2025-05-01

Thu 01 May 2025, 13:00 - 16:00

Agenda

13:00 - 13:00
0 min

1. PRELIMINARY MATTERS

D&P_Agenda_01May2025final.pdf (3 pages)

1.1. Welcome and Apologies

Verbal *Chair*

1.2. Declarations of Interest & Board Members Register of Interests

Verbal/Attached *All*

D&P_1.2_Board Members Declaration Of Interests summary 2024-25.pdf (4 pages)

13:00 - 13:00
0 min

2. CONSENT AGENDA BUSINESS

The Chair will ask if there are any items from the Consent Agenda (Item 7) that Committee Members wish to bring forward to the main agenda.

13:00 - 13:00
0 min

3. ITEMS FOR APPROVAL/DECISION/RATIFICATION

3.1. Minutes of the previous meeting held on 06 February 2025

Attached *Chair*

D&P_3.1_DRAFT_Minutes_D&P_06Feb2025.pdf (14 pages)

3.2. Committee Action Log

Attached *Chair*

D&P_3.2_Action Log 2025-26.pdf (1 pages)

3.3. 2025/2026 Committee Work programme

Attached *Director of Corporate Governance*

D&P_3.3_D&P_Committee work plan_2025-26.pdf (1 pages)

13:00 - 13:00
0 min

4. ESCALATED ITEMS

4.1. Organisational Status (NHS Wales escalation framework) Level 4 monitoring report

Verbal *Deputy Chief Executive/ Executive Director of Finance, Capital and Support Services/ Executive Director of Planning, Performance and Commissioning*

13:00 - 13:00
0 min

5. ITEMS FOR ASSURANCE

5.1. Finance Performance Report Month 12

To Follow *Deputy Chief Executive/ Executive Director of Finance, Capital and Support Services*

D&P_5.1_Financial Performance Report Mth 12.pdf (19 pages)

5.2. Integrated Quality and Performance Report Month 11

Attached *Executive Director of Planning, Performance and Commissioning*

D&P_5.2_Month11_IQPR_Cover_Report.pdf (9 pages)
D&P_5.2a_IQPR_24-25_Month 11.pdf (16 pages)

5.3. Q4 Annual Delivery Progress Report

Attached *Executive Director of Planning, Performance and Commissioning*

D&P_5.3_Q4 Delivery Plan Cover Paper.pdf (9 pages)
D&P_5.3a_Q4 Progress Against Plan.pdf (62 pages)

5.3.1.

5.4. In-reach fragility 6-month update

Verbal *Executive Director of Primary, Community Care and Mental Health*

5.5. Health and Safety Annual Report

Attached *Executive Director of People and Culture*

D&P_5.5_Health and Safety Annual Report (Q4 - 2024-25).pdf (30 pages)

5.6. Committee Risk Register

Verbal *Director of Corporate Governance*

5.7. Annual Assessment of Committee Effectiveness

Attached *Director of Corporate Governance*

D&P_5.7_D&P Committee effectiveness_2024-25.pdf (27 pages)

5.8. Review Terms of Reference

Attached *Director of Corporate Governance*

D&P_5.8_Delivery and Performance Terms of Reference Review.pdf (3 pages)
D&P_5.8a_Appendix A - Delivery and Performance Committee Terms of Reference (Approved May 2024).pdf (11 pages)
D&P_5.8b_Appendix B - Delivery and Performance Committee Terms of Reference (Draft April 2025).pdf (11 pages)

13:00 - 13:00
0 min

6. ITEMS FOR DISCUSSION

There are no items for inclusion within this section

13:00 - 13:00
0 min

7. CONSENT AGENDA

7.1. Committee Annual Report (including IC elements) (For Approval)

Attached *Director of Corporate Governance*

D&P_7.1_D&P_Committee Annual Report_2024-25.pdf (11 pages)

7.2. Internal Audit Reports: (For Assurance)• Community Cardiology• Patient Flow and Discharge Management • Pharmacy Stores• Primary Care GMS Unified Contract

Attached *Director of Corporate Governance*

- D&P_7.2a_Community Cardiology Service Final Internal Audit Report..pdf (13 pages)
- D&P_7.2b_Patient Flow and Discharge Management Final report.pdf (17 pages)
- D&P_7.2c_Pharmacy Stores Final Internal Audit Report (1).pdf (9 pages)
- D&P_7.2d_Primary Care GMS Unified Contract.pdf (9 pages)

7.3. JCC Planning, Performance & Finance Sub-Committee Highlight Report (For information)

Attached *Director of Corporate Governance*

- D&P_7.3_JCC-Planning, Performance & Finance sub committee Highlight Report.pdf (5 pages)

7.4. PTHB Glossary

Attached *Director of Corporate Governance*

- D&P_7.4_Powys Teaching Health Board Glossary.pdf (5 pages)

13:00 - 13:00
0 min

8. OTHER MATTERS

8.1. Any Other Urgent Business

Verbal *Chair*

8.2. Items to be brought to the attention of the Board and/or other Committees

Verbal *Chair*

8.3. Committee Reflections

Verbal *All*

8.4. Date of the next meeting: 26 June 2025 via Microsoft Teams

8.5. Representatives of the press and other members of the public shall be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest

DELIVERY AND PERFORMANCE COMMITTEE
01 MAY 2025
13:00 – 16:00
VIA MICROSOFT TEAMS
CHAIR: RONNIE ALEXANDER

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

AGENDA				
Time	**Item**	**Title**	**Attached / Verbal**	**Owner**
	1	**PRELIMINARY MATTERS**		
13:00	1.1	Welcome and apologies	Verbal	Chair
	1.2	Declarations of interest • Board Members Register of Interests	Verbal/ Attached	All
	2	**CONSENT AGENDA BUSINESS**		
The Chair will ask if there are any items from the Consent Agenda (Item 7) that Committee Members wish to bring forward to the main agenda.				
	3	**ITEMS FOR APPROVAL / DECISION / RATIFICATION**		
	3.1	Minutes of previous meeting held on 06 February 2025	Attached	Chair
	3.2	Committee Action log	Attached	Chair
	3.3	2025/2026 Committee Work programme	Attached	Director of Corporate Governance
	4	**ESCALATED ITEMS**		
13:10 15min	4.1	Organisational status (NHS Wales escalation framework) - Level 4 monitoring report	Verbal	Deputy Chief Executive/ Executive Director of Finance, Capital and Support Services / Director of Corporate Governance
	5	**ITEMS FOR ASSURANCE**		
13:25 20min	5.1	Finance Performance Report Month 12	Attached	Deputy Chief Executive/ Executive Director of Finance, Capital and Support Services
13:45 20min	5.2	Integrated Quality and Performance Report Month 11	Attached	Executive Director of Planning, Performance and Commissioning
14:05 15min	5.3	Annual Delivery Progress Report Q4	Attached	Executive Director of Planning, Performance and Commissioning
14:20	**COMFORT BREAK (10mins)**			
14:30 5min	5.4	In-reach fragility 6-month update	Verbal	Executive Director of Primary, Community Care and Mental Health
14:45 15min	5.5	Health and Safety Annual Report	Attached	Executive Director of People and Culture

14:55 5min	5.6	Committee Risk Register	Verbal	Director of Corporate Governance
15:00 10min	5.7	Annual Assessment of Committee Effectiveness	Attached	Director of Corporate Governance
15:10 10min	5.8	Review Terms of Reference	Attached	Director of Corporate Governance
	6	**ITEMS FOR DISCUSSION**		
	There are no items for inclusion within this section.			
	7	**CONSENT AGENDA**		
	7.1	Committee Annual Report (including IC elements) (For Approval)	Attached	Director of Corporate Governance
	7.2	Internal Audit Report: (For Assurance) • Community Cardiology • Patient Flow and Discharge Management • Pharmacy Stores • Primary Care GMS Unified Contract	Attached	Director of Corporate Governance
	7.3	JCC Planning, Performance & Finance Sub-Committee Highlight Report (For information)	Attached	Director of Corporate Governance
	7.4	PTHB Glossary (For information)	Attached	Director of Corporate Governance
	8	**OTHER MATTERS**		
15:20	8.1	Any other urgent business	Verbal	Chair
	8.2	Items to be brought to the attention of the Board and/or other Committees	Verbal	Chair
	8.3	Committee reflections	Verbal	All
	8.4	Date of the next meeting: 26 June 2025 at 10:00 via Microsoft Teams		
8.5 The Chair, with advice from the Director of Corporate Governance/Board Secretary, has determined that the following items include confidential or commercially sensitive information which is not in the public interest to discuss in an open meeting at this time. The Board is asked to take this advice into account when considering the following motion to exclude the public from this part of the meeting: Motion under Section 1(2) Public Bodies (Admission to Meetings) Act 1960 ***"Representatives of the press and other members of the public shall 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"***				
15:30	8.6	Welcome and apologies	Verbal	Chair
	8.7	Declarations of interest	Verbal	All
	8.8	Minutes from the previous In-Committee Meeting held on 06 February 2025	Attached	Chair

		• Minutes of the Joint D&P and PPPH meeting held on 17 March 2025		

Powys Teaching Health Board is committed to openness and transparency and conducts as much of its business as possible in a session that members of the public are normally welcome to attend and observe.

Meetings are currently held virtually, should you wish to observe a virtual meeting of a committee, please contact the Director of Corporate Governance at PowysDirectorate.CorporateGovernance@wales.nhs.uk at least 24 hours in advance of the meeting in order that your request can be considered on an individual basis.

Papers for the meeting are made available on the website in advance and a copy of the minutes are uploaded to the website once agreed at the following meeting.

Whilst Committee meetings are not public meetings, questions are invited and welcome from members of the public – pleased submit these at least 48 hours in advance of the meeting so a response can either be incorporated into the Board meeting or be provided directly to the requester. Please submit any questions to PowysDirectorate.CorporateGovernance@wales.nhs.uk.

POWYS TEACHING HEALTH BOARD - REGISTER OF DECLARATION OF INTERESTS 2024/25

Updated: February 2025

Position	Name	Nature of Interest	Nature of Declaration	Relevant Dates from	Relevant Dates to	Description of Declaration	Comment	Date Returned	Last day in Powys Teaching Health Board
INDEPENDENT MEMBERS									
PTHB Chair	**Carl Cooper**	Personal	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	2017	2025	Board Member, Social Care Wales	Remunerated Public Appointment	03/02/2025	
		Spouse/Partner/Other	Ownership or part ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with PTHB.	2018	Ongoing	Sole Trader, Mandy Williams, Consulting	NIL		
			A personal or departmental interest in any part of the Pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	2025	Ongoing	Stepdaughter's partner is a Pharmaceutical Control Analyst employed by Cardiff & Vale Health Board.	Nil		
Vice Chair	**Kirsty Williams**	Personal	A position of authority in a Charity of Voluntary Body in the field of health and/or social care	May-22	Current	Deputy Director Samaritans Powys	None	22/05/2024	
			Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	Nov-22	Current	ILEP- A Subsidory of Cardiff University	None		
			Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice	Feb-24	Ongoing	Commissioner for South Wales Fire and Rescue	Ministerial Appointment		
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Independent Member (General)	**Rhobert Lewis**	Personal	Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.	Nov-21	Current	Chair NPTC Group of Colleges	NIL	08/04/2024	
				Sep-23	Current	Chair Confederal Governance UWTSD	NIL		
				Nov-21	Current	Member of National Assesmbly of Wales Cross-Party Group on STEMM	NIL		
		Spouse/Partner/Other	NIL	NIL	NIL	NIL			
Independent Member (Trade Union)	**Cathie Poynton**	Personal	NIL	NIL	NIL	NIL	NIL	02/04/2024	
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Independent Member (Information and Technology)	**Ian Phillips**	Personal	Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.	01-Aug-21	Current	Independent Chair Welsh Kidney Network	Remunerated	08/04/2024	22/08/2024
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Independent Member (finance)	**Steve Elliot**	Spouse/Partner/Other	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	04/02/2024	Current	Director of Oshi's World Private Limited Company	NIL	19/08/2024	
		Personal	Ownership or part ownweship of private companies, businesses or consultancies likely or possibly seeking to do business with PTHB	22/09/2023	31/03/2024	Special Advisor (Finance) to Powys tHB Audit and Delivery and Performance Committees	Yes		
		Spouse/Partner/Other	A position of authority in a Charity or Voluntary Body in the field of health and/or social care	04/02/2024	Current	Trustee of Oshi's World Charity	NIL		
Independent Member (General)	**Ronnie Alexander**	Personal	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	2012	Current	Director of RA and CJ Consulting Limited	Dividend Payment only	15/08/2024	
			A position of authority in a Charity or Voluntary Body in the field of health and/or social care.	2017	Current	Member of Finance, Risk and Audit Committee Hafod/Hendre Housing Association	£2500.00 per annum		
			Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests	Mar-21	Current to Dec-27	Personal: Independent Monitoring Authority (IMA) – Non Executive Director	£7500.00 per annum		
		Spouse/Partner/Other	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	2017	Current	Director of RA and CJ Consulting Limited	Dividend Payment only		
Independent Member (University)	**Simon Wright**	Personal	Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.	2015	Current	Personal: Academic Registrar, Cardiff University-Various Healthcare Programmes	Salaried Employment		

		Spouse/Partner/Other	A personal or departmental interest in any part of the Pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	2001	Current	Sister: Senior Operational Manager, Milestone Trust, Bristol	Salaried Employment	08/07/2024	
			Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.	2021	Current	Spouse: District Nurse, Cardiff and Vale UHB	Salaried Employment		
Independent Member (Third Sector)	**Jennifer Owen Adams**	Personal	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	Jun-16	Ongoing	Member (not a NED) of Glas Cymru the holding company of Dwr Cymru/Welsh Water	None	30/04/2024	
			Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests	Apr-14	Ongoing	Trustee of Impelo Dance CIO	None		
				Jul-05	Ongoing	Chair Public Services Board Scrutiny Committee	None		
		Spouse/Partner/Other	Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests	2013	Ongoing	Brother - Senior Manager Freedom Leisure (Lead responsibility for Swansea and South Powys).	NIL		
Independent Member (Local Authority)	**Christopher Walsh**	Personal	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.			Member of Community Speed Wath Group Member of Society Genealogists Associate Member of the Association of Genealogists and Registered Archivists	NIL	09/09/2024	
			Ownership or part ownweship of private companies, businesses or consultancies likely or possibly seeking to do business with PTHB		Ongoing	Sole Trader/Owner of Celebratory Gifts Heraldic Names Sole Trader/Owner:CTW Genealogy Research and	NIL		
			A position of authority in a Charity or Voluntary Body in the field of health and/or social care.		Ongoing	Elected Member Powys County Council •Trustee/Chair: Brecon University Scholarship Fund •Brecon Town Council Elected Member •Governor of Priory Church in Wales School •Member Brecon Beacons National Park Authority SDF & Grant Advisory Panel	NIL		
			Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.		Ongoing	•Member of Royal College of Nursing •Registered Member of Nursing and Midwifery Council	NIL		
			Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.		Ongoing	Labour Party	NIL		
Independent Member (Capital)	**Michael Giannai**	Personal	Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.	2019	Current	Chair of the Board of Social Care Wales (Welsh Government Sponsored Body).	Remunerated	01/04/2024	
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Independent Member	**Ian Thomas**	Personal	Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.	Jan-23	Current	Family Fund (UK Charity)	NIL	09/01/2025	
				Jun-24	Currne t	Family Fund Business Services (FFBS)	NIL		
EXECUTIVE MEMBERS									
Chief Executive Officer	**Hayley Thomas**	Personal	NIL	NIL	NIL	NIL	NIL	30/05/2024	
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Executive Director of Planning, Performance & Commissioning	**Stephen Powell**	Personal	NIL	NIL	NIL	NIL	NIL	03/07/2024	18/10/2024
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Executive Director of Finance, Capital	**Pete Hopgood**	Personal	NIL	NIL	NIL	NIL	NIL		

and Support Services		Spouse/Partner/Other	A personal or departmental interest in any part of the Pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	Ongoing	Ongoing	Partner is Finance Manager working in SBUHB	Not Relevant	22/05/2024	
Executive Director of Allied Health Professions, Health Science and Digital	**Claire Madsen**	Personal	Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.	07-Jan-19	Current	Occasional Lecturer for University of West of England.	Hourly rate	02/04/2024	
			Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	10-Jun-05	Current	Member of the The Chartered Society of Physiotherapy	NIL		
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Executive Director of Nursing, Quality, Women and Family Health	**Claire Roche**	Personal	A personal or departmental interest in any part of the Pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	2018	Current	Member of the Royal College of Nursing	NIL	22/08/2024	
				1994	Current	Member of the Royal College of Midwifery			
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Executive Medical Director	**Kate Wright**	Personal	Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.	01-Aug-91	Current	Member of the British Medical Association		12/08/2024	
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Executive Director of People and Culture	**Debra Wood Lawson**	Personal	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	01-Nov-24	Current	Non Executive Board Director - Cadarn Housing Group Limited (Powys is a zonal partner)	NIL	18/11/2024	
		Spouse/Partner/Other	NIL	NIL	NIL	NIL	NIL		
Executive Director of Public Health	**Mererid Bowley**	Personal	Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.	NIL	NIL	Member of Faculty of Public Health	NIL	23/05/2024	
		Spouse/Partner/Other	Ownership or part ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with PTHB.	NIL	NIL	Husband works for Mitie Engineering who hold contracts/work with some NHS bodies/organisations. Shares held by husband and myself and Mitie Company	NIL		
Interim Executive Director of Operations	**Joy Garfitt**	Personal	NIL	NIL	NIL	NIL	NIL	No change from 2023 submission	30/09/2024
		Spouse/Partner/Other	A personal or departmental interest in any part of the Pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	2012	Current	Spouse employed by PTHB within Mental Health Department	NIL		
Director of Corporate Governance/ Board Secretary	**Helen Bushell**	Personal	Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.	Nov-21	Current	School Governor – primary school (Bridgend Local Authority)	Not remunerated	03/06/2024	
		Spouse/Parter or other Relative	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	Sep-16	Current	Board Diretor and Chair of the Board Cadarn Housing Ltd (Powys is a zonal partner)	Remunerated part time role, 2-4 days per month		
			A personal or departmental interest in any part of the Pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team	Jul-24	Oct-24	Spouse member of the PTHB Bank working occasionally for the Health Board	Paid per hour/day of work		
			Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.	Sep-22	Current	Public Appointment - Youth Work strategy and implementation Board - Oct 22 - Sept 24	Remunerated 2-4 days per month		
Associate Director of Capital and Estates	**Wayne Tannahill**	Personal	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	1996	2016	Director of Pembrokeshire Surveyors Ltd. Sole proprietor, small architectural business, made dormant April 2016 (formally closed April 2017)		24/04/2024	
		Spouse/Parter or other Relative	Directorships, including non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.	1996	2016	Daughter Kate was Company Secretary			
Director of Strategic	**Lucie Cornish**								

Improvement and Transformation		Nil	Nil	Nil	Nil	Nil	Nil	13/11/2024	
Executive Director of Planning, Performance & Commissioning	**Nicola Johnson From 07/10/24**	Nil	Nil	Nil	Nil	Nil	Nil	16/10/2024	
Executive Director of Primary, Community Care and Mental Health	**Elaine Lorton From 30/09/2024**	Personal	A position of authority in a Charity or Voluntary Body in the field of health and/or social care.	Nov-19	Current	Chair – West Wales Care & Repair	Nil	17/10/2024	
				Apr-24	Current	Independent Member – ateb	£2,960 Per Annum		

DELIVERY & PERFORMANCE COMMITTEE

UNCONFIRMED MINUTES OF THE MEETING HELD ON THURSDAY 06 FEBRUARY 2025, VIA MICROSOFT TEAMS

Members Present:		
Rhobert Lewis	RL	Independent Member (General) Chair
Kirsty Williams	KWi	Independent Member (PTHB Vice-Chair)
Cathie Poynton	CP	Independent Member (Trade Union)
Steve Elliot	SE	Independent Member (Finance)
In Attendance:		
Pete Hopgood	PH	Deputy Chief Executive and Executive Director of Finance, Capital and Support Services
Elaine Lorton	EL	Executive Director of Primary, Community Care and Mental Health Services
Claire Madsen	CM	Executive Director of Allied Health Professions, Health Sciences and Digital Services
Nicola Johnson	NJ	Executive Director of Planning, Performance and Commissioning Services
Hayley Thomas	HT	Chief Executive Officer
Vicki Cooper	CR	Chief Digital Officer
Kate Wright	KW	Executive Medical Director
Jayne Lawrence	JL	Assistant Director of Primary Care
Helen Bushell	HB	Director of Corporate Governance/Board Secretary
Laura Keighan	LK	Cancer Recovery Business Manager- NHS Executive
Tomos Jones (Observing)	TJ	Audit Wales
Katie Blackburn (Observing)	KB	Chief Officer -Llais
Stella Gwynne (Observing)	SG	Deputy Board Secretary
Ian Thomas (Observing)	IT	Independent Member (General)
Bethan Powell	BP	Corporate Governance Officer
Apologies for Absence:		
Ronnie Alexander	RA	Independent Member (General)
Carl Cooper	CC	PTHB Chair
Mick Giannasi	MG	Independent Member (General)

PRELIMINARY MATTERS
1.1 WELCOME AND APOLOGIES FOR ABSENCE (D&P/24/094)
RL welcomed everyone to the meeting. Apologies for absence were noted as recorded above. RL confirmed he was chairing the meeting in the absence of RA.
1.2 DECLARATIONS OF INTERESTS (D&P/24/095)
KWi requested an amendment to her declaration submitted within the Board members Declarations register and that she is now the Director of Samaritans Powys. KWi would provide the relevant amendments to the register.

