Board and delegated to this Committee for review, in-line with the Board's Policy Management Framework and Scheme of Delegation and Reservation of Powers.

3.3 The Committee will seek assurances on the management of strategic risks delegated to the Committee by the Board, via the Corporate Risk Register.

Authority

3.4 The Committee is authorised by the Board to investigate or have investigated any activity within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the Health Board relevant to the Committee's remit and ensuring patient/client and staff confidentiality, as appropriate.

The Committee may seek any relevant information from any:
- employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and
- any other committee, sub committee or group set up by the Board to assist it in the delivery of its functions.

3.5 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary (subject to the Board's procurement, budgetary and any other applicable standing requirements).

Access

3.6 The Head of Internal Audit shall have unrestricted and confidential access to the Chair of the Committee.

3.7 The Chair of the Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

3.8 The Committee may, subject to the approval of the Board, establish sub committees or task and finish groups to carry out on its behalf specific aspects of Committee business.

Committee Programme of Work

3.9 Each year the Board will determine the Committee's priorities for its annual programme of work, based on the Board's Assurance

Framework and Corporate Risk Register. This approach will ensure that the Committee's focus is directed to the areas of greatest assurance needs. This will therefore mean that these Terms of Reference are provided as a framework for the Committee's annual programme of work and is not an exhaustive list for full coverage. This approach recognises that the Committee's programme of work will be dynamic and flexible to meet the needs of the Board throughout the year.

4. MEMBERSHIP

Members

4.1 Membership will comprise:

Chair	Independent member of the Board
Vice Chair	Independent member of the Board
Members	3 x Independent member of the Board
	The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

Attendees

4.2 In attendance: The following Executive Directors of the Board will be regular attendees:

- Director of Finance and IT (Joint Officer Lead)
- Director of Planning and Performance (Joint Officer Lead)
- Director of Workforce & OD
- Director of Primary, Community Care and Mental Health
- Director of Therapies and Health Sciences

4.3 By invitation:
The Committee Chair extends an invitation to the PTHB Chair and Chief Executive to attend committee meetings.

The Committee Chair will extend invitations to attend committee meetings, dependent upon the nature of business, to the following:

- other Executive Directors not listed above;
- other Senior Managers and
- other officials from within or outside the organisation to attend all or part of a meeting to assist it with its discussions on any particular matter.

Secretariat

4.4 The Office of the Board Secretary will provide secretariat services to the Committee.

Member Appointments

4.5 The membership of the Committee shall be determined by the Board, based on the recommendation of the Chair of PTHB - taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

4.6 Members shall be appointed to hold office for a period of one year at a time, up to a maximum of their term of office. During this time a member may resign or be removed by the Board.

4.7 Terms and conditions of appointment, (including any remuneration and reimbursement) in respect of co-opted independent external members are determined by the Board, based upon the recommendation of the Chair of PTHB.

Support to Committee Members

4.8 The Board Secretary, on behalf of the Committee Chair, shall:

- arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and
- ensure the provision of a programme of development for committee members as part of the Board's overall Development Programme.

5. COMMITTEE MEETINGS

Quorum

5.1 At least **three** members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair or Vice Chair.

5.2 Where members are unable to attend a meeting and there is a likelihood that the Committee will not be quorate, the Chair can invite another independent member of the board to become a temporary member of the Committee.

Frequency of Meetings

5.3 The Chair of the Committee shall determine the timing and frequency of meetings, which shall be held no less than **bi-monthly**, and in line with the Health Board's annual plan of Board Business.

5.4 The Chair of the Committee may call additional meetings if urgent business is required to be taken forward between scheduled meetings.

Openness and Transparency

5.5 Section 3.1 of PTHB Standings Orders confirms the Board's commitment to openness and transparency in the conduct of all its business and extends equally to the work carried out on its behalf by Committees. The Board requires, wherever possible, meetings to be held in public. The Committee will:

- hold meetings in public, other than where a matter is required to be discussed in private (see point 5.6);
- issue an annual programme of meetings (including timings and venues) and its annual programme of business;
- publish agendas and papers on the Health Board's website in advance of meetings;
- ensure the provision of agendas and minutes in English and Welsh and upon request in accessible formats, such as Braille, large print, and easy read; and
- through PTHB's website, promote information on how attendees can notify the Health Board of any access needs sufficiently in advance of a proposed meeting, e.g., interpretation or translation arrangements, in accordance with legislative requirements such as the Equality Act 2010 and Welsh Language Standards 2018.

Withdrawal of individuals in attendance

5.6 There may be circumstances where it would not be in the public

interest to discuss a matter in public, e.g., business that relates to a confidential matter. In such cases the Chair (advised by the Board Secretary where appropriate) shall schedule these issues accordingly and require that any observers withdraw from the meeting. In doing so, the Committee shall resolve:

That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960 (c.67).

In these circumstances, when the Committee is not meeting in public session it shall operate in private session, formally reporting any decisions taken to the next meeting of the Committee in public session.

6. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions (as set out within these terms of reference), the Board retains overall responsibility and accountability for all matters relating to performance and resources.

The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

6.2 The Committee will work closely with the Board's other committees, joint and sub committees and groups to provide advice and assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business;
- sharing of appropriate information; and
- applicable escalation of concerns.

in doing so, this contributes to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

6.3 The Committee shall embed the Health Board's agreed Values and Behaviours, as set out in the Board's Values and Behaviours Framework, through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes verbal updates on activity, and the submission of Committee minutes and written reports;
- bring to the Board's specific attention any significant matters under consideration by the Committee;
- ensure appropriate escalation arrangements are in place to alert the Chair of PTHB, Chief Executive or Chairs of other relevant committees/groups of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

7.2 The Board may also require the Committee Chair to report upon the Committee's activities at public meetings, e.g., Annual General Meeting, or to community partners and other stakeholders, where this is considered appropriate, e.g., where the committee's assurance role relates to a joint or shared responsibility.

7.3 The Board Secretary shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of further committees established.

7.4 The Committee shall provide a written annual report to the Board on its activities. The report will also record the results of the Committee's self-assessment and evaluation.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 The requirements for the conduct of business as set out in PTHB's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum
- Issue of Committee papers

9. CHAIR'S ACTION ON URGENT MATTERS

9.1 There may, occasionally, be circumstances where decisions which would normally be made by the Committee need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Committee. In these circumstances, the Chair of the Committee, supported by the Board Secretary as appropriate, may deal with the matter on behalf of the Committee - after first consulting with at least two other Independent Members of the Committee. The Board Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

9.2 Chair's action may not be taken where the Chair has a personal or business interest in the urgent matter requiring a decision.

10. REVIEW

10.1 These Terms of Reference shall be reviewed annually by the Committee. The Committee Chair will report any changes to the Board for ratification.