2. CONSENT AGENDA BUSINESS (D&P/24/096)

The Chair asked members if they wish to bring forward any items from the Consent agenda to the main agenda. No items were raised.

3. ITEMS FOR APPROVAL/DECISION/RATIFICATION

3.1 MINUTES OF THE PREVIOUS MEETING (D&P/24/097)

The minutes of the meeting held on 05 December 2024 were **CONFIRMED** as an accurate record.

3.2 COMMITTEE ACTION LOG (D&P/24/098)

HB introduced the Action Log that recorded updates with the following information provided:

D&P/24/064- GMS Access

Was further action required to communicate GMS access with Llais?

EL explained that discussions were underway regarding specific actions with Llais. A Board Development session was due to be scheduled with Llais in the near future.

D&P/24/065- Clusters Review

The following amendment would be updated. *The team would undertake a review of the effectiveness of clusters in achieving their purpose on an annual basis.*

The following actions were AGREED to be transferred to the Patient Experience, Quality and Safety Committee for further discussion:

D&P/24/86a - In-reach Fragility
D&P/24/83c - Primary Care: General Dental Services (GDS)

The following actions were AGREED for closure:

D&P/24/064
D&P/24/079
D&P/24/083
D&P/24/083a
D&P/24/083b
D&P/24/087
D&P/24/87a
D&P/24/87b
D&P/24/065

The Committee **RECEIVED** the Action Log updates and noted the closed items.

4. ESCALATED ITEMS

4.1 ORGANISATIONAL STATUS (NHS WALES ESCALATION FRAMEWORK) ENHANCED MONITORING REPORT (D&P/24/099)

NJ confirmed that Powys had been placed in escalation status Level 4 of the targeted intervention framework for Strategy, Planning and Finance. The team were awaiting confirmation of a meeting with Welsh Government to discuss the Level 4 escalated status which will be chaired by the Director General / NHS Wales Chief Executive. The Board would have oversight of the discussions, with Delivery and Performance Committee members providing scrutiny and assurance on behalf of the Board.

A mapping exercise had been undertaken to understand the roles across other Committees. Work was ongoing to develop and monitor actions against the draft

criteria, however the de-escalation criteria was expected to be received in early March 2025.

Committee members asked the following questions:

Given that Powys was in targeted intervention for Planning, what support was being provided by Welsh Government as Powys moves towards submitting the Integrated Plan (IP)?
Feedback from neighbouring health boards confirmed that a formal meeting with Welsh Government requires a considerable amount of work. As Powys had previously been placed in Level 3 escalation, the draft de-escalation criteria had already been received. The Level 4 criteria had not changed considerably, and Powys continue to be in close dialogue with the Director of Planning in Welsh Government regarding clinical services plans and were awaiting formal feedback.

KWi shared concern regarding the time taken to receive confirmation of a formal meeting with Welsh Government, given that Powys had been in level 4 targeted intervention for several months. Additional support was welcomed to enable Powys to satisfy Welsh Government concerns regarding performance across Finance and Planning.

HB highlighted the importance of the formal meetings to discuss Level 4 escalation and recognise that Welsh Government's Chief Operating Officer (COO) had attended a recent Board development session to contribute to discussions.

Was there any standardised documentation that should be shared with members of the Board prior to the meeting with Welsh Government?
NJ confirmed that the de-escalation criteria had been received and was not aware of any other documents that require action.

Were there any internal staff that may have historically experienced de-escalation criteria, which may be of benefit to share personal experiences?
NJ confirmed that Mick Giannasi, Independent Member, had experienced escalation processes across other Trusts. In addition, a number of the Executive Director team had experienced Level 4 escalation, so were familiar with processes.

The Committee **RECEIVED** the report as part of a package of assurance that PTHB continues to report as required in relation to its organisational escalation status. The Committee also **NOTED** the latest position on organisational escalation status for PTHB.

5.ITEMS FOR ASSURANCE

5.1 FINANCE PERFORMANCE REPORT MONTH 09 (D&P/24/100)

PH presented the month 09 report and noted the same report has been presented to the Board in January. The following key areas were highlighted:

- Powys Teaching Health Board (PTHB) continue to monitor against the current year-end deficit plan which had been revised from £22.948m to £15.770m;
- At month 9, there was a £18.333m overspend against the revised planned year to date deficit of £11.828m giving the Health Board an operational overspend of £6.504m;

- The year end forecast remains in line with the adjusted plan at £15.770m, but given the current overspend surpasses this figure, significant remedial actions of over £9m, as discussed by the Board, would be required to achieve the Plan;
- The Month 10 position was being assessed to understand the anticipated year-end position and to assess the additional actions approved by the Board;
- Additional funding had been received to support the longest waiting times across Powys. The assessment had been completed and would be incorporated into the Month 10 report to Welsh Government.

Committee members sought assurance by asking the following questions:

Was there an update against the risks related to Commissioning demand across the Joint Commissioning Committee (JCC)?
PH confirmed that it was anticipated that an update would be received this week which would be incorporated into the overall position.

Could assurance be provided against the Capital spend progression target?
PH explained that Powys received significant funding in October 2024 to support three areas to discharge in Q4. The programme of work across the areas were monitored and are expected to deliver against plans within the Capital resource limit.

Was it expected that an improvement in relation to agency spend would become a permanent feature?
Additional action and focus had been undertaken across the Community Servies Group, resulting in a decrease in agency expenditure. The Director of Primary, Community Care and Mental Health had implemented additional scrutiny, grip and control across the Mental Health services, and it was expected that locum and agency trends would continue to decrease to the end of the financial year.

EL explained that positive recruitment had taken place to stabilise and strengthen the reduction in variable pay costs. It had been recognised that further work was required, noting an escalation process had been implemented and would be closely monitored. Members recognised and applauded the successful recruitment across Mental Health Services which demonstrates the importance of substantial appointments.

The Committee:

- **RECEIVED** the Financial Month 09 Report,
- Took **ASSURANCE** that the organisation has effective financial monitoring and reporting mechanisms in place and;
- **NOTED** the current increased risk of achieving the projected in year forecast for 2024/25.

5.2 INTEGRATED QUALITY AND PERFORMANCE REPORT MONTH 09 SCORECARD (D&P/24/101)

NJ provided an update on the latest performance position by exception against the NHS Wales Performance Framework 2024/25 and highlighted the changes since the previous report. Diagnostic performance had flat lined, however it was projected to improve in 2025/26.NJ acknowledged the work undertaken across the Health Board,

particularly across performance given that the organisation is under routine monitoring. The following key areas across Performance were highlighted:

- Overall performance across Powys had maintained;
- Provider performance had strengthened with 104 week waits targets met. Powys continue with insourcing in place;

Areas for improvement:

- Adult Mental Health: A mixed picture largely down to small teams, however recent recruitment within the service should be of benefit.

Interventions:

- Care and treatment plans decreased last month due to staff fragility;
- Neurodevelopmental services across Children and Young People remains in internal escalation. As previously agreed, the Patient Experience, Quality and Safety (PEQS) Committee would monitor the position and is due to receive an update in Q1. A change in service model was anticipated to increase capacity, working towards specific Neurodevelopmental standards to reduce waiting times and closure of cases.

Commissioning:

- Acknowledged the waiting time standards between England and Wales. It had been agreed by the Board to not change the commissioning position.

NHS Wales had anticipated four out of six health boards would meet 104 week waits for year-end with the target to maintain in the next financial year.

- Waiting times for all providers across Cancer and ambulances remains a concern;
- Access to A&E services conveys and improvement in Wales in comparison to England;

Committee members sought assurance by asking the following questions:

Was it possible to confirm which two of the six health boards would not meet the 104 week wait target, given the potential impact on Powys residents?
NJ confirmed both Cardiff and Vale University Health Board and Betsi Cadwaladr University Health Board would not meet the 104 weeks wait target for this financial year.

What was the anticipated target waiting time in NHS England for next year?
The ambition was to achieve 65% of patients waiting 18 weeks or less, with significant improvement in reduction of waiting times this year. NHS England are working towards full delivery by 2029, noting this remains a significant financial risk for Powys. Powys would consider choices at a Board Development session the following week to build into next year's plans.

What more could be done to improve Cancer Services performance?
Work is underway to review the Cancer tracking service with the use of Power BI which provides live intelligence. There was a need to define causes for delay, recognising patient and acute flows remain complex. The service was reviewing gaps across pathways to intervene where appropriate, recognising that numbers were relatively small in Powys.

It was suggested that a report focused on internal cancer performance progress and external cancer pathways be brought forward to the Committee in Q2. This would allow sufficient time for engagement with all relevant parties and work to progress across the service. Committee Members SUPPORTED the proposal.
Action: Executive Director of Planning, Performance and Commissioning

SE observed the consistent poor level of ambulance response times reported and asked what was actively being done through the Joint Commissioning Committee (JCC), to address this. Concerns were raised around patient clinical outcomes, given the delay in ambulance response times and the long-term impact on Powys residents.

NJ added that a quarterly programme would be setup to allow service deep dives and transparency to committee members. NJ noted that Welsh Ambulance Service Trust (WAST) were changing the clinical model regarding how they triage and respond to patients. This was largely to address concerns raised around quality and the impact across the system. An update on progress would be scheduled to Committee in due course.
Action: Executive Director of Planning, Performance and commissioning.

The following updates were agreed to be incorporated into future performance reporting:

- Amber 1 calls: to confirm data for patients who travel longer distances to Stroke Centres.
- A&E departments: to confirm the total patient wait time from the emergency call to the hospital which excludes time that patients are waiting within an ambulance.

The Committee:

- **DISCUSSED** the report and took **ASSURANCE** that the Health Board has appropriate systems in place to monitor performance and respond to relevant issues.
- **SUPPORTED** that an update report would be brought back to committee for discussion.

5.3 Q3 ANNUAL DELIVERY PROGRESS REPORT (D&P/24/102)

NJ provided an update of the progress made against the Integrated Plan for Q3 2024/25. Good progress had been made with delivery of the actions and priorities in the Plan as reported at Q3. Following discussion at Executive Committee, further analysis had been carried out to provide a fuller and more consolidated picture of the Year-to-Date position and delivery confidence assessment to Year End.

NJ highlighted that a recent Internal Audit had been undertaken against the Planning Processes, including reporting on progress against the Delivery Plan which had received Reasonable Assurance. The progress report scheduled at the next meeting in May 2025 would provide the year-end position, the team would draw out the achievements and changes for the Powys population and patients in addition to the Delivery plan for 2025/26. This would be highlighted within the cover report for ease.

Given the positive impact of the Child and Adolescent Mental Health (CAMHS) emergency crisis service located at Llandrindod Wells Hospital, how was this funded and what was the long-term plan for the service to secure a permanent workforce?
EL confirmed this was a Welsh Government funded scheme, and the Health Board were awaiting confirmation whether this would be continued. This position was the same across all Welsh health boards. Capital was also provided to support the implementation of the environment established at Llandrindod Wells Hospital.

Committee members asked the following questions:

Given the financial position, was it expected that elements of the plan would need to be deferred and could we confirm what was deliverable?
NJ confirmed that the Board had signed off the initial strategic priorities for next year in terms of the deliverable position. The 2025/26 plan would need to address priority risks and planning to enhance sustainability. The Executive team had reviewed the emerging plan which would be recommended to the Board in February, this outlined elements to be deferred and also a number of high impact priorities for delivery. NJ noted that the service was building on good delivery confidence to deliver the plans given Powys' escalation status, recognising that a different lens was required.

Given the demographics of Powys' ageing population, how should we future proof phase frailty to a high standard?
Overall, the aging population of Powys is expected to peak in 2040 and the importance of supporting the older population to remain independent would be ciritcal from a Health and Social care strategy perspective. KW explained that consolidation of services was ongoing with cluster collaboration and prevention. EL noted that a review would be undertaken around integrated Community resource teams and virtual ward responses across Powys which was a critical starting point.

The Committee were **ASSURED** that there was a process in place for monitoring progress against the plan and **SUPPORTED** the report for onward submission to the Board.

5.4 PRIMARY CARE: OUT OF HOURS (OOH) (D&P/24/103)

JL provided an update against the Out of Hours (OOH) General Medical Services (GMS) provision for Powys patients for Q1 and Q2 in 2024/25.Meeting the standard for completing home visits within one and two hours remained a challenge for Shropdoc. Due to the geography of Powys the achievement of both these standards would always be challenging.

The current Shropdoc contract would terminate on 31 March 2025. A new short-term contract was being progressed to be in place from 01 April 2025, with advice from NHS Wales Shared Services Legal and Risk to secure OOH services with Shropdoc. The new regulations once passed, would allow the Health Board to direct award the continuation of the OOH service with Shropdoc. Due to the tight timescale Pthe Health Board would not be able to enact the new regulations by the 31 March 2025.

Weekend base cover at Ystradgynlais Hospital had not been achieved since the pandemic. It is recommended that PTHB confirm to Swansea Bay University Health Board (SBUHB) that the weekend pathway continues to follow the weekday pathway.

Members asked the following questions:

Could clarity be given as to whether Powys have been operating a service without a contract and what was the reason that the new contract was yet to be confirmed?
EL explained that the contract had not been signed due to visitation attendance at Ystradgynlais Community Hospital (YCH) during the weekends. There were also concerns from SBUHB that PTHB does not have a 24/7 District Nursing service. A lack of data continues around the total contract provision, response times and District Nursing services.

As SBUHB had not been able to deliver weekend service from YCH, had Powys been paying for a service which hadnot being received and if patients were expected to be seen at Morriston Hospital, how would this pathway be reflected within the contract?
JL confirmed that the service had been delivered for Powys throughout 2024/25, although it was recognised the position would be kept under review. Historic arrangements in place during the weekends would see a SBUHB GP in YCH aligned to medical cover on the wards which were applied for a number of years although not specified within the contract. JL explained a formal decision was required moving forward.

KB observed an engagement and communication plan with the public regarding the service change. JL confirmed that a plan was in place and should the recommendations be approved by Committee members, engagement with the public would be communicated.

Members raised concern that no formal contract was in place and the lack of patient data available for the residents in Ystradgynlais. Members proposed a further discussion around the service change agreement and timelines of process. EL confirmed that further work would be progressed around contract negotiations, data source and provision to provide assurance around OOH provision in line with Shropdoc changes in Ystradgynlais. A report would be brought back to committee for endorsement.
Action: Executive Director of Primary Care, Community and Mental Health

The Committee:

- **RECEIVED** the update provided,
- Took **ASSURANCE** that the OOH Commissioning Assurance Framework monitoring process was providing assurance to PTHB on OOH contract management and;
- **NOTED** the concerns around lack of data from Swansea Bay University Health Board and;

- **AGREED** that a further report would be brought back to committee around contract negotiations, data source and provision and Shropdoc changes across in Ystradgynlais.

5.5 SIX MONTHLY REPORT ON CONTINUING HEALTH CARE COSTS (D&P/24/104)

EL provided an overview of the current operational pressures and financial performance in relation to Continuing Health Care and Complex Care position which remained an area of concern. A systematic approach was being taken to address some of the challenges and has established a working group to review the improvement required. A meeting had been setup for 19 February and feedback would be provided to the committee following this.

RD explained that overall, there had been an increase in packages across EMI and Learning Disabilities which drive increased costs and wider market issues. The service had developed staff training in partnerships with Powys County Council (PCC) and achieved good working relationships with Care Homes. Compliance regarding reviews has been maintained but this is a constant balance and keeping this on a positive trajectory impacts on other team functions.

The priorities for Complex Care will be identified in the Integrated Plan for 2025/26 and will include:

- **Data management** – The development of a clear dashboard / dataset to ensure performance of the team. This was linked to one of the national recommendations through the Value and Sustainability Board.
- **Workforce plans** – Team structure options recognising that the current organisation of the teams was based on the recognition of the different functions of each specialised area of work.
- **Review collaborative opportunities** with the local authority to ensure a timely and appropriate commissioning system – ensuring a getting It Right First Time (GIRFT) approach which has a clear timeframe for delivery. Plans to meet with the local authority are in place.
- **Focus on the spend** – Work with the national team to develop a clear programme of work and the benchmarking with Hywel Dda University Health Board was underway.

The Committee:

- **REVIEWED** and **DISCUSSED** the report and **NOTED** the actions in place to manage service demand, improve performance and control spending.

5.6 SIX MONTHLY REPORT ON CATERING SERVICES (D&P/24/105)

PH presented an overview of the current compliance levels of food safety in relation to statutory regulations, guidelines and best practices. The following key highlights were noted:

- the successful implementation of a refined Food Safety Management System (FSMS), maintaining high Food Hygiene Ratings (Level 5) across all sites, and the introduction of a new catering assurance system that has effectively reduced serious non-compliance issues.
- Enhanced Staff training efforts with improved completion rates

- challenges remain with achieving 100% compliance in audit completion rates and further refining allergen control systems. Actios are in place to mitigate this.

The Committee **RECEIVED** the report and were **ASSURED** that appropriate quality control measures are in place.

5.7 DIGITAL FIRST ASSURANCE REPORT (MID-YEAR) (D&P/24/106)

CM introduced the report and highlighted that an Annual Digital First assurance report was presented to the Board in January 2025, noting that the report in which members received for this committee focuses on specific progress undertaken with a look forward.

VC provided an overview of the progress, challenges and areas that require improvement. A newly established clinically led digital group would systematically review performance dashboards with the objective of enhancing clinical patient outcomes.

Members asked the following questions:

What progress has been made for patients to utilise the Welsh App to its full extent in order to access personal information and appointments should they need treatment cross border?
The NHS Wales App had been launched and was fully accessible to individuals should their GP be registered and connected. This enables individuals to access a number of health care pathways and information. The Digital team have worked with Digital Health and Care Wales and the NHS Wales App teams to discuss options for cross border challenges. Engagement with Cluster leads and the National Lead for the NHS App has included direct training with GP Clusters.

What was the position on those service areas that were not utilising video consultations and what engagement has taken place with clinical managers to date?
This is for PTHB services only which is being standardised to ensure it is made available to patients. To date, positive feedback had been received from those patients using the platform, however it was recognised that further work is required to better understand what was preventing services from utilising this. It was agreed that an update in terms of progress would be included in the next report to Committee.

Given that Shrewsbury and Telford Hospital Trust(SaTH) are excluded from this work, how can the service engage with them to encourage uptake of the App?
SaTH had been excluded in the short term given the recent clinical system replacement with minimal capacity to support Powys as required. Engagement with the Integrated Care Board (ICB) for SaTH had taken place to support communications of the work being undertaken. Committee members acknowledged the breadth of work undertaken across the digital service, in additional to the clinical based work.

The Committee were **ASSURED** that work had progressed and delivery against the Digital Strategic Framework, to embed a clinically led digitally enabled service in support of Digital First as a Strategic enabler for transformation, improvement, quality, safety and efficiency. Members **NOTED** the key achievement and **NOTED** the challenges.

5.8 APPROACH TO ANNUAL ACCOUNTS (D&P/24/107)

HB provided members with a verbal update against the approach to Annual Accounts and noted draft guidance had been received from Welsh Government which indicated a number of changes required from Health Boards. The Performance element of the Annual Report would be shared with Delivery and Performance members prior to the 01 May meeting for comments. The following key dates were noted:

- 09 May 2025 – Draft submission of Annual Accounts and Annual Report submission to Audit Wales and Welsh Government.
- A series of Committees of the Board would then receive the Annual Accounts and Annual Report for consideration and scrutiny.
- PTHB Board 25 June 2025 – Receive Final Annual Account and Annual Report.
- 30 June 2025 – Final submission to Audit Wales and Welsh Government.
- 30 July 2025 – Final submission to PTHB Annual General Meeting (AGM)

PH explained that a paper was taken to the Audit, Risk and Assurance Committee on an annual basis, which outlines the methodology and approach to the year-end process. This highlights key areas of expenditure and areas to reflect within the financial position.

The Committee **RECEIVED** the update on the approach to Annual Accounts.

5.9 CAPITAL AND ESTATES COMPLIANCE REPORT (D&P/24/108)

WT provided members with an overview on the position in relation to Capital and Estates compliance which had been considered at Informal Executive Committee on 30 January 2025. Powys had benefitted from an increase in Welsh Government capital allocation in 2024/25 with the committed Capital Resource Limit (CRL) at circa £13M, and with circa 56 schemes being delivered, this represents the largest capital delivery programme for many years. Slippage monies had recently been secured which added circa £900K and 8 projects to the pipeline. This would place pressure on the existing internal capital team resource to manage the step-change in activity within the financial year cycle.
The following key changes were highlighted:

- Environmental Financial Advisory Board (EFAB) have changed to Targeted Estates funding, there is £40m available for Powys to bed into alongside the rest of the NHS in recognition of the maintenance backlog.
- Welsh Government have increased Powys discretionary Capital allocation from £1.431M to 2.7M recurring.

Committee members asked the following questions:

What was the position across the Powys estate in terms of Reinforced aerated autoclaved concrete (RAAC)?

WT confirmed that RAAC is not present across the PTHB estate, and no incidents have been reported. The search had been broadened across the leased Primary Care estates in addition to PTHB.

How was Powys adhering to good practice across an old estate?
Investment of £4.2M through the Welsh Government Scheme REFIT has been allocated of which £3.6M is anticipated to be spent within this financial year. WT confirmed that this investment will provide significant savings on electrical and gas utilisation across the estate.

How was backlog maintenance across Capital planning being managed?
WT confirmed this remains a significant challenge. An Estates Condition Audit was conducted last year across all health boards in Wales which received Limited Assurance. This was primarily due to Capital not being available to address the backlog.

Was it anticipated that the additional funding would present pressures and challenge?
WT highlighted that £9M of the £12M had been allocated within the second half of this financial year and to date, Powys had not spent 50% of the allocation, recognising the substantial planning work required. A significant challenge iwas around confidence in delivery, recognising the positive impact that Capital investment will bring to Powys estate.

The Committee **RECEIVED** the report and were **ASSURED** that the organisation has appropriate systems in place to monitor capital and estates compliance.

5.10 COMMITTEE RISK REGISTER (D&P/24/109)

HB presented the report explaining that the Committee Risk Register inclusive of six risks allocated to the Committee by the Board for enhanced oversight. Two of the risks, CRR 008 and CRR 012 would be held in private session given the sensitivity of its content. All corporate risks continue to be reviewed by the relevant lead Directors prior to the next iteration of updates. The committee cycle and timing of each meeting will impact on whether the risk register updates have already been considered by the Board. The version shared in meeting had been presented to the Board on 29 January.

HB highlighted that at a meeting on 29 January, the Board supported the increase in score against CRR 001 from 16 to 20 which related to the in-year financial projections. This change had been reflected within the Corporate Risk Register.

Members observed Risk CRR 003 around the longer-term financial sustainability allocation of resources and how this aligns to the Transformation and Better Together Programme. It was acknowledged that the Board Assurance Framework (BAF) is inclusive of the wider health board challenges and highlighted that the Transformation team are undertaking a review of the resources required across specific areas.

The Committee **RECEIVED** and **DISCUSSED** the Corporate Risks within the Committees remit and took **ASSURANCE** that the risks are being managed in line with the Risk Management Framework.

6. ITEMS FOR DISCUSSION

There were no items for discussion.

7. CONSENT AGENDA

7.1 ENDOSCOPY UPDATE TO INCLUDE JAG ACCREDITATION (D&P/24/110)

HB provided an update to members that Endoscopy (including JAG Accreditation) was presented to the Planning, Partnerships and Population Health (PPPH) Committee on 04 February 2025 for detailed review. It was recognised that Delivery and Performance members shared a specific interest in Endoscopy and therefore the report was shared with members for information. It was noted that the PPPH Committee would continue to receive progress reports for Endoscopy and JAG Accreditation.

The Committee **NOTED** the Endoscopy Update and JAG Accreditation.

7.2 INTERNAL AUDIT REPORTS (D&P/24/111)

The Committee **RECEIVED** the following Internal Audit Reports for **ASSURANCE.**

- Core Financial Systems – Treasury Management *(Substantial Assurance)*
- Board & Committee Structure / Effectiveness *(Substantial Assurance)*
- Capital Systems *(Reasonable Assurance)*
- Energy Management *(Reasonable Assurance)*

7.3 COMMITTEE WORK PROGRAMME (FOR INFORMATION) (D&P/24/112)

The Committee **RECEIVED** the Committee Work Programme for 2024/2025.

7.4 POWYS TEACHING HEALTH BOARD (PTHB) GLOSSARY (FOR INFORMATION) (D&P/24/113)

The Committee **RECEIVED** the PTHB Glossary for Information.

8. OTHER MATTERS

8.1 ANY OTHER URGENT BUSINESS (D&P/24/114)

No urgent business was raised.

8.2 ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND/OR OTHER COMMITTEES (D&P/24/115)

There were none.

8.3. COMMITTEE REFLECTIONS (D&P/24/116)

The following summary of business and reflections were provided by members:

- Thanks were given to RL for conducting the meeting in absence of RA.
- Good balance of topics discussed
- Quality of reports and appropriate to the Committee

8.4 DATE OF THE NEXT MEETING (D&P/24/117)

The date of the next meeting is scheduled on 01 May 2025 at 13:00 via Microsoft Teams.

8.5 The following resolution was passed:

'Representatives of the press and other members of the public shall 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.'

Members Present:		
Rhobert Lewis – Chair	RL	Independent Member (General)
Kirsty Williams	KWi	Independent Member (PTHB Vice-Chair)
Cathie Poynton	CP	Trade Union
Steve Elliot	SE	Independent Member (Finance)
In Attendance:		
Pete Hopgood	PH	Deputy Chief Executive and Executive Director of Finance, Capital and Support Services
Elaine Lorton	EL	Executive Director of Primary, Community Care and Mental Health Services
Claire Madsen	CM	Executive Director of Allied Health Professions, Health Sciences and Digital
Nicola Johnson	NJ	Executive Director of Commissioning, Performance and Planning
Hayley Thomas	HT	Chief Executive Officer
Helen Bushell	HB	Director of Corporate Governance/Board Secretary
Beth Powell (Forum Support)	BP	Corporate Governance Business Officer
Apologies for Absence:		
Ronnie Alexander	RA	Independent Member (Chair)
Mick Giannasi	MG	Independent Member (General)
Carl Cooper	CC	PTHB Chair
Kate Wright	KW	Executive Medical Director

6.8 CORPORATE RISK REGISTER: CYBER SECURITY AND NATIONAL DIGITAL PROGRAMMES (D&P/IC/24/026)

Rationale for item being held in private: The details of the report and sensitive, confidential and not in the public interest.

The Committee **RECEIVED** the following Committee Risks and **NOTED** the updates:

- Cyber Security
- National Digital Programme

6.9 **MINUTES OF THE PREVIOUS IN-COMMITTEE MEETING (D&P/IC/24/027)**

The Committee **RECEIVED** the item and **APPROVED** the In-Committee Minutes of the meeting held on 05 December 2024 as an accurate and true record.

Meeting Closed at 13:15

Powell,Bethan
01/05/2025 10:03:13

Beth Powell								
RAG Status:								
At risk	Red - action date passed or revised date needed							
On track	Yellow - action on target to be completed by agreed/revised date							
Completed	Green - action complete							
No longer neede	Blue - action to be removed and/or replaced by new action							
Transferred	Grey - Transferred to another group							

Delivery and Performance Committee

Meeting Date	Item Reference	Lead	Meeting Item Title	Details of Action	Update on Progress	Original target date	Revised Target Date	RAG status
OPEN ACTIONS FOR REVIEW - (01 MAY 2025)								
05-Dec-24	D&P/24/086	Executive Director of Primary, Community Care and Mental Health.	In-reach Fragiity	It was agreed to bring an update report back to Committee in December 2025 to review the position.	**06.02.25 update** - item scheduled for December 2025 - to consider reports by exception in May and September if there are any significant changes/financial challenges impacting on in reach capacity. **01.05.2025 update** - A verbal update to be provided at the May 2025 Committee. (assurance report scheduled for Dec 2025)	Dec-25		On track
OPEN ACTIONS - IN PROGRESS BUT NOT YET DUE (01 MAY 2025)								
06-Feb-25	D&P/24/101	Executive Director of Planning, Perofrmance and Commissioning	IQPR	Setup a quarterly programme of Deep Dives: Ambulance Response due June 2025.	**17.03.2025 Update:** Discussions underway with WAST around data. Item scheduled for June 2025 agenda	Jun-25		On track
06-Feb-25	D&P/24/101a	Executive Director of Planning, Perofrmance and Commissioning	IQPR	A report focused on internal cancer performance progress and external cancer pathways be brought forward to the Committee in Q2.	**09.04.2025 update:** Item scheduled for September 2025 Agenda	Sep-25		On track
06-Feb-25	D&P/24/103	Executive Director of Primary, Community Care and Mental Health.	Primary Care: OOH	To provide a report to Committee around Contract negotiations, data source and provision and Shropdoc changes in Ystradgynlais.	**01.05.2025 update** - item added to work programme for June 2025.	Jun-25		On track
26/03/2025	PTHB/24/205	DPCCMH	Finance Report	Assurance Report on use of private providers in MH services to June D&P		Jun-25		Transferred
26/03/2025	PTHB/24/205b	DCG	Finance Report	Lessons learnt from the financial year to be incorporated into decision-making to June D&P		Jun-25		Transferred

Delivery and Performance Committee 2025-26							
Theme	Item Title	May 01/05/2025	June 26/06/2025	September 02/09/2025	October 21/10/2025	December 04/12/2025	February 26/02/2026
Governance	Minutes of previous meeting	✓	✓	✓	✓	✓	✓
Governance	Declaration of Interests	✓	✓	✓	✓	✓	✓
Governance	Action Log	✓	✓	✓	✓	✓	✓
Governance	Committee Reflections	✓	✓	✓	✓	✓	✓
Governance	Committee Risk Register	✓	✓	✓	✓	✓	✓
Governance	Annual Work Programme	✓					
Governance	Work Programme (updated through year)		✓	✓	✓	✓	✓
Governance	Annual Assessment of Committee Effectiveness	✓					
Governance	Committee Annual Report (including IC elements)	✓					
Governance	Review of Terms of Reference	✓					
Performance	Integrated Quality and Performance Report	✓	✓	✓	✓	✓	✓ Mnth 9
Performance	Enabling Actions		✓			✓	
Performance	Annual Delivery Progress Report	✓ Q4		✓ Q1	✓ Q2		✓ Q3
Finance	Finance Report	✓	✓	✓	✓	✓	✓
Finance	Savings - (Six monthly report on Continuing Heath Care costs)			✓			✓
Finance	Variable Pay			✓			
Innovative Environments	Capital Programme Delivery					✓	
Innovative Environments	Capital and Estates Compliance Report						✓
Innovative Environments	Capital and Estates Strategy Monitoring		✓				
Innovative Environments	Capital Pipeline Overview					✓	
Innovative Environments	Powys PSB Climate Working Group Update				✓		
Primary Care	GMS			✓			
Primary Care	GDS				✓		
Primary Care	Out of Hours			✓			
Primary Care	Community Pharmacy Annual Report					✓	
Digital First	Digital First Annual Plan			✓			
Digital First	Digital First Monitoring Report (Quarterly)		✓	✓		✓	✓
Audit Reports	Any Internal Audit/Wales Audit reports received - for information	N/A	N/A	N/A	N/A	N/A	N/A
Communications	Comms and Engagement Report		✓			✓	
Innovative Environments	Six monthly report on catering services				✓		✓
Performance	Organisational Escalation Status Presentation	✓	✓	✓	✓	✓	✓
Digital First	Digital First: annual deep dive into the Digital Programme and lighter touch assurance reports through the year To include Cyber Security Update			✓ Lite			✓
Finance	Deep Dive - CHC savings track growth on case numbers.		✓				
Performance	Endoscopy Update to include JAG accreditation			✓			✓
Health and Safety	Health and Safety Annual Report	✓					
Health and Safety	Health & Safety (Fire and Patient Safety) 6 monthly report					✓	
Actions	Deep Dive - from Performance report (Action at Feb meeting) Ambulance Response (May)	✓					✓
	Review the effectiveness of clusters in achieving their purpose on an Annual basis					✓	
	To provide a report to Committee around Contract negotiations, data source and provision and Shropdoc changes in Ystradgynlais.		✓				
Planning	Integrated Plan 2025/2026 Development and Draft Maturity Matrix - Second look needed at joint PPPH and D&P meeting March 2026						
Key							
Date to be confirmed							
Item to be confirmed							
Item deferred							
Item brought forward							
Going to Board							
Find Exec Cttee date							
Added to draft agenda							

Powys THB Finance Department
Financial Performance Report
Delivery and Performance Committee

Period 12 (March 2025)
FY 2024/25

Date Meeting: 1 May 2025

Introduction

Subject:	**FINANCIAL PERFORMANCE REPORT FOR MONTH 12 OF FY 2024/25**
Approved & Presented by:	Pete Hopgood, Director of Finance
Prepared by:	Hywel Pullen, Deputy Director of Finance
Other Committees and meetings considered at:	Executive Committee

PURPOSE:

This paper provides an update on the March (Month 12) Financial Position, including progress with savings delivery.

RECOMMENDATION:

The Board is asked to:

- receive the financial report and take assurance that the organisation has effective financial monitoring and reporting mechanisms in place.
- note that, subject to audit, it is reported that the Health Board has achieved the 2024/25 financial plan of a £15.8m deficit.
- note that the underlying deficit is assessed as deteriorating by £2.0m to £32.6m.

THE PAPER IS ALIGNED TO THE DELIVERY OF THE FOLLOWING STRATEGIC OBJECTIVE(S) AND HEALTH AND CARE STANDARD(S):

Strategic Objectives:	• Focus on Wellbeing	✖
	• Provide Early Help and Support	✖
	• Tackle the Big Four	✖
	• Enable Joined up Care	✖
	• Develop Workforce Futures	✖
	• Promote Innovative Environments	✖
	• Put Digital First	✖
	• Transforming in Partnership	✓
Health and Care Standards:	• Staying Healthy	✖
	• Safe Care	✖
	• Effective Care	✖
	• Dignified Care	✖
	• Timely Care	✖
	• Individual Care	✖
	• Staff and Resources	✓
	• Governance, Leadership & Accountability	✖

Approval/Ratification/Decision	Discussion	Information
	✓	

Summary Health Board Position 2024/25

Revenue			
Financial KPIs : To ensure that net operating costs do not exceed the revenue resource limit set by WG	**Plan £'000**	**Actual £'000**	**Trend**
Reported in-month financial position – (deficit)/surplus	-1,314	-1,275	↓
Reported Year To Date financial position – (deficit)/surplus	-14,457	-15,753	↓
Year end – (deficit)/surplus	-15,770	-15,753	↓

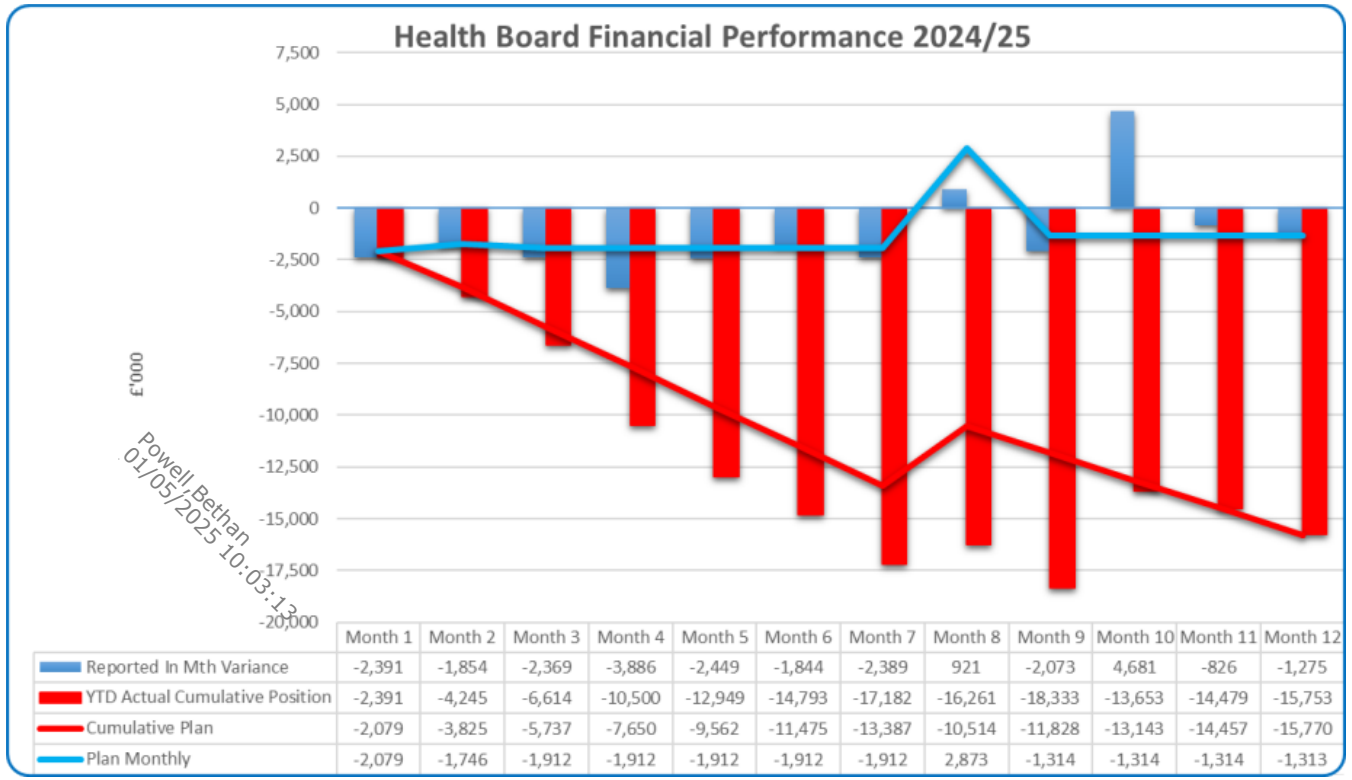
Capital		
	Value £'000	**Trend**
Capital Resource Limit	14,517	↑
Reported Year to Date expenditure	14,466	→
Reported year end – (deficit)/surplus – Forecast	-51	→

Following notification of additional WG funding allocations of £7.178m in Month 8, the Financial Plan for 2024/25 has been revised from a £22.948m deficit to a deficit £15.770m.

At month 12, there is a £15.753m overspend against the revised planned year to date deficit of £15.770m giving the Health Board an operational underspend of £0.017m.

This position excludes an unexpected £5m invoice from Wye Valley NHS Trust. The basis for the invoice and its value has been refuted. (Further information on Page 11)

The capital resource limit for 2024/25 is £14.517m, the outturn was £14.466m.



	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Reported In Mth Variance	-2,391	-1,854	-2,369	-3,886	-2,449	-1,844	-2,389	921	-2,073	4,681	-826	-1,275
YTD Actual Cumulative Position	-2,391	-4,245	-6,614	-10,500	-12,949	-14,793	-17,182	-16,261	-18,333	-13,653	-14,479	-15,753
Cumulative Plan	-2,079	-3,825	-5,737	-7,650	-9,562	-11,475	-13,387	-10,514	-11,828	-13,143	-14,457	-15,770
Plan Monthly	-2,079	-1,746	-1,912	-1,912	-1,912	-1,912	-1,912	2,873	-1,314	-1,314	-1,314	-1,313

DAY FIVE – summary report

- Commissioning is £1.972m M12 outturn. The overspend is lower than previously due to non-recurrent WG funding of £6.4m to support commissioned services.
- Agency expenditure of £0.581m in the month, which is lower than last month and at a similar level to the equivalent month in the prior year.
- CHC is overspent by £2.350m M12 outturn. There are 355 packages of care, a net increase of 7 this month.
- Mental Health Private Provider forecast overspend has increased from £3.3m to £3.7m this month. This is subject to urgent focus. (New further info page 7)
- Pressures above have been offset due to underspend on prescribing, dental services and one-off accountancy gains.

Revenue Variance Position 2024/25

Overall Summary of Variances £'000s

Table B Categories	Budget YTD	Actual YTD	Operational Variance YTD
01 - Revenue Resource Limit	(450,464)	(450,464)	**0**
02 - Capital Donations	(141)	(141)	**(0)**
03 - Other Income	(10,438)	(10,475)	**(38)**
Total Income	**(461,043)**	**(461,081)**	**(38)**
05 - Primary Care - (excluding Drugs)	49,987	47,672	**(2,315)**
06 - Primary care - Drugs & Appliances	38,208	35,817	**(2,391)**
07 - Provided services -Pay	122,170	124,370	**2,199**
08 - Provided Services - Non Pay	26,997	22,038	**(4,958)**
09 - Secondary care - Drugs	1,416	1,367	**(49)**
10 - Healthcare Services - Other NHS Bodie	184,261	186,234	**1,972**
12 - Continuing Care and FNC	32,948	35,592	**2,644**
13 - Other Private & Voluntary Sector	4,550	7,419	**2,869**
14 - Joint Financing & Other	10,228	10,287	**59**
15 - DEL Depreciation etc	5,115	5,115	**(0)**
16 - AME Depreciation etc	932	932	**(0)**
18 - Profit\Loss Disposal of Assets	0	(9)	**(9)**
Total Costs	**476,813**	**476,834**	**21**
Reported Position	**15,770**	**15,753**	**(17)**

At Month 12, there is a £15.753m underspend against the planned deficit of £15.770m giving the Health Board an operational underspend of £0.017m.

The most significant adverse variances are on:

- Continuing Care and FNC at £2.644m. The number of CHC packages has increased to 355, a net increase of 7 patients in March.
- Provider Pay at £2.199m - driven by the use of agency, from both on and off contract suppliers running at a high rate.
- Other private and voluntary sector is overspent YTD by £2.869m. This is due to an increased number of acute mental health placements with private providers.
- Commissioning of Healthcare Services from other NHS Bodies is £1.972m overspent at M12.
    - This is predominantly caused by issues in the health and social care system manifesting in increased costs in the acute and community sector and increased elective activity.

The pressures above have been offset due to reduced expenditure on Prescribing, Dental and other non-pay expenditure.

Health Board Provider Services

We are focused on this because:
This page gives a directorate level view of PTHB's corporate and provider services. There are significant budget variances to be understood and managed.

Subset of Table B Categories and Directorate View Variances

Subset of Table B Categories	WTE Bud	WTE Act	WTE Var	Average WTE	Budget to Date £000	Actual to Date £000	Variance
03 - Other Income	0	0	0	0	(£10,438)	(£10,475)	**(£38)**
07 - Provided services -Pay	2,322	2,113	(209)	2,108	£122,170	£124,370	**£2,199**
08 - Provided Services - Non Pay	0	0	0	0	£26,997	£22,044	**(£4,953)**
Grand Total	**2,322**	**2,113**	**(209)**	**2,108**	**£138,729**	**£135,938**	**(£2,791)**

Direcorate View	WTE Bud	WTE Act	WTE Var	Average WTE	Budget to Date £000	Actual to Date £000	Variance
Assistant Director Community Services	999	913	(86)	48,254	£46,501	(£1,753)	**(£1,602)**
Assistant Director MH/LD	503	421	(82)	25,719	£30,430	£4,711	**£4,589**
Assistant Director Women and Children	165	160	(5)	7,541	£7,886	£345	**£106**
Estates and Support Services	198	203	5	16,312	£16,369	£57	**(£23)**
Corporate and Other Services	458	416	(42)	40,903	£34,753	(£6,150)	**(£4,225)**
Grand Total	**2,322**	**2,113**	**(209)**	**2,108**	**£138,729**	**£135,938**	**(£2,791)**

Note: The above table only relates to the directly provided services for the directorates shown. These directorates are also accountable for other areas, such as CHC, Commissioning, Private Providers and Voluntary Sector, which is not included in the above.

Risks

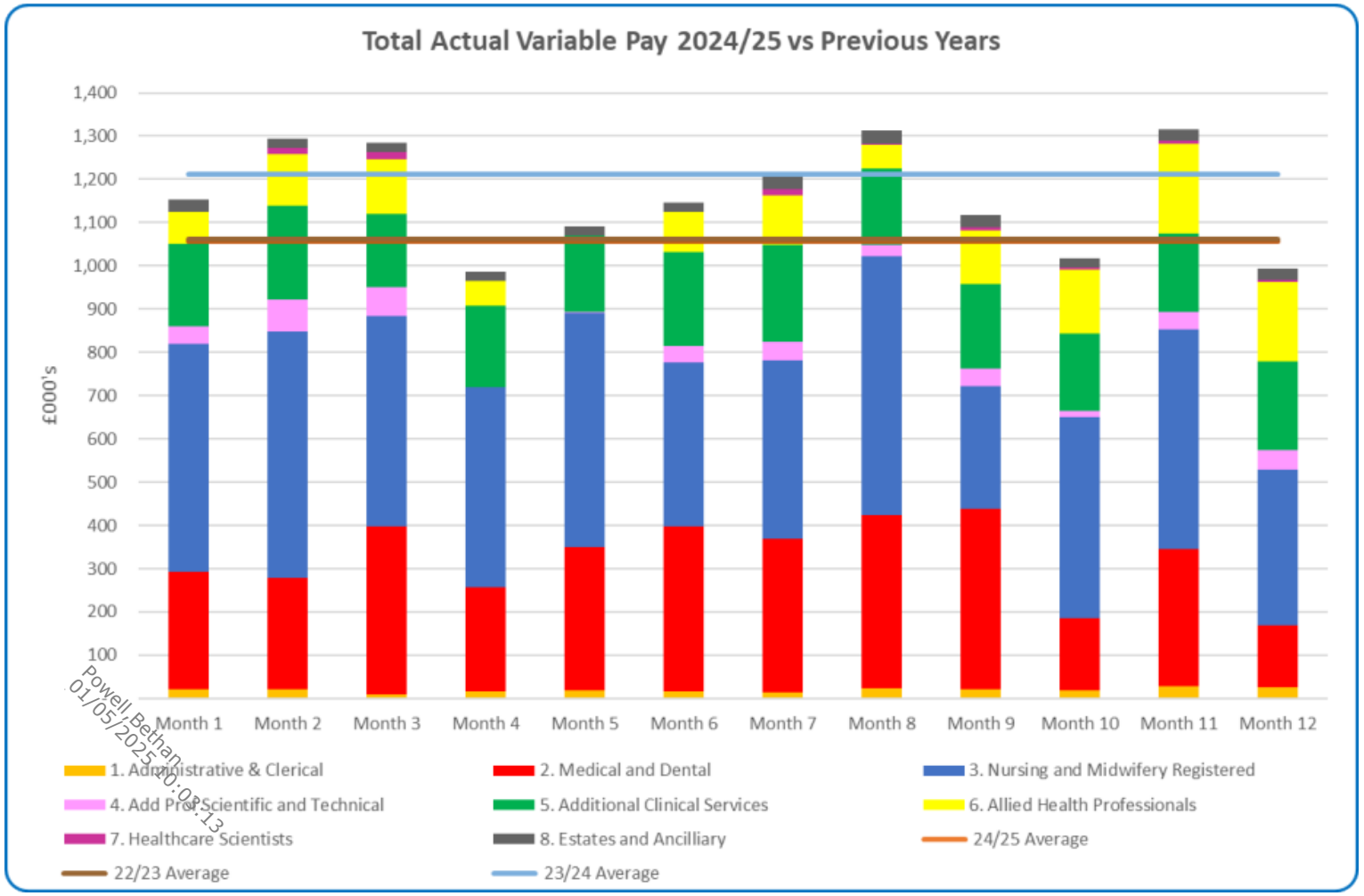
- Increased workforce gaps resulting in greater requirement for temporary workforce and associated premium spend.

Explanation of Performance

- The Month 12 position is showing an underspend of £2.791m over these categories.
- The service with the largest overspend is Mental Health. This is due to increased agency and locum expenditure and the underachievement of savings.
- Community Services is underspent due to management of vacancies and slippage against non-recurrent funding received.
- Vacancies are running at 16% (86 WTE) for MH Services and 9% (82 WTE) for Community Services.
- Corporate and other Service are underspent. This is where accountancy gains of £3.5m are recorded. Plus, vacancies and slippage on investments.
- The following page provides more detail on agency expenditure and the actions being taken to address the high usage.

Health Board Agency and Locum Spend

We are focused on this because:
Tackling our high agency spend levels (volume and price) is key to successfully mitigating financial risk and achieving the financial plan. Agency spend is far too high and is adversely impacting upon our use of resources (and wider outcomes).



What the charts tells us: Agency usage is at an unsustainable level and poses a significant risk to the achievement of the financial plan.

Performance and Actions

- Pay budgets have overspent by £2.199m against the plan, due to the high level of vacancies.
- The chart opposite demonstrates in March variable pay is lower than prior months. It is broken down by staff type.
- Powys continues to be an outlier within NHS Wales as agency spend was on average 9.2% of total pay in Month 11, against the Wales average of 2.7%.
- The HB's Variable Pay Reduction group is implementing its action plan. There are improvements on the wards in CSG, but high expenditure run rates remain in non-ward services and Mental Health.

Risks

- Level of agency (% of pay).
- Increased workforce gaps resulting in greater requirement for temporary workforce.
- Supply and demand price pressures leading to use of off-contract agencies.

Commissioning and Contracting

We are focused on this because:
Commissioning of secondary and tertiary healthcare services is circa 40% of all expenditure and has been growing steadily. It is a core component of the Health Board's Strategy facilitated through the transformation programme.

Status Update
Welsh LTAs for 2024/25 were agreed by the deadline of 30 June and, with the exception of WVT, the contract proposals from English providers are agreed. The variances against budget are based on the 10 months of activity information that has been received to date, with the exception of SaTH, which is unable to report its activity (block contract agreed). Providers ability to deliver both core and recovery activity is variable and is monitored closely.

NHS Commissioning Variance to Date 2024/25

Commissioning	Budget to Date £000	Actual to Date £000	Variance to Date £000
Welsh Providers	45,327	46,289	962
English Providers	77,423	78,057	635
JCC	56,108	56,312	204
Other NHS Providers	4,517	4,699	182
Mental Health (LTAs Only)	887	877	(10)
Total	**184,261**	**186,234**	**1,972**

Risks

- Capacity and performance of Adult Social Care services
- Providers exceed their RTT recovery targets.
- Winter pressures and capacity of the system generally to treat patients and thus avoid secondary care admissions.
- Delivery of saving plans.

Performance

Expenditure is affected by system delays for patients (see next page), increased emergency activity and the pace of recovery of elective activity by provider organisations.

Additional funding of £5.7m for contracting with English NHS and £0.650m for specialist services (JCC) has helped mitigate the overspend this year.

Notable pressures:

- Cwm Taf Morgannwg Health Board is reporting a 19% increase in emergency activity (at Prince Charles Hospital in Merthyr Tydfil).
- Wye Valley Trust - significant increase in community hospital attendances; length of stay in hospital and emergency and elective admissions.
- JCC - the ICP approved on an All Wales consensual basis above financial plan allocation with assumption that further savings would be achieved.

Secondary Care and Community hospital delays

We are focused on this because:
The delay in discharges from community and district general hospitals due to capacity and performance challenges within Adult Social Care services is causing an increasing pressure on the Health Board.

- The table opposite includes both health and adult social care (ASC) related delayed discharges. It distinguishes between Powys community hospitals and the two English health systems (Shropshire and Herefordshire).
- The District General Hospital (DGH) delays includes information from our neighbouring hospitals around the perimeter of Powys.
- The table shows that of delayed discharges to date:
  - 6,190 days within Powys community hospitals related to Health processes and 16,459 days as a result of Social Care. Associated costs of £3.7m and £9.7m, respectively.
  - 5,718 days within English community and district general hospitals (DGHs) related to Health processes and 12,121 days as a result of Social Care. Associated costs of £1.8m and £3.9m, respectively.

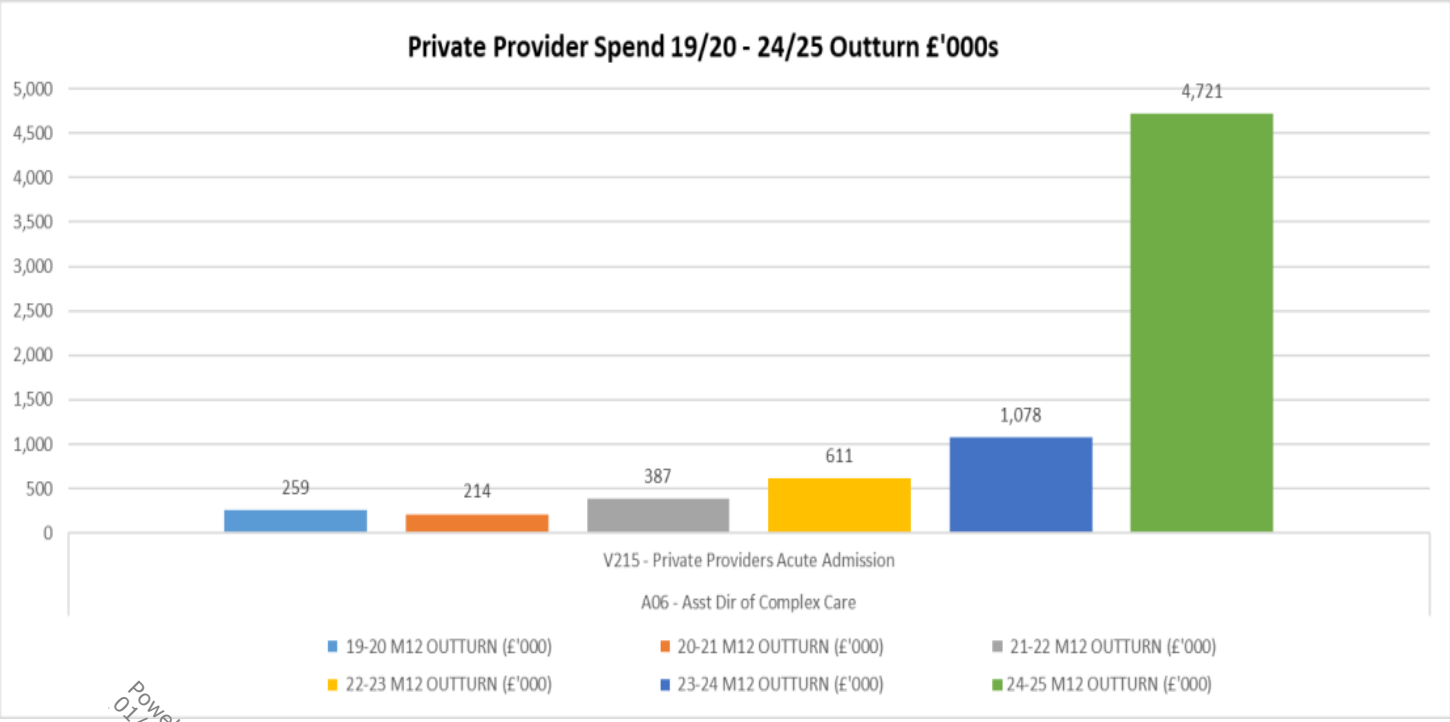
Please note the days are costed at full cost to PtHB of £590 in Powys, £432 for a community hospital in England and £301 for an excess bed day in a DGH.

	Health		Social Care	
Gross Cost of Delays	**YTD**		**YTD**	
	Days	**£m**	**Days**	**£m**
PTHB Provider Delays	1,934	£1.1	8,739	£5.2
PTHB Provider Assessment Delays	4,256	£2.5	7,720	£4.6
Subtotal PTHB Provider	**6,190**	**£3.7**	**16,459**	**£9.7**
Shropshire Community Bed Delays	47	£0.0	495	£0.2
WVT Community Bed Delays	249	£0.1	1,591	£0.7
DGH Bed Delays	5,421	£1.6	10,036	£3.0
Subtotal English & Welsh Providers	**5,718**	**£1.8**	**12,121**	**£3.9**
Total Opportunity Cost (at full cost)	**11,908**	**£5.4**	**28,580**	**£13.6**

Performance and action:
This is a challenging situation with increased risks for patients, the effective operation of services and the financial performance. The Heath Board works in partnership with the Council to address the underlying issues.

Private Providers

We are focused on this because:
Commissioning of Private providers packages is an area of significant expenditure growth (price inflation and number of packages).
Maintaining strong and transparent governance over Private providers processes is crucial for financial sustainability and relationships with our partners.
(previously this has been highlighted on the Commissioning and Contracting page, but due to increasing significance it has been drawn out separately)



Powell,Bethan 01/05/2025 10:03:14

Performance and Action

The 2024/25 financial plan had provision for private provider inflation and growth.

As at month 12, there is an overspend of £3.796m on a budget of £0.925m. The number of open packages is 26 at the end of February.

The forecast spend of £4.7m is a significant increase on prior years.

Increase in demand has been experienced due to internal bed/ward closures on Velindre Wards earlier in the year. Pressures remain with limited acute capacity and no capacity for Psychiatric Intensive Care Unit beds (PICU).

The level of patient acuity has not been seen since 2017. Prior to that, pressures were absorbed into the capacity of the other health boards that were providing services to PTHB.

What the table tells us

The table shows the significant growth in Private provider costs across all categories (mental health, learning disability,). If this continues unabated it poses a significant risk to the achievement of the financial plan and medium-term sustainability.

Risks

The HB has seen a significant increase in the complexity and number of patients requiring Private provision , there is a risk the growth continues in 2024/25 above that planned for and beyond the levels that can be mitigated.
There is a pressure on the weekly fees charged for packages of care.

Prescribing

We are focused on this because:

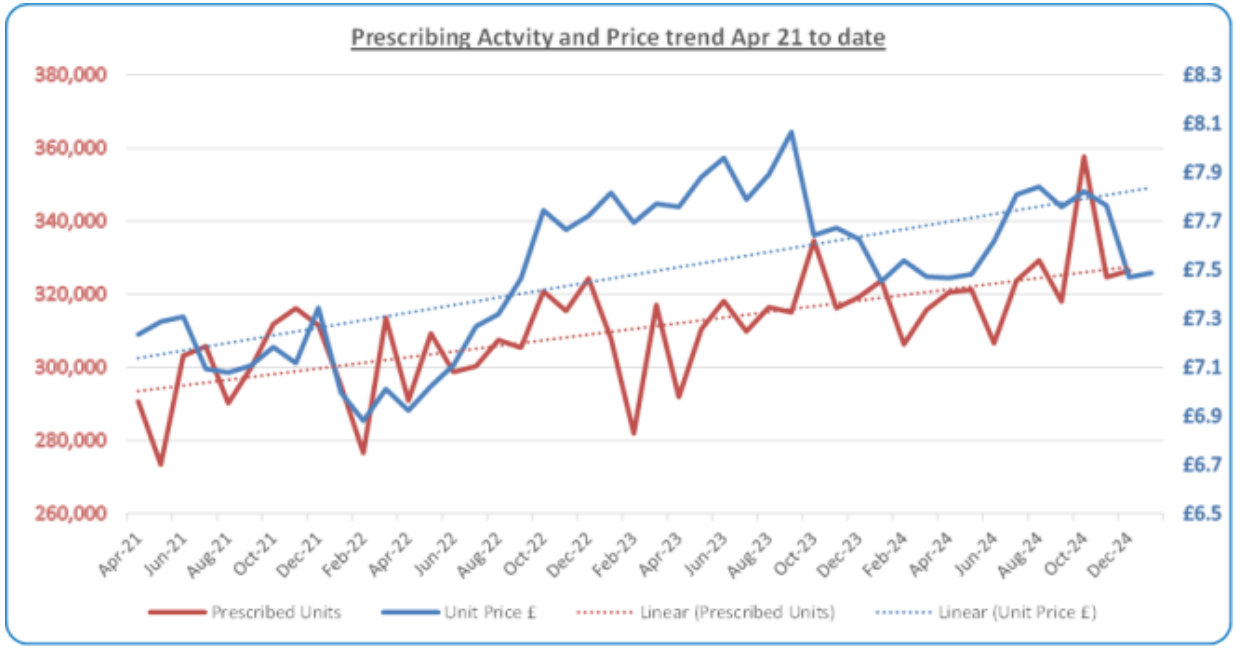
The costs of prescribing have risen significantly from April 2022. This was driven by both price inflation and increased prescribing activity. Whilst prescribing costs rose during FY23-24, the final outturn reduced significantly from earlier forecasts in line with reduced prices on certain drugs, and other successful savings initiatives. This trend has continued into FY24-25 which is driving a significant saving against budget in the FY24-25 financial position.

Status Update

An outturn underspend of -£1.62m on 2024/25 budget of £31.1m (incl £1.1m saving target). Prescribing costs are reported 2 months in arrears. This is change from the M10 forecast and is still based on best intelligence for the final two months.

- YTD costs, M1-M10, are broadly in line with M1-M10 in 2023-24, 1.2% increase.
- Unit price decrease year on year of -0.7%.
- Reducing % in FY24-25, driven by NCSO/price concessions. Unit costs are expected to continue at a lower rate into FY25-26 as the full year effect of the Apixaban cost reduction is included.
- Prescribing activity year on year increase of 3.6%.

Prescribing cost increases	FY20-21	FY21-22	FY22-23	FY23-24	FY24-25
	£k	£k	£k	£k	£k
Prescribing Budget	22,320	23,182	24,694	28,959	31,161
Prescribing Annual costs	25,953	25,610	27,469	29,195	29,538
Yr on Yr % increase/decrease	4.4%	-1.3%	7.3%	6.3%	1.2%
Yr on Yr increase £ Total	**1,086**	**-344**	**1,859**	**1,727**	**343**
Yr on Yr increase £ Growth	-109	475	655	747	1,061
Yr on Yr increase £ Inflation	1,196	-819	1,204	980	-718



Risks & Challenges

- High proportion of dispensing practices: (38% of patients receive medicines from a dispensing practice; 79% of patients are registered with a dispensing practice)
- Access and control to prescribing data, audit participation, other services driving prescribing activity.
- Responsibilities for prescribing vs accountability for the prescribing budget.

Medicines Management savings performance and actions

- Schemes delivered £2.181m savings, an increase over target of £1.081m.
- Guidance and support is given to Primary Care including, decision support software, monthly KPI reporting, practice visits, shared formulary and presc. guidelines, audit & shared care agreements.
- Active involvement in NHS Wales pharmacy and finance forums, including the Value and Sustainability Board workstream.

Continuing Healthcare

We are focused on this because:
Commissioning of complex healthcare packages is an area of significant expenditure growth (price inflation and number of packages).
Maintaining strong and transparent governance over CHC processes is crucial for financial sustainability and relationships with our partners.

Area	19/20 Year end Position £'000	20/21 Year end Position £'000	21/22 Year end Position £'000	22/23 Year end Position £'000	23/24 Year end Position £'000	24/25 Budget £'000	24/25 Actuals £'000	Growth 2023/24 to 2024/25 Actuals £'000	Growth 2023/24 to 2024/25 Actuals %
Children	£267	£151	£157	£296	£310	£339	£623	£312	100.6%
Learning Disabilities	£957	£1,568	£1,639	£2,461	£3,549	£3,925	£4,322	£773	21.8%
Mental Health	£7,344	£7,801	£10,611	£13,949	£16,201	£17,728	£19,714	£3,513	21.7%
Mid Locality	£981	£925	£1,635	£1,882	£2,123	£2,350	£2,301	£177	8.4%
North Locality	£1,365	£1,537	£2,098	£2,646	£3,475	£3,906	£3,927	£452	13.0%
South Locality	£1,495	£1,958	£1,853	£1,904	£1,955	£2,077	£1,670	(£285)	-14.6%
CHC Provisions	£8	£42	£1,796	£779	£683	£134	£248	(£436)	-63.8%
Grand Total	**£12,402**	**£13,983**	**£19,790**	**£23,917**	**£28,296**	**£30,460**	**£32,803**	**£4,507**	**15.9%**
Number of active clients	**230**	**243**	**285**	**295**	**327**	**315**	**355**	**28**	**8.6%**
D2RA				**£696**	**£201**	**£0**	**£7**	(£195)	-96.6%
FNC	**£2,218**	**£2,095**	**£1,960**	**£2,131**	**£2,279**	**£2,489**	**£2,782**	**£504**	**22.1%**
Total	**£14,620**	**£16,078**	**£21,750**	**£26,744**	**£30,777**	**£32,948**	**£35,592**	**£4,816**	**15.6%**

Performance and Action
The 2024/25 financial plan had provision for CHC inflation and assumed that the number of packages would remain consistent with the position in autumn 2024.

As at month 12, there is an overspend of £2.644m on the budget of £32.948m against Continuing Care and FNC. The number of CHC packages has increased by 7 in March to 355.

Across Wales, at Month 10, the forecast is for an 9.3% increase in costs in 2024/25 compared to 2023/24. It is 15.9% in Powys.

The CHC team is working with local care homes to simplify the fee rates and promptly review placements. It is responding to the opportunities identified by the national V&S Board.

What the table tells us

The table shows the significant growth in CHC costs across all categories (mental health, learning disability, children and frail adults). If this continues unabated it poses a significant risk to the achievement of the financial plan and medium-term sustainability.

Risks

The HB has seen a significant increase in the complexity and number of patients requiring CHC, there is a risk the growth continues in 2024/25 above that planned for and beyond the levels that can be mitigated.

There is a pressure on the weekly fees charged for packages of care.

Health Board 2024/25 Savings Programme

We are focused on this because:
Delivering savings is key to successfully mitigating financial risk and achieving the financial plan. Maximising recurrent savings is key to our financial sustainability and tackling our underlying deficit into the medium term.

Forecast Performance of Saving Schemes by Programme

	(£ '000s)						
	In-year 2024/25					Recurrent for future years	
Targeted Area	24/25 Recurrent Savings Target	Green (forecast)	Amber (forecast)	Green + Amber (forecast)	Forecast vs Target	Forecast FYE	FYE vrs Recurrent Target
2% Saving	**970**	4,545	0	4,545	3,575	923	-47
Continuing Health Care (CHC)	**430**	430	0	430	0	430	0
Commissioning	**1,650**	808	0	808	-842	810	-840
Community	**1,180**	1,262	0	1,262	82	1,171	(9)
Covid	**1,250**	1,236	0	1,236	-14	730	-520
Medicine Management	**1,100**	2,181	0	2,181	1,081	2,181	1,081
Mental Health	**1,320**	655	0	655	-665	0	-1,320
Commissioning - Delayed Transfer of Care Repatriation	**750**	434	0	434	-316	434	-316
Community - Discharge Support	**1,250**	176	0	176	-1,074	0	-1,250
Total	**9,900**	11,728	0	11,728	1,828	6,680	-3,220

Performance and Actions

- As shown in the table £11.728m savings have been achieved in 2024/25, against the £9.9m target.
- The recurrent impact of saving schemes at £6.680m, is a shortfall of £3.220m against the £9.900m recurrent target. This has an adverse impact on the Health Board's underlying deficit.

Note: RAG rating is per WG's guidance in WHC (2023) 012: Welsh Health Circular 2023 012 (English).pdf

What the table tells us

Focus is on converting opportunities into deliverable schemes. Particularly recurrent schemes to impact upon the underlying financial deficit.

Risks

Timescales and capacity of teams to deliver the schemes.

WG Value & Sustainability Board

V&S Board Category	24/25 Recurrent Savings Target £'000
CHC	430
Medicines Management	1,100
Other - Commissioning	2,400
Other - Primary Care	0
Pathway	0
Procurement & Non-pay	3,470
Workforce	2,500
Grand Total	9,900

Risk – WVT invoice

Unexpected invoice for £5m from Wye Valley NHS Trust:

Without prior notification, an invoice for £5m from Wye Valley NHS Trust (WVT) has been received (dated 13th March 2025). It has the description "*Recognition of discussions regarding parity of funding with English commissioners inc remoteness uplift, PFI and inflation*".

The Health Board strongly refutes the basis for the charge and the amount and immediately corresponded with and spoke to WVT seeking a credit note. Neither backing information giving the rationale for the sum sought or a credit note has been forthcoming. Although, just before Easter a letter was received, which included a table of figures amounting to £5m.

This is a serious matter for both organisations in terms of agreeing the end of year position and the preparation of annual accounts. The £5m invoice has not been included within the Health Board's 2024/25 month 12 financial position reported to Welsh Government. Senior officials have been alerted to the situation, as has Audit Wales.

The Health Board is seeking to resolve the issue through the disputes mechanism contained within the LTA. If this is unsuccessful, then resolution between Welsh Government and NHS England will be sought.

Care will be taken to ensure that the situation is appropriately and transparently reflected in the Annual Accounts.

Summary & Key Messages

1. At month 12, PTHB is reporting a £15.753m deficit. This comprises the profiled revised planned deficit £15,770m, with an operational underspend of £0.017m. This position has been supported by additional one-off funding from Welsh Government amounting to £6.350m.

2. Following the additional allocations of £7.178m in Month 8, there is a revised plan for 2024/25, which aims to achieve a deficit £15.770m. Due to a combination of additional funding and actions to reduce and defer expenditure the Health Board has achieved its financial plan**.**

3. There is a risk to this position of up to £5m relating to an invoice that has been received from Wye Valley NHS Trust.

4. Due to continued increased expenditure on private providers for mental health services, the Health Board's planned underlying position has been revised to £32.6m at month 12 from £30.6m at month 11. Over 2024/25, this is a deterioration compared to £26.9m reported at the end of 2023/24.

5. Other financial matters:
   - The Health Board has a £14.517m capital allocation. This has been fully utilised on a range of estates projects, digital investments and equipment.
   - Due to the £15.8m revised forecast financial deficit, the THB has received Strategic Cash to meet its obligations to suppliers and staff.
   - The Health Board is not currently achieving the target of paying 95% of non-NHS invoices within 30 days. This is due to delays in the process for approving agency invoices. By number, the YTD performance is 93.5%.

Powys THB Finance Department
Financial Performance Report – Appendices

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

Monitoring Return Reported

Embedded below are extracts from the Monthly Monitoring Return submitted to Welsh Government on 13th March 2025.

MMR Narrative

MMR Tables

Capital 2024/25

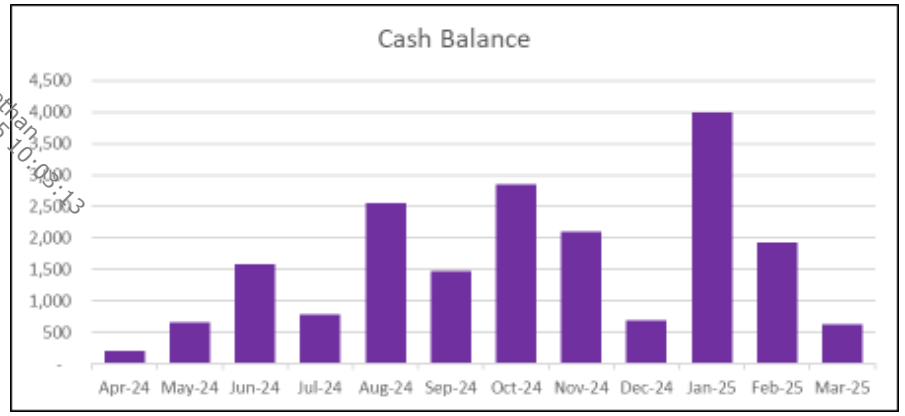
Appendix 2

Scheme	Capital Resource Limit	Annual Planned Expenditure	Expenditure to 31st March 2025
WG CRL FUNDING	**£M**	**£M**	**£M**
Discretionary Capital	0.978	0.978	1.829
EFAB Infrastructure	0.304	0.304	0.343
EFAB Fire	1.208	1.208	0.945
Replacement Roofing, Bronllys Hospital	0.216	0.216	0.134
Diagnostic Equipment 2024-25	1.700	1.700	1.742
Backlog Maintenance 2024-25 - Llandrinodod Wells	3.000	3.000	2.616
DPIF - RISP	0.368	0.368	0.323
DPIF - Electronic Prescribing and Medicines Administration (	0.198	0.198	0.197
Decarbonisation Programme	3.624	3.624	3.361
Year End Funding - October 2024	1.028	1.028	1.095
Diagnostic and Medical Equipment 2024-25	0.100	0.100	0.108
Digital Equipment - December - 2024-25	0.391	0.391	0.391
Year End Funding - January 2025	0.188	0.188	0.176
Year End Funding - February 2025	0.300	0.300	0.292
IFRS16 Leases - Tranche 1	0.177	0.177	0.177
IFRS16 Leases - Tranche 2	0.610	0.610	0.610
IFRS16 - 2024-25 Year End Allocations	0.127	0.127	0.127
Donated assets - Purchase	0.141	0.141	0.141
Donated assets (receipt)	(0.141)	(0.141)	(0.141)
TOTAL APPROVED FUNDING	**14.517**	**14.517**	**14.466**

Cash Flow 2024/25

Appendix 3

	Mth 1 £'000	Mth 2 £'000	Mth 3 £'000	Mth 4 £'000	Mth 5 £'000	Mth 6 £'000	Mth 7 £'000	Mth 8 £'000	Mth 9 £'000	Mth 10 £'000	Mth 11 £'000	Mth 12 £'000
OPENING CASH BALANCE	**215**	**201**	**663**	**1,577**	**783**	**2,559**	**1,465**	**2,845**	**2,092**	**682**	**3,998**	**1,927**
Receipts												
WG Revenue Funding - Cash Limit (excluding NCL) - LHB & SHA	39,840	39,210	34,850	36,165	39,722	33,631	35,502	40,899	35,800	38,570	37,129	36,587
WG Revenue Funding - Non Cash Limited (NCL) - LHB & SHA only	(140)	(160)	(150)	(150)	(150)	(150)	(150)	(150)	(131)	(152)	(232)	(64)
WG Revenue Funding - Other (e.g. invoices)	405	4	289	4	18	76	1,061	57	4	969	308	1,017
WG Capital Funding - Cash Limit - LHB & SHA only	0	0	0	0	500	549	0	300	3,128	500	4,464	7,339
Income from other Welsh NHS Organisations	1,075	484	343	419	731	778	403	681	425	887	817	1,438
Sale of Assets	0	0	0	0	0	0	0	0	0	0	0	0
Other	1,439	587	502	653	1,179	686	860	567	700	671	703	1,108
Total Receipts	42,619	40,125	35,834	37,091	42,000	35,570	37,676	42,354	39,926	41,445	43,189	47,425
Payments												
Primary Care Services : General Medical Services	2,996	2,435	3,298	2,724	2,566	2,716	2,990	2,781	2,779	3,287	4,457	2,949
Primary Care Services : Pharmacy Services	274	1,161	0	391	929	0	425	1,087	319	607	626	0
Primary Care Services : Prescribed Drugs & Appliances	1,441	2,889	0	1,468	2,896	0	1,589	3,022	1,561	1,484	1,430	0
Primary Care Services : General Dental Services	478	426	474	484	523	367	439	407	494	449	334	562
Non Cash Limited Payments	86	130	152	135	134	118	117	137	116	90	140	211
Salaries and Wages	8,859	8,851	8,790	8,748	8,754	8,836	8,898	10,557	10,953	9,567	9,696	9,674
Non Pay Expenditure	28,499	23,660	22,123	23,872	24,374	24,565	21,428	24,655	23,752	21,731	24,347	28,463
Capital Payment	0	111	83	63	48	62	410	461	1,362	914	4,230	6,864
Other items	0	0	0	0	0	0	0	0	0	0	0	0
Total Payments	42,633	39,663	34,920	37,885	40,224	36,664	36,296	43,107	41,336	38,129	45,260	48,723
NET CASH FLOW IN MONTH	**(14)**	**462**	**914**	**(794)**	**1,776**	**(1,094)**	**1,380**	**(753)**	**(1,410)**	**3,316**	**(2,071)**	**(1,298)**
Balance c/f	**201**	**663**	**1,577**	**783**	**2,559**	**1,465**	**2,845**	**2,092**	**682**	**3,998**	**1,927**	**629**



Due to the £15.8m revised forecast financial deficit, the THB received Strategic Cash to meet its obligations to suppliers and staff.

Core Financial Plan Year 1 2024/25

Financial Plan	(£m)
Underlying Deficit	25.4
Inflationary Pressures	11.7
Demand / Service Growth	5.7
Net Effect of Allocation Adjustments and COVID	-10.0
Mitigating Actions	-9.9
Additional Funding from Welsh Government	-7.2
TOTAL DEFICIT	**15.8**

The original 2024/25 Financial Plan was a deficit of £24.9m.

The Health Board was asked to revisit the Financial Plan to reassess the underpinning assumptions and actions with an aim of reducing/ providing greater assurance on the forecast financial deficit.

Submission of supplementary papers and associated Minimum Data Set on 31 May 2024 revised the deficit financial plan to £22.9m, after £2.0m of additional savings were identified.

There is a range of significant risks to be managed.

Following the additional allocations of £7.178m in Month 8, the 2024/25 Financial Plan has been revised further. It aims to achieve a deficit £15.770m.

GIG CYMRU NHS WALES

Bwrdd Iechyd Addysgu Powys

Powys Teaching Health Board

Agenda item: 5.2

Delivery and Performance Committee	**Date: 01 May 2025**
Subject:	Powys Teaching Health Board Integrated Quality & Performance Report Scorecard – Month 11 (February 2025)
Presented by:	Executive Director of Planning, Performance and Commissioning
Approved by:	Executive Director of Planning, Performance and Commissioning Assistant Director of Performance and Commissioning
Prepared by:	Head of Performance Administrative Officer, Integrated Performance
Other Committees and meetings considered at:	Executive Committee -23 April 2025

PURPOSE:

This Integrated Quality & Performance Report (IQPR) provides an update on the latest available performance position for Powys Teaching Health Board against the NHS Wales Performance Framework 2024/25 up until the end of February 2025 (month 11). This document supports the IQPR scorecard.

RECOMMENDATION(S):

The Delivery and Performance Committee is asked to:

- **DISCUSS** the content of this report; and
- Take **ASSURANCE** that the Health Board has appropriate systems in place to monitor performance and respond to relevant issues.

Approve/Take Assurance	Discuss	Note
Y	Y	Y

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	Y	
2. Provide Early Help and Support	Y	
3. Tackle the Big Four	Y	
4. Enable Joined up Care	Y	
5. Develop Workforce Futures	Y	
6. Promote Innovative Environments	Y	
7. Put Digital First	Y	
8. Transforming in Partnership	Y	

SUMMARY:

This report provides the Delivery and Performance Committee with the latest performance information to highlight performance achievements and challenges at a high level via the scorecard. It does include benchmarking where available but only narrative for level 3 escalations in brief.

Summary for Month 11

Provider

Planned care:

- Diagnostic waits reported slight increased breaches with 79 reported in February vs 70 in January. Most breaches involve echocardiograms (73 pathways), endoscopy (2 pathways), and non-obstetric ultrasound (4 pathways).

  The health board is not achieving its ministerial priority trajectory and complexity around clinical practice change has increased echo cardiogram demand significantly. An operational review of capacity is being undertaken with additional clinics being undertaken in PTHB Community Cardiology service. A full evaluation of the service is to be undertaken to inform future plans for the service coverage to be expanded to mid and south Powys. It is anticipated that this review will be completed by the end of May 2025 and report to the Community Services Group Directorate Management Team.

- Referral to treatment (RTT) compliance remains positive :
  - 104-week waits: 0 pathways.
  - 52-week outpatient waits: 0 pathways.
  - 52-week treatment waits: improved performance reporting 9 breaches in February compared to 22 in January.

- Therapies waits remain robust with 100% of under 18s seen within 14 weeks, however there are 2 adult breaches, both of which were booked to be seen in March 2025.

- Provider cancer pathway performance for outpatients and diagnostics remains robust with key diagnostics (endoscopy) being carried out within target. Downgrades within 28 days performance has improved to 60.7% but remains challenged by numerous factors including acute centre diagnostics and reporting delays.

- Overall performance broadly continues to improve aligned to national requirements and ministerial priorities. Challenges remain with in-reach capacity fragility, and complex diagnostic delays affecting specialties including Ophthalmology, ENT, and Orthopaedics. Insourced capacity remains in place to boost capacity especially for the key urgent and urgent suspected cancer pathways.

Mental Health:

- Under-18s: Compliance achieved in February for assessments, interventions, and care treatment plans (CTP).

- For Adults:
    - Assessments: Performance is now reporting 85.5% against the target of 80%. This measure has now achieved the planned recovery trajectory and has been de-escalated. It is expected that with the recent recruitment of 3 whole time equivalent mental health practitioners and agency mental health practitioner's performance improvement will be sustained.

    - Interventions: Improved to 96.2%, significantly above the target of 80%.

    - CTP compliance: Has shown a decreasing trend since the summer with a further reduction in month to 79.8%, below the target of 90%. Performance has been impacted by sickness absence of two of the CMHT team leads. Both have returned with targeted piece of work undertaken with Ystradgynlais and Newtown Community Mental Health Teams (CMHTs) with expectation of improved performance position from December 2024 and sustained into 2025 which has not yet materialised.

    - Psychological therapy waiting times is not meeting target with a reported performance of 67.7% in February (target: 80%). The performance is impacted by new staff inductions, introduction of new allocation process, locum turnover and sickness absence. Work is ongoing to sustain performance but delays in recruitment to psychology posts will impact on this in the first quarter of 2025.

Neurodevelopmental Services:

- Significant challenges persist, with slight improvement in performance against the nationally reported measure reported in January of 24.4% to 25.9% compliance in February.
- Patients will be taken from RTA from March 2025 having addressed the backlog and internal waits.
- The internal Executive Oversight Group (Level 3) is in place.
- Performance aligned to the accelerated waiting list monies received from WG exceeded forecast and delivered 147% performance.

- Expected to achieve ministerial priority for 0 waits > 2 years by end of March with work to continue to maintain <104 week waits.

Emergency Care:

- Powys provider Minor Injuries Units (MIU) services performed very well, meeting the 4-hour target (100% compliance) and reporting median waits of 4 minutes for triage and 5 minutes for senior clinician assessment. This will be kept under review as the temporary service changes progress.

Commissioned services

Planned care:

- Long waits remain challenging, though Welsh providers show slow progress on RTT targets with the health board tracking the ongoing impact of the additional planned care funding that has been released to Welsh providers.

  Total waiting lists are growing, with increasing demand forecast to risk further breaches. Pathways in NHS England tend to result in faster treatment than NHS Wales, though key wait bands remain a concern.

  The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH) continue to have challenging and increasing long waits 2+ years for complex spinal pathways, knee and sports; and The Shrewsbury and Telford Hospital NHS Trust (SATH) are challenged with whole system pressures.

Cancer Pathways:

- Performance against the 62-day target remains poor in both English and Welsh commissioned services, with diagnostic delays, outpatient, and treatment capacity provided as key reason of delay via assurance and monitoring engagement.

  Wye Valley NHS Trust (WVT) is the only Commissioned provider that is showing consistent positive improvement towards English targets and reports better than All-England average for all measures.

Commissioned Emergency Care:

- Welsh Ambulance Service (WAST) 8-minute response times to RED calls remains poor but improved reporting 50.3% in February.

- No commissioned service meets the required national 4 or 12hr targets for their A&E departments. However Welsh emergency department performance for Powys residents is better than the English counterparts, though significant delays persist, especially in ambulance handovers. I

- It should be noted that The Shrewsbury and Telford Hospital NHS Trust (SATH) data has not been available since July-24 following reporting challenges and this is expected to be in place in quarter 1 2025/216.

Month 11 measures by escalation level

There are a total of 50 reportable measures, with 4 reported at level 3 as follows:

- Percentage of patients offered an index colonoscopy procedure within 4 weeks of booking their Specialist Screening Practitioner assessment appointment.

- Number of patients waiting more than 8 weeks for a specified diagnostic.

- Number of patients waiting for a follow-up (FUP) outpatient appointment who are delayed by over 100% due to data quality issues.

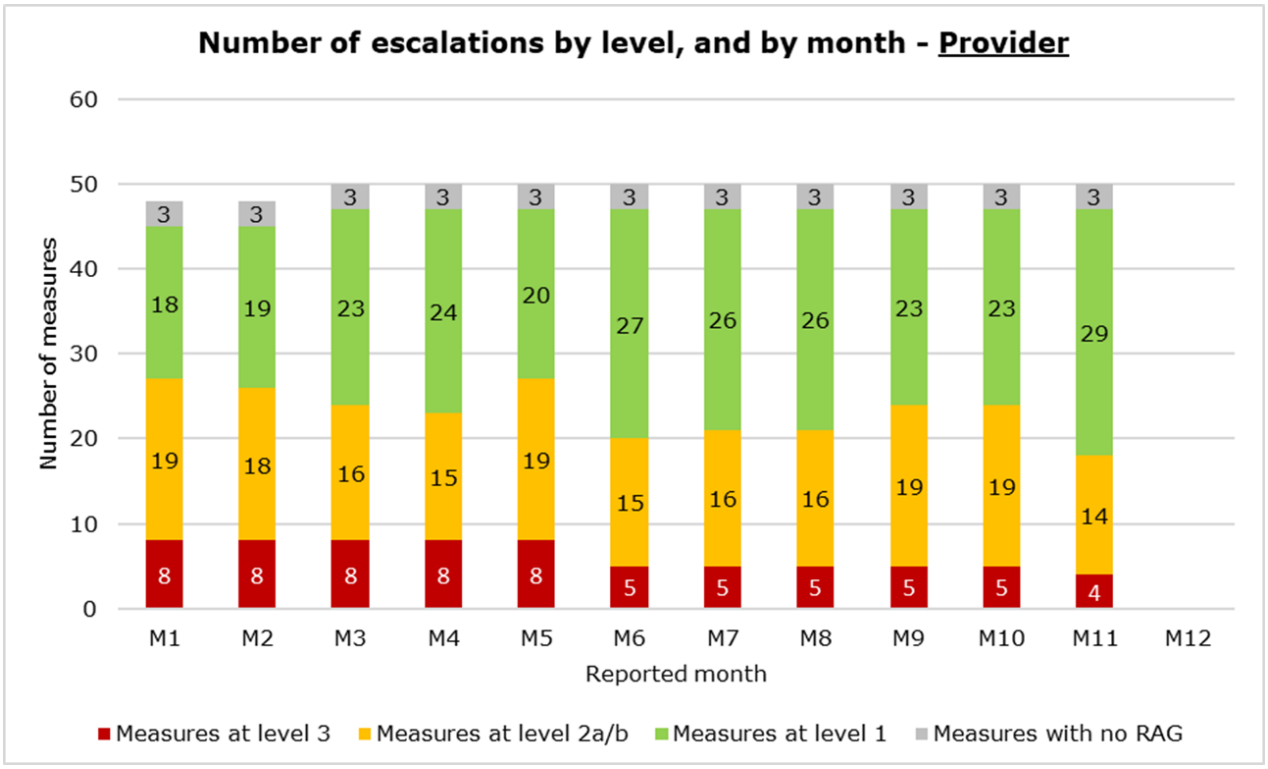
- Percentage of children and young people waiting less than 26 weeks to start an ADHD or ASD neurodevelopment assessment.

It should be noted that Percentage of Local Primary Mental Health Support Service (LPMHSS) assessments undertaken within (up to and including) 28 days from the date of receipt of referral for adults aged 18 years and over has achieved planned improvement against both national target and trajectory achieving 85.5% in February, compliance is expected to improve further in month 12. Consequently, the service has now been de-escalated.

A further 14 measures are rated at level 2a, and 29 are achieving level 1 compliance e.g., no issues reported. To note measure 1 "Percentage of adult smokers who make a quit attempt via smoking cessation services" is rated as level 1, although not compliant in Q3 and remain on track for meeting their respective end of year performance target (cumulative annual target).

A further 3 health care acquired infections (HCAI) measures are currently non-rated with ongoing discussions between the Nursing Directorate and Welsh Government on integration into the national targets.

The following provides the relative performance of the Health Board against the NHS Performance Framework that is applicable to the provider e.g., no commissioned or local measures are accounted for even if they are listed within the below exception/escalation reports or other areas of the IQPR.



Key performance indicators 2024/25 (Health Board submitted trajectories)

For the February 2025 snapshot the Health Board reports compliance on 5 of 6 Powys applicable submitted key performance indicator trajectories. The measures unable to meet trajectory are:

- Patients waiting over 8 weeks for a diagnostic, the trajectory of zero not being achieved, with 70 pathway breaches reported.

Please note that for the below tables scoring is colour and icon coded dependant on compliance of trajectory and national target:

- Value cell shading is red/green and denotes compliance to health board submitted trajectory as a key performance indicator.
- Value cell icon either green tick or red cross denotes compliance against the NHS Performance Framework target (mental health improvement trajectory targets match the NHS performance targets bar two with slight variation as noted in table).

Ministerial Priority Measures			Baseline		Month										
Measure	NHS Performance Target	KPI Improvement Target	Mar-24		Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
Number of patients waiting more than 52 weeks for a new outpatient appointment	Zero	40% reduction by end of September 2024 Zero by March 2025	0	Performance trajectory	55	65	55	45	20	8	5	0	0	0	0
				Actual	✓ 0	✓ 0	✓ 0	✗ 1	✗ 1	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0
Number of patients waiting more than 104 weeks for referral to treatment	Zero	Zero end of December 2024	1	Performance trajectory	0	0	0	0	0	0	0	0	0	0	0
				Actual	✓ 0	✗ 1	✗ 2	✗ 3	✗ 3	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0
Number of patients waiting over 8 weeks for a specified diagnostic	Zero	95% to be zero by December 2024	116	Performance trajectory	230	200	150	75	30	0	0	0	0	0	0
				Actual	✗ 140	✗ 171	✗ 157	✗ 155	✗ 140	✗ 124	✗ 107	✗ 83	✗ 84	✗ 70	✗ 79
Number of patients who spend 12 hours or more in all major and minor emergency care facilities from arrival until admission, transfer or discharge	Zero	20% reduction by September 2024 Further 20% reduction by March 2025	0	Performance trajectory	0	0	0	0	0	0	0	0	0	0	0
				Actual	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0
Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS for people age under 18 years	80%	80% by December 2024	97.7%	Performance trajectory	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%
				Actual	✗ 80.0%	✓ 86.5%	✓ 83.7%	✓ 93.1%	✓ 90.0%	✓ 87.5%	✓ 92.1%	✓ 89.2%	✓ 92.9%	✓ 86.7%	✓ 91.2%
Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS for adults age 18 years and over	80%	80% by December 2024	91.1%	Performance trajectory	85.6%	85.6%	85.6%	85.6%	85.6%	85.6%	85.6%	85.6%	85.6%	85.6%	85.6%
				Actual	✓ 95.2%	✓ 95.3%	✓ 93.0%	✓ 95.10%	✓ 87.50%	✓ 91.7%	✓ 92.3%	✓ 98.3%	✓ 95.6%	✗ 79.0%	✓ 96.2%

Of the key mental health improvement trajectories submitted by the health board, 6 of the 9 performance orientated measures have achieved the health board trajectory in February.

Non-compliant to trajectory/target measures include;

- Percentage of children and young people waiting less than 26 weeks to start an ADHD or ASD neurodevelopment assessment. The measure reported 25.9% (Feb-25) against a target of 80% and the health board set trajectory of 45% for the same period.

- Percentage of health board residents in receipt of secondary mental health services who have a valid care and treatment plan for adults 18 years and over. Performance improved but did not meet the 90% national target and health board set trajectory for February.

- Percentage of patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult Mental Health. Again, measure performance improved but does not meet the 80% national target or 95% health board set trajectory.

Age Group	Policy Lead Priority Measures: Measure	Target		Month: Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
Under 18's	Mental Health Measure Part 1a - % of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral	80%	Performance trajectory	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%
			Actual	98.0%	98.1%	100.0%	94.6%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	Mental Health Measure Part 1b - % of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS	80% by December 2024 (80% monthly is NHS Performance Framework Target)	Performance trajectory	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%
			Actual	80.0%	86.5%	83.7%	93.1%	90.0%	87.5%	92.1%	89.2%	92.9%	86.7%	91.2%
	Mental Health Measure Part 2 - % of health board residents in receipt of secondary mental health services who have a valid care and treatment plan	90%	Performance trajectory	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%
			Actual	94.1%	93.9%	90.8%	91.0%	93.6%	94.9%	94.9%	97.8%	94.8%	96.3%	95.7%
	Neurodevelopmental - % of children and young people waiting less than 26 weeks to start an ADHS or ASD neurodevelopment assessment	80%	Performance trajectory	45.0%	45.0%	45.0%	45.0%	45.0%	45.0%	45.0%	45.0%	45.0%	45.0%	45.0%
			Actual	45.4%	45.8%	39.6%	42.0%	37.2%	34.3%	30.9%	30.5%	27.3%	24.4%	25.9%
	SCAMHS - % of patients waiting less than 28 days for a first appointment for sCAMHS	80%	Performance trajectory	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%
			Actual	98.0%	92.7%	93.8%	100.0%	100.0%	100.0%	100.0%	100.0%	97.1%	100.0%	100.0%
18 years and over	Mental Health Measure Part 1a - % of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral	80%	Performance trajectory	70.0%	70.0%	70.0%	75.0%	75.0%	75.0%	75.0%	75.0%	80.0%	80.0%	80.0%
			Actual	44.1%	54.1%	69.2%	74.0%	45.3%	46.7%	58.7%	71.4%	78.7%	58.0%	85.5%
	Mental Health Measure Part 1b - % of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS	80% by December 2024 (80% monthly is NHS Performance Framework Target)	Performance trajectory	86%	86%	86%	86%	86%	86%	86%	86%	86%	86%	86%
			Actual	95.2%	95.3%	93.0%	95.1%	87.5%	91.7%	92.3%	98.3%	95.6%	79.0%	96.2%
	Mental Health Measure Part 2 - % of health board residents in receipt of secondary mental health services who have a valid care and treatment plan	90%	Performance trajectory	80%	83%	86%	88%	90%	90%	90%	90%	90%	90%	90%
			Actual	89.0%	90.4%	91.3%	91.5%	90.6%	89.6%	88.6%	84.1%	78.6%	79.1%	79.8%
	Psychological Therapies - % of patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult Mental Health	80%	Performance trajectory	80.0%	83.0%	85.0%	88.0%	90.0%	93.0%	95.0%	95.0%	95.0%	95.0%	95.0%
			Actual	75.1%	69.4%	75.2%	76.9%	78.7%	79.9%	72.9%	67.0%	63.1%	66.4%	68.2%

NEXT STEPS:

- 2025/26 Performance Framework is now available.
- Enabling Actions for 2025/26 released April 2025 – metric reporting to be confirmed by Welsh Government Performance by May 2025.

IMPACT ASSESSMENT – NOT REQUIRED FOR THIS REPORT

Powys Teaching Health Board

Integrated Quality & Performance Report

Month 11 - Summary
Updated on 15/04/2025

Background of the IQPR

What is the Integrated Quality & Performance Report (IQPR)

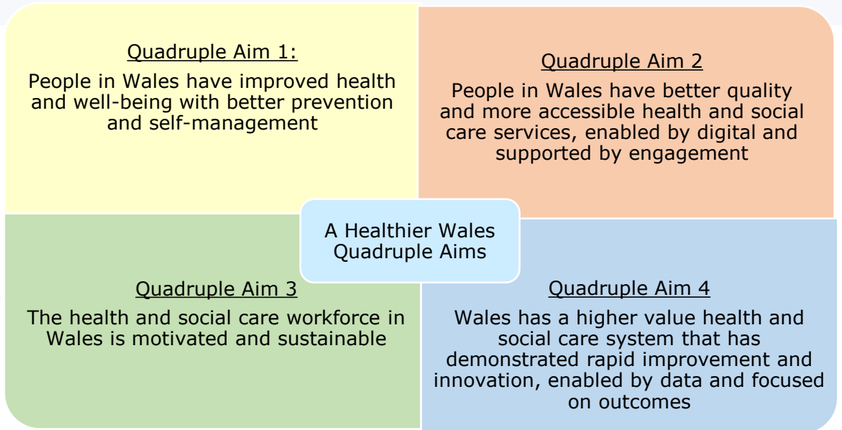
This report is a key part of the health boards Integrated Quality and Performance Framework (IQPF) designed to drive improvement in health board performance and health outcomes for those patients that Powys is responsible for.

The IQPR uses key NHS Performance Framework measures updated for 2024/25 which include Ministerial priorities and other timely local measures to provide robust assessment of the health boards performance as both a provider and commissioner of care focusing on key challenge and success.

This process utilises both quantitative and qualitative measurements which are backed by statistical process, business rules, and narrative provided by leads of the service area. The IQPR will continue to be developed with further inclusion of key measures.

What is the NHS Performance Framework?

The NHS Performance Framework is a key measurement tool for "A Healthier Wales" outcomes, The NHS Wales Quadruple Aim Outcomes are a set of four interconnected goals or aims that aim to guide and improve healthcare services in Wales. These aims were developed to enhance the quality of care, patient experience, and staff well-being within the National Health Service (NHS) in Wales. Link to the NHS Wales performance framework 2024 to 2025 | GOV.WALES



Powell Bethan 01/05/2025 10:03:13

What is the Integrated Quality and Performance Framework (IQPF) in Powys?

The Integrated Quality & Performance Framework (IQPF) aims to report holistically at service, directorate or organisation level the performance of the resources deployed, and the outcomes being delivered. Overall performance assessed via intelligence gathered across key domains including activity, finance, workforce, quality, safety, outcomes and performance indicators.

The IQPF is a revision of the 2023/24 Integrated Performance Framework with a greater focus on quality, it remains undergoing phased implementation across the health board.

Key for the framework is they system review, reporting, escalation and assurance process that aligns especially to the NHS Performance measures and any priority trajectories. In the provider Integrated Quality & Performance Group meetings will address key challenges and provide a robust forum for support and escalation to Executive leads and provide actions and recovery trajectories for escalated metrics.

As part of the operationalisation of the IQPF there is an expected element of exception or escalation either in a clinical or corporate service area triggering cause for concern. In such circumstances the Clinical Service Area or corporate team may be put into an escalation arrangement. Escalation will be considered against 4 domains (Access & Activity; Finance & Value; Quality; Workforce & Culture) and 3 levels of escalation. The levels of the framework, triggers and escalation response are set out below.

1. Level 1 : Normal e.g., earned autonomy meeting key objectives
2. Level 2a : Failure to achieve / maintain delivery
3. Level 2b : Specific for financial overspend by more than £0.5m per year
4. Level 3 : Serious concerns on quality, governance, ongoing failure to achieve key priority metrics.
5. De-escalation : Challenge rectified, requirement change, or senior committee decision.

Link to escalation descriptor slide

PTHB Integrated Quality & Performance Framework Escalation Framework 2024/25

Please note that this framework replaces the 23/24 business reporting rules as used within the Integrated Performance Framework and report.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Escalation level	Trigger	Action expected	Monitoring and support
Level 1 (No concerns)	• Local delivery of agreed objectives and performance, finance ambitions in line with agreed trajectories. • No exceptions or quality concerns. • Sound governance arrangements in place. • Performance within expected targets either national or local	• No escalation action. • Could result in frequency adjustment for some monitoring mechanisms and meetings including IQPG.	Main monitoring through base performance review process. Key measures bi-annually in IQPR to the Board.
Level 2a (Exception)	• Failure to achieve / maintain delivery in more than 1 key deliverable / area of performance. • Sustained deterioration on 1 or more domain. **This can include:** • Failure to deliver on an NHS Performance Framework target or local target trajectory. • A deviation or departure from the normal or expected course of action signifying specific condition or event that requires attention or further action to address the deviation. • Failure of quality standard. • Where SPC methodology notes variance of concern.	• Correspondence to Clinical service area/corporate dept on reasons for escalation – areas of concern, expected response and confirm any enhanced monitoring. • Recovery plan to be developed that address issues to be recovered/improved. • Depending on issue – change in frequency of and focus of standard meeting and consideration of increasing frequency including IQPG. • Reported through to Executive Committee. • Monthly reporting where appropriate via IQPR as an exception to performance.	**Options include:** • IQPG engagement monthly with Executive • Internal support as required (QI/vbhc/planning – issue dependent). • Consideration of compliance with Professional clinical codes and standards and proportionate response. • Consideration of compliance with managerial code of practice. • Internal peer review. • Executive support (directly or from other teams). • Consider need for bespoke response. • Minimum monthly updates to Executive Committee.
Level 2b (Exception)	**Specially for finance:** • Where Corporate Directorate or Clinical Service Area level budget is overspending by more than £0.5m Year to date or £1m forecast.	Identified through monthly financial reporting	CEO to call a special 'Budget Review Meeting' of all Executive Directors and the Divisional or Directorate budget holder (up to 3 team members may attend in support). **Agreed action plan established:** • Monitored through financial reporting arrangements. • Review period established if plan failing.
Level 3 (Escalation)	• Serious concerns on quality and governance. • Continued and consistent failure to meet agreed performance improvements and trajectories across a number of objectives. • Clear articulation of reasons for escalation and criteria for escalation. **This can include:** • Where a performance matter (exception) does not meet target and hits criteria for higher level of resolution, decision making or further action. • Any measure that continues to fail a health board submitted trajectory as part of the Ministerial Priority measures. • Performance recovery is failing to improve or maintain performance. • Any significant failure of quality standard. • Where IQPG deems that a service or measured outcome requires escalation resulting from identified challenge or significant concern.	• Correspondence to service area/corporate dept on reasons for escalation – areas of concern, expected response and confirm any enhanced monitoring. • Service Area or corporate directorate demonstrating recognition of issues and commitment to improve. • Improvement/recovery plan required to address issues identified. • Reported through to executive and relevant committee. • Escalated frequency of IQPG meetings and resultant remedial action plan completion. • Challenge review on appropriate shift to the Escalations Oversight Group (EOG). • Monthly reporting where appropriate via IQPR as an exception to performance.	**Actions could include:** • Escalation Oversight Group (EOG) • Independent review of service/corporate department effectiveness. • Deployment of appropriate HR policies e.g. Capability policy. • Weekly/fortnightly meetings with CEO and/or relevant execs to track progress against improvement actions (which directly related to de-escalation criteria). • Consideration of compliance with Professional clinical codes and standards and proportionate response. • Consideration of compliance with managerial code of practice. • Suspension or revision of service provision. **De-escalation:** The appropriate outcome for a challenge to be de-escalated. Either challenge has been rectified, requirement has changed, or via senior committee decision. A level 3 escalation may return to any previous lower level of escalation dependant on the remaining challenge and required monitoring.

Summary of Performance Provider – Month 11

Provider

Planned care:

- Diagnostic waits reported slight increased breaches with 79 reported in February vs 70 in January. Most breaches involve echocardiograms (73 pathways), endoscopy (2 pathways), and non-obstetric ultrasound (4 pathways). The health board is not achieving its ministerial priority trajectory although complexity around clinical practice change has increased echo cardiogram demand significantly. An operational review of capacity is being undertaken with additional clinics being undertaken in PTHB Community Cardiology service. A full evaluation of the service is to be undertaken to inform future plans for the service coverage to be expanded to mid and south Powys.

- Referral to treatment (RTT) compliance remains positive :
  - 104-week waits: 0 pathways.
  - 52-week outpatient waits: 0 pathways.
  - 52-week treatment waits: improved performance reporting 9 breaches in February compared to 22 in January

- Therapies waits remain robust with 100% of under 18s seen within 14 weeks, however there are 2 adult breaches.

- Provider cancer pathway performance for outpatients and diagnostics remains robust with key diagnostics (endoscopy) being carried out within target. Downgrades within 28 days performance has improved to 60.7% but remains challenged by numerous factors including acute centre diagnostics and reporting delays.

- Overall performance broadly continues to improve aligned to national requirements and ministerial priorities. Challenges remain with in-reach capacity fragility, and complex diagnostic delays affecting specialties including Ophthalmology, ENT, and Orthopaedics. Insourced capacity remains in place to boost capacity especially for the key urgent and urgent suspected cancer pathways through quarter 4.

Mental Health:

- Under-18s: Compliance achieved in February for assessments, interventions, and care treatment plans (CTP).
- For Adults:
  - Assessments: Performance shows an increasing trend since August now reporting 85.5% against the target of 80%. This measure has now achieved the planned recovery trajectory and has been de-escalated. It is expected that with the recent recruitment of 3 whole time equivalent mental health practitioners and agency mental health practitioner's performance improvement will be sustained.
  - Interventions: Improved to 96.2%, significantly above the target of 80%.
  - CTP compliance: Has shown a decreasing trend since the summer to 79.8% for February, below the target of 90%. Performance has been impacted by sickness absence of two of the CMHT team leads. Both have returned with targeted piece of work undertaken with Ystradgynlais and Newtown Community Mental Health Teams (CMHTs) with expectation of improved performance position from December 2024 and sustained into 2025 which has not yet materialised.
  - Psychological therapy waiting times is not meeting target with a reported performance of 67.7% in February (target: 80%). Performance impacted by new staff inductions, introduction of new allocation process, locum turnover and sickness absence. Work is ongoing to sustain performance thereafter but delays in recruitment to psychology posts will impact on this in the first quarter of 2025.

Neurodevelopmental Services:

- No improvement in performance against the nationally reported measure reported in February (25.9% compliance). Patients will be taken from RTA from March 2025 having addressed the backlog and internal waits, Internal Executive oversight (Level 3) is in place. Performance aligned to the accelerated waiting list monies received from WG exceeded forecast and delivered 147% performance. Exepcted to achieve ministerial priority for 0 waits > 2 years by end of March with work to continue to maintain <104 week wait.

Emergency Care:

- Powys provider Minor Injuries Units (MIU) services performed very well, meeting the 4-hour target (100% compliance) and reporting median waits of 4 minutes for triage and 5 minutes for senior clinician assessment. This will be kept under review as the temporary service changes progress.

Summary of Performance Commissioned – Month 11

Commissioned services

Planned care:

- Long waits remain challenging, though Welsh providers show slow progress on RTT targets, and we are tracking the ongoing impact of the additional planned care funding that has been released to Welsh providers. Total waiting lists are growing, with increasing demand forecast to risk further breaches. Pathways in NHS England tend to result in faster treatment than NHS Wales, though key wait bands remain a concern. The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH) continue to have challenging and increasing long waits 2+ years for complex spinal pathways, knee and sports; and The Shrewsbury and Telford Hospital NHS Trust (SATH) are challenged with whole system pressures.

Cancer Pathways:

- Performance against the 62-day target remains poor in both English and Welsh commissioned services, with diagnostic delays, outpatient, and treatment capacity provided as key reason of delay via assurance and monitoring engagement. Wye Valley NHS Trust (WVT) is the only Commissioned provider that is showing consistent positive improvement towards English targets and reports better than All-England average for all measures.

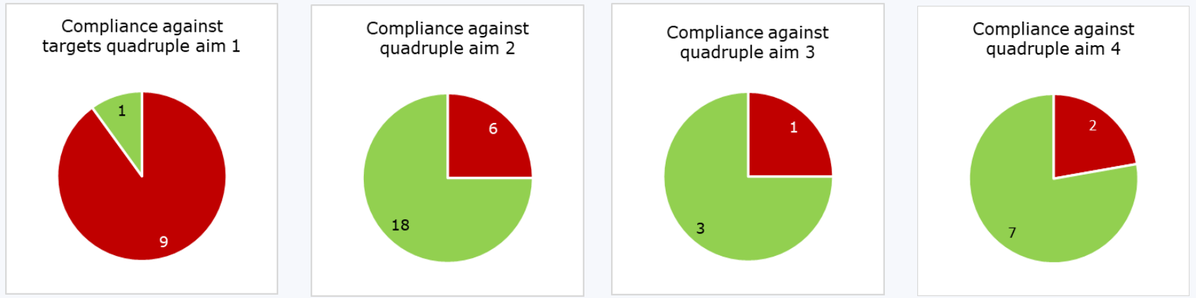
Commissioned Emergency Care:

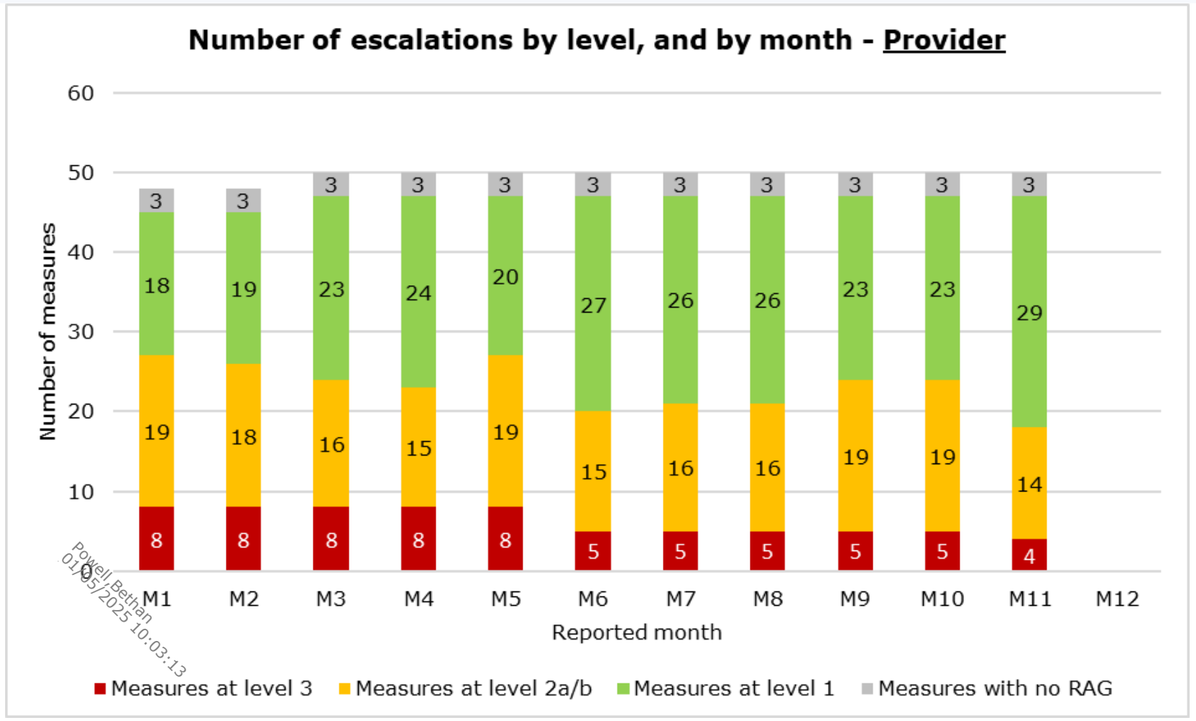
- Welsh Ambulance Service (WAST) 8-minute response times to RED calls remains poor but improved reporting 50.3% in February.
- No commissioned service meets the required national 4 or 12hr targets for their A&E departments. However Welsh emergency department performance for Powys residents is better than the English counterparts, though significant delays persist, especially in ambulance handovers. It should be noted that The Shrewsbury and Telford Hospital NHS Trust (SATH) data has not been available since July-24 following reporting challenges.

Visual summary of performance at month 11 (February 2025)

Only measures with a compliance rating e.g., compliant (green), non-compliant (red) are included within the quadruple aims compliance pie charts.
No commissioned metrics are included within graphs below.
No non-RAG rated measures are included.

Compliance against NHS Performance Framework measures at month 11 by quadruple aim area.





- 50 quantitative measures as a provider are reportable of the 52 total in the NHS Performance Framework with the inclusion from June of median emergency unit wait times.
- This graph provides the relative performance of the health board against the NHS Performance Framework that is applicable to the provider e.g., no commissioned or local measures are accounted for even if they are listed within the below exception/escalation reports or other areas of the IQPR.
- It should also be noted however that any measure can have its escalation level raised or lowered by senior agreement for example serious concerns can result in a level 3 escalation, even if performance meets national target e.g., the escalation rating can override compliance against national target.
- Measures with no RAG rating are those with either insufficient data to determine compliance e.g. 12-month reduction trends (normally new metrics), and those where PTHB reports but has no national target as a non-acute provider.

Level 3 - Performance Challenges

Serious concerns on quality and governance or continued and consistent failure to meet agreed performance improvements and trajectories.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

No.	Measure description, target, performance and other information	Reason for escalation level	Key Performance Drivers	Key Actions
8	**Percentage of patients offered an index colonoscopy procedure within 4 weeks of booking their Specialist Screening Practitioner assessment appointment** Period: Dec-24 | Target: 90% | Actual: 10.0% | SPC icon	Escalated by Powys Performance team for historic and current poor target compliance	• In-reach consultant unavailable during Q1, Q3, Q4 due to unplanned circumstances, backfill provided by in-source provider. • Insource re-procurement process with Shared Services delays. • BSW Nurse capacity re-allocated by Bowel Screening Wales to support regional pressures.	• Agreed joint appointment of band 7 screening practitioner with CTMUHB, this role is now out for recruitment with plans to have staff member in place end of March 2025. • Insource capacity utilised for both screening and symptomatic service. • The measure performance is not reflective of PTHB access times as a provider with PTHB often achieving or exceeding the 4-week target. PTHB Performance Team resolving reporting with Public Health Wales colleagues ongoing.
26	**Number of patients waiting more than 8 weeks for a specified diagnostic** Period: Feb-25 | Target: 0 | Actual: 79 | SPC icon	This metric has been escalated due to ongoing service pressure and non-compliance against Welsh Government set target. The service is reporting significant challenge of improvement and sustainability via the internal Performance and Engagement group linked to in-reach fragility.	• Key challenge within Echo-cardiograms because of in-reach fragility of ABUHB. Patients are also now sent straight to test by consultant prior to first outpatient appointment increasing demand. Endoscopy challenged primarily through in-reach service capacity in South Powys. Increased demand and urgency. NOUS challenge linked to North Powys in-reach from BCUHB.	• Cardiology in-reach service escalated via CQPRM with ABUHB. Operational review of capacity ongoing with additional clinics being undertaken within the PTHB Community Cardiology service. Full evaluation of Community Cardiology Service to be undertaken in March 2025. Expected business case for service to be expanded to mid and south Powys in Q1 2025. Key use of agency to support NOUS.
31	**Number of patients waiting for a follow-up (FUP) outpatient appointment who are delayed by over 100%** Period: Feb-25 | Target: < same month pre. year | Actual: 1203 | SPC icon	FUP pathways recording and reporting was escalated in Q4 2021/22 following service identified significant accuracy challenge in the reporting of pathway time banding. Resulting reporting checks by the Powys Data Intelligence team highlighted a significant quantity of un-reported pathways and local reporting was aligned to the National WPAS team's process. This measure remains escalated until suitably resolved with Executive signoff.	• Service pressure and demand to prioritise urgent and cancer pathways reducing FUP capacity. Ongoing data quality and validation challenges including patient administration system problems which are being resolved working with national team.	• SOS & PIFU reporting has now been resolved with the National Digital Team, improved local reporting identified and commenced to support national work stream. • New action plan including standard operating procedure for validation, new validation report and work with services to meet escalation recommendations Q1 2025/26.
34	**Percentage of children and young people waiting less than 26 weeks to start an ADHD or ASD neurodevelopment assessment** Period: Feb-25 | Target: 80% | Actual: 25.9% | SPC icon	Challenged whole pathway compliance with significant wait times for patients. Performance continues to fall against the measure and because of ongoing concern the Neurodevelopment service has been escalated to level 3. This service challenge has also triggered the Executive led Escalation Oversight Group process.	• From April 2022 the ND service has been in receipt of non-recurrent funding via the Regional Partnership Board's (RPB) Revenue Integration Fund (RIF) (2022-27) plus Welsh Government Neurodivergence monies (2022-25), all of which is supporting temporary staff to address the RTT and waiting list backlog. • Internal backlog completed and children appointed from RTA list since 01/03/25 • Priority to manage waits to retain <104weeks. • KPI's in place to ensure timely management of open pathways, number of appointments required along with experiential information.	• Robust scheduling in place with the utilisation of joint appointments. • Demand and capacity data to inform business case to support substantive structure. • Improvement plan in place aligned to HB escalation process, all actions on track for completion. • TNA completed and training arranged within Q1 2025/26.

Quadruple Aim 1: Performance Scorecard

2024/25 Performance Framework Measures					Performance					SPC	Welsh Government Benchmarking (*in arrears)		IQPF Escalation
Area	Executive Lead	Officer Lead	No.	Abbreviated Measure Name	Target	Latest Available	12month Previous	Previous Period	Current	Icon	Ranking	All Wales	Level
Quadruple Aim 1: People in Wales have improved health and well-being with better prevention and self-management	Executive Director of Public Health	Consultant in Public Health	1	% Attempted to quit smoking	5% annual target	Q3 2024/25	3.77%	2.75%	3.96%	N/A	4th	3.85%	Level 1
	Executive Director of Public Health	Consultant in Public Health	2	% of Adult smokers who made a quit attempt via smoking cessation services who are CO-validated as quit at 4 weeks	40% annual target	Q3 2024/25		15.6%	14.7%	N/A	5th	17.0%	Level 2a
	Executive Director of Primary Care, Community and Mental Health	Assistant Director of Mental Health	3	Percentage of people who have been referred to health board services who have completed treatment for substance misuse (drugs/alcohol)	4 quarter improvement trend	Q3 2024/25	65.6%	69.8%	65.5%	N/A	3rd	56.2%	Level 2a
	Executive Director of Public Health	Consultant in Public Health	4	% of children up to date with scheduled vaccinations by age 5	95%	Q3 2024/25	92.1%	93.0%	91.6%	N/A	1st	88.1%	Level 2a
	Executive Director of Public Health	Consultant in Public Health	5	% of children receiving the HPV vaccination by the age of 15	90%	Q3 2024/25	77.2%	78.6%	76.5%	N/A	3rd	72.3%	Level 2a
			6	Flu Vaccines - 65+	75%	Feb-25	69.3%	68.6%	69.2%	N/A	4th	70.1%	Level 2a
			7	% uptake of COVID-19 vaccination for those eligible (Autumn booster)	75%	Feb-25	59.6%	50.9%	50.6%	N/A	1st	46.7%	Level 2a
	Executive Director of Primary Care, Community and Mental Health	Senior Manager - Planned Care	8	% of patients offered an index colonoscopy within 4 weeks of booking specialist screening appointment	90%	Dec-24	5.6%	0.0%	10.0%		7th*	32.5%	Level 3
	Executive Director of Nursing, Quality, Womens and Family Health	Assistant Director of Women's and Childrens Services	9	% of well babies completing the hearing screening programme within 4 weeks	90%	Dec-24	89.4%	97.3%	78.2%	L	7th	92.0%	Level 2a
			10	% of eligible newborn babies who have a conclusive bloodspot screening result by day 17	95%	Dec-24	94.3%	97.5%	98.8%		1st	95.3%	Level 1

Quadruple Aim 2: Performance Scorecard

2024/25 Performance Framework Measures						Performance				SPC	Welsh Government Benchmarking (*in arrears)		IQPF Escalation
Area	Executive Lead	Officer Lead	No.	Abbreviated Measure Name	Target	Latest Available	12month Previous	Previous Period	Current	Icon	Ranking	All Wales	Level
Quadruple Aim 2: People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement	Executive Director of Primary Care, Community and Mental Health	Assistant Director of Primary Care	11	% of GP practices that have achieved all standards set out in the National Access Standards for In-hours GMS	100%	2023/24	100.0%		100.0%	N/A	1st	97.3%	Level 1
			12	% of patients (aged 12+) with diabetes who received all 8 NICE recommended care processes	Improvement compared to the same month in the previous year	Jan-25	48.1%	48.5%	48.7%		1st	41.5%	Level 1
		Assistant Director of Primary Care	13	% of the primary care dental services (GDS) contract value delivered (for courses of treatment for new, new urgent and historic patients)	A month on month increase towards a minimum of 30% contract value delivered by 30	Feb-25	63.5%	61.7%	67.2%		5th	76.6%	Level 1
	Executive Medical Director	Chief Pharmacist	14	No of consultations delivered through the Pharmacist Independent Prescribing Service (PIPS)	Increase compared to the same month in the previous year	Jan-25	451	632	604		7th	16,490	Level 1
	Executive Director of Primary Care, Community and Mental Health	Assistant Director of Mental Health	15	Assessments <28 days <18	80%	Feb-25	100.0%	100.0%	100.0%		1st*	80.8%	Level 1
			16	Interventions <28 days <18	80%	Feb-25	83.3%	86.7%	91.2%		5th*	73.2%	Level 1
			17	Assessments <28 days 18+	80%	Feb-25	49.1%	58.0%	85.5%		6th*	74.0%	Level 1
			18	Interventions <28 days 18+	80%	Feb-25	91.4%	79.0%	96.2%		6th*	86.8%	Level 1
	Executive Director of Planning, Performance and Commissioning	Assistant Director of Performance and Commissioning	19	Percentage of emergency responses to red calls arriving within (up to and including) 8 minutes	65%	Feb-25	44.7%	47.9%	50.3%		5th	51.1%	Level 2a
			20	Median emergency response time to amber calls	12 month reduction trend	Feb-25	00:53:57	01:13:20	01:14:30		1st	02:03:30	Level 2a
	Executive Director of Planning, Performance and Commissioning	Assistant Director of Performance and Commissioning	21	Median time from arrival at an emergency department to triage by a clinician	15 minutes or less	Jan-25	4	4	4	N/A	PTHB is not nationally benchmarked against this measure		Level 1
			22	Median time from arrival at an emergency department to assessment by a senior clinical decision maker	60 minutes or less	Jan-25	5	4	5	N/A			Level 1
	Executive Director of Primary Care, Community and Mental Health	Senior Manager Unscheduled Care	23	% of patients who spend less than 4 hours in all major & minor emergency care facilities from arrival until admission, transfer or discharge	Improvement compared to the same month in the previous year, towards the national target of 95%	Feb-25	99.9%	100.0%	100.0%		1st	67.7%	Level 1
			24	Number of patients who spend 12 hours or more in all hospital major and minor emergency care facilities from arrival until admission, transfer or discharge	Reduction compared to the same month in the previous year, towards the national target of zero	Feb-25	0	0	0		1st	8,955	Level 1

Quadruple Aim 2: Performance Scorecard

2024/25 Performance Framework Measures						Performance				SPC	Welsh Government Benchmarking (*in arrears)		IQPF Escalation
Area	Executive Lead	Officer Lead	No.	Abbreviated Measure Name	Target	Latest Available	12month Previous	Previous Period	Current	Icon	Ranking	All Wales	Level
Quadruple Aim 2: People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement	Executive Director of Primary Care, Community and Mental Health	Assistant Director of Community Services	26	Number of diagnostic breaches 8+ weeks	0	Feb-25	143	70	79	L	1st*	43,663	Level 3
			27	% of children <18 waiting 14 weeks or less for a specified AHP	100%	Feb-25	90.2%	100.0%	100.0%	H	1st*	89.4%	Level 1
			28	Number of therapy breaches 14+ weeks (all ages)	0	Feb-25	104	3	2	L	1st*	4,621	Level 2a
			29	Number of patients (adult hearing aids only) waiting more than 14 weeks	0	Feb-25	93	2	0	L	1st*	3,980	Level 1
			30	Number of patients waiting >52 weeks for a new outpatient appointment	0	Feb-25	13	0	0	L	1st*	78,525	Level 1
			31	Number of patient follow-up outpatient appointment delayed by over 100%	Reduction compared to the same month in the previous year	Feb-25	1256	1134	1203	L	1st	243,441	Level 3
			32	RTT patients waiting more than 104 weeks	0	Feb-25	0	0	0	-	1st*	21,087	Level 1
			33	RTT patients waiting more than 52 weeks	Month on month reduction towards the national target of zero by 30 June 2025	Feb-25	48	22	9	L	1st*	168,234	Level 1
	Executive Director of Nursing, Quality, Womens and Family Health	Assistant Director of Women's and Children's	34	Children/Young People neurodevelopmental waits	80%	Feb-25	44.2%	24.4%	25.9%	L	3rd*	19.0%	Level 3
	Executive Director of Primary Care, Community and Mental Health	Assistant Director of Mental Health	35	Adult psychological therapy waiting < 26 weeks	80%	Feb-25	88.3%	66.4%	67.7%	L	2nd*	56.3%	Level 2a

Powell Bethan 01/05/2025 10:03:13

Quadruple Aim 3: Performance Scorecard

2024/25 Performance Framework Measures					Performance					SPC	Welsh Government Benchmarking (*in arrears)		IQPF Escalation
Area	Executive Lead	Officer Lead	No.	Abbreviated Measure Name	Target	Latest Available	12month Previous	Previous Period	Current	Icon	Ranking	All Wales	Level
Quadruple Aim 3: The health and social care workforce in Wales is motivated and sustainable	Executive Director of People and Culture	Deputy Director of People and Culture	36	(R12) Sickness Absence	12 month reduction trend	Feb-25	5.4%	5.3%	5.3%	L	5th (Oct-24)	6.2%	Level 1
			37	Turnover rate for nurse and midwifery registered staff leaving NHS Wales	Rolling 12 month reduction against a baseline of 2019/20	Oct-24	12.1%	8.4%	9.4%	L	9th	6.4%	Level 1
	Executive Director of Primary Care, Community and Mental Health	Assistant Director of Community Services Group	38	Agency spend as a percentage of the total pay bill	12 month reduction trend	Feb-25	10.8%	7.6%	2.5%	L	12th (Nov-24)	2.8%	Level 1
	Executive Director of People and Culture	Deputy Director of People and Culture	39	Performance Appraisals (PADR)	85%	Feb-25	78.1%	81.7%	82.4%	H	5th (Oct-24)	77.0%	Level 2a

Quadruple Aim 4: Performance Scorecard

2024/25 Performance Framework Measures						Performance				SPC	Welsh Government Benchmarking (*in arrears)		IQPF Escalation
Area	Executive Lead	Officer Lead	No.	Abbreviated Measure Name	Target	Latest Available	12month Previous	Previous Period	Current	Icon	Ranking	All Wales	Level
Quadruple Aim 4: Wales has a higher value health and social care system that has demonstrated rapid improvement and innovation, enabled by data and focused on outcomes	Executive Director of Allied Health Professions, Health Sciences and Digital	Head of Information- Digital Transformation and Informatics	40	% of episodes clinically coded within one month post discharge end date	Maintain 95% target or demonstrate an improvement trend over 12 months	Dec-24	100.0%	100.0%	100.0%		1st	69.4%	Level 1
			41	% of all classifications' coding errors corrected by the next monthly reporting submission	90%	Dec-24	100.0%	100.0%	100.0%		1st	52.8%	Level 1
	Executive Director of Primary Care, Community and Mental Health	Assistant Director of Community Services	42	% of calls ended following WAST telephone assessment (Hear and Treat)	17% or more	Apr-24	9.4%	10.5%	10.3%		7th	15.2%	Level 2a
			43	No of Pathways of Care delayed discharges	12 month reduction trend	Feb-25	56	70	56		2nd	1,497	Level 1
		Assistant Director of Mental Health	44	% residents with CTP <18	90%	Feb-25	95.4%	96.3%	95.7%		4th*	96.5%	Level 1
			45	% residents with CTP 18+	90%	Feb-25	87.1%	80.0%	79.8%		5th*	77.4%	Level 2a
	Executive Director of Nursing, Quality, Women and Family Health	Assistant Director of Quality & Safety	46	Number of service user feedback experience responses completed and recorded on CIVICA	Month on Month Improvement	Jan-25	366	221	469		8th*	21,905	Level 1
	Executive Director of Nursing, Quality, Women and Family Health	Deputy Director of Nursing	47	HCAI - Klebsiella sp and Aeruginosa cumulative number	Health Board Specific Target	Feb-25	0	0	0		PTHB is not nationally benchmarked for infection rates		
			48	HCAI - E.coli, S.aureus bacteraemia's (MRSA and MSSA) - Cumulative rate of confirmed cases per 100,000	Health Board Specific Target	Feb-25	2.45	8.79	3.26				
			49	HCAI - cumulative rate of C.Difficile cases per 100,000 population	Health Board Specific Target	Feb-25	20.40	19.6	17.96				
	Executive Director of Primary Care, Community and Mental Health	Assistant Director of Community Services	51	Percentage of ophthalmology R1 patients who attended within their clinical target date (+25%)	12 month improvement trend towards national target of 95%	Feb-25	63.1%	69.1%	73.6%		1st	60.3%	Level 1
	Executive Director of Nursing, Quality, Women and Family Health	Assistant Director of Quality & Safety	54	No of patient safety incidents that remain open 90 days or more	12 month reduction trend	Feb-25	12	14	12		5th	182	Level 1

Commissioned and Local Measures

Commissioned and Local Measures							Performance			SPC	IQPF Escalation
Area	Executive Lead	Officer Lead	No.	Abbreviated Measure Name	Target	Latest Available	12month Previous	Previous Period	Current	Icon	Level
Planned Care & Cancer	Executive Director of Primary Care, Community and Mental Health	Assistant Director of Community Service Group	Local Measure	Powys provider cancer pathways additions and downgrade performance against 28-day NICE guidance of best practice - SCP Referrals into Powys Provider	N/A	Feb-25	39.0	39.0	50.0		
			Local Measure	Powys provider cancer pathways additions and downgrade performance against 28-day NICE guidance of best practice - SCP Downgrades within 28 days best practice	N/A	Feb-25	19.2%	29.2%	60.7%		
Quality & Safety	Executive Director of Nursing, Quality, Women and Family Health	Assistant Director Quality & Safety	Local Measure	Patient safety notice/alerts compliance	N/A	Jan-25			100.0%	N/A	
			Local Measure	Total complaints settled within final reply (Reg24) - % settled within 30 days	75%	Apr-24 - Jan-25			80.0%	N/A	
			Local Measure	Reported never events	N/A	Mar-25			0	N/A	
			Local Measure	National reportable incident rate per 100k pop.	N/A	Jan-25			2.23	N/A	
Commissioned Services - RTT	Executive Director of Planning, Performance and Commissioning	Assistant Director of Performance and Commissioning	Local Measure	Welsh Commissioned RTT - Over 36 weeks	Individual Health Board recovery targets aligned to Ministerial priorities.	Feb-25	2325	2602	2587		
			33	Welsh Commissioned RTT - Over 52 weeks		Feb-25	1316	1458	1404		
			32	Welsh Commissioned RTT - Over 104 weeks		Feb-25	206	155	100		Level 3
			Local Measure	English Commissioned RTT - Over 36 weeks	NHSE set targets for RTT	Jan-25	2331	3396	3423		
			33	English Commissioned RTT - Over 52 weeks		Jan-25	894	1296	1348		
			32	English Commissioned RTT - Over 104 weeks		Jan-25	12	42	33		Level 3
			Local Measure	Private dermatology service provider RTT performance - Over 36 weeks	Service targets assurance aligned to NHS Wales targets & KPI's	Jan-25	15	18	15	N/A	
			Local Measure	Private dermatology service provider RTT performance - Over 52 weeks		Jan-25	3	0	0	N/A	

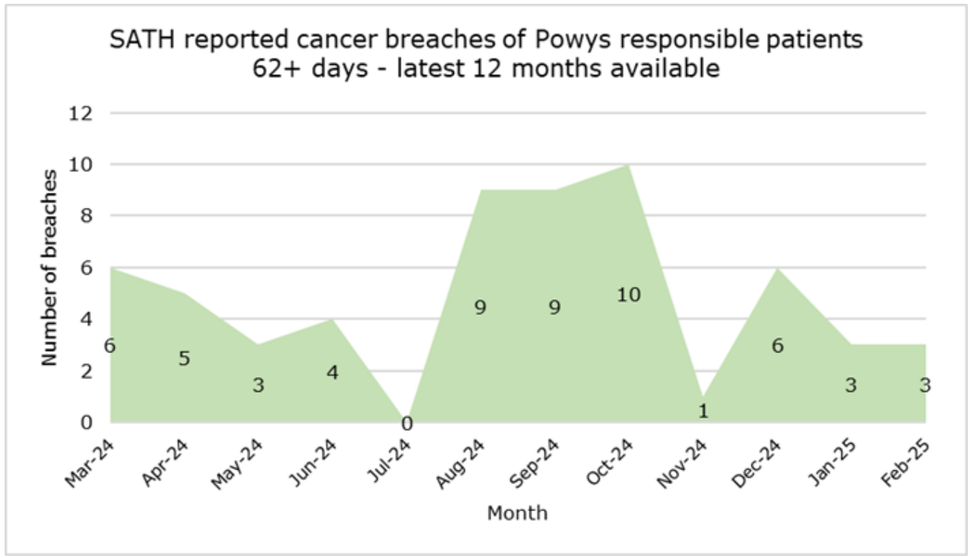
Commissioned and Local Measures – November 2024

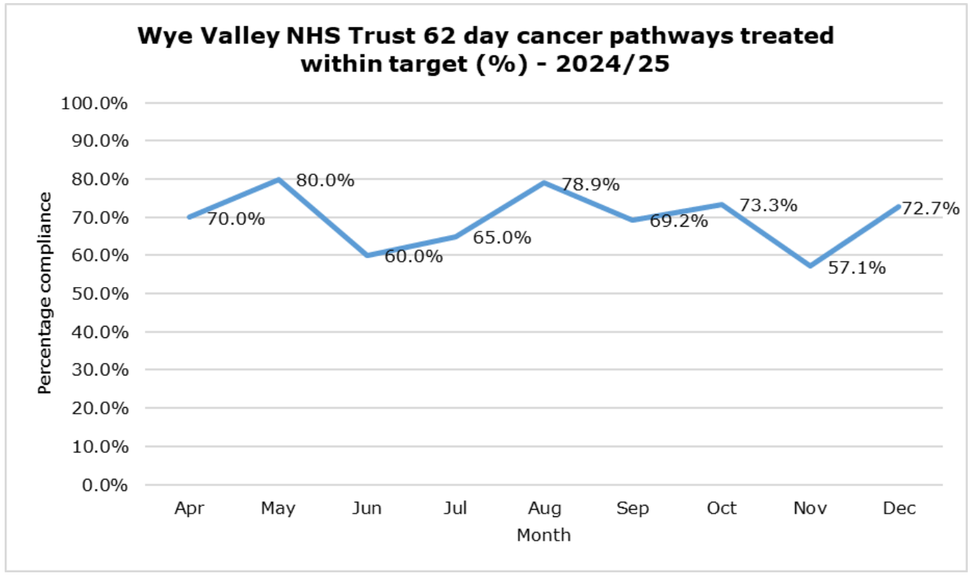
Single cancer pathway compliance – Welsh Commissioned providers – Source DHCW

HealthBoard	2024-04	2024-05	2024-06	2024-07	2024-08	2024-09	2024-10	2024-11	2024-12	2025-01	2025-02
Aneurin Bevan UHB											
Pathways With Treatment	18	10	11	18	16	11	9	13	16	15	16
Treated Within 62 Days	11	5	9	10	10	7	8	7	9	11	9
Breaching 62 Day Target	7	5	2	8	6	4	1	6	7	4	7
% Treated Within Target	61%	50%	82%	56%	63%	64%	89%	54%	56%	73%	56%
Betsi Cadwaladr UHB											
Pathways With Treatment				4	1	1	1	2	2		1
Treated Within 62 Days							1	2	2		
Breaching 62 Day Target				4	1	1					1
% Treated Within Target				0%	0%	0%	100%	100%	100%		0%
Cardiff And Vale UHB											
Pathways With Treatment					1				1	1	
Treated Within 62 Days					1					1	
Breaching 62 Day Target									1		
% Treated Within Target					100%				0%	100%	
Cwm Taf Morgannwg UHB											
Pathways With Treatment	4	4	3	4	7	6	5	3	7	4	3
Treated Within 62 Days	1	1	1	1	4	2	4		4	1	1
Breaching 62 Day Target	3	3	2	3	3	4	1	3	3	3	2
% Treated Within Target	25%	25%	33%	25%	57%	33%	80%	0%	57%	25%	33%
Hywel Dda UHB											
Pathways With Treatment	9	8	8	8	8	8	6	8	7	9	7
Treated Within 62 Days	3	3	5	6	6	5	2	7	2	6	5
Breaching 62 Day Target	6	5	3	2	2	3	4	1	5	3	2
% Treated Within Target	33%	38%	63%	75%	75%	63%	33%	88%	29%	67%	71%
Swansea Bay UHB											
Pathways With Treatment	8	7	11	10	14	7	9	9	10	11	4
Treated Within 62 Days	6	6	5	8	8	5	5	5	7	6	1
Breaching 62 Day Target	2	1	6	2	6	2	4	4	3	5	3
% Treated Within Target	75%	86%	45%	80%	57%	71%	56%	56%	70%	55%	25%
Pathways With Treatment	**39**	**29**	**33**	**44**	**47**	**33**	**30**	**35**	**43**	**40**	**31**
Treated Within 62 Days	**21**	**15**	**20**	**25**	**29**	**19**	**20**	**21**	**24**	**25**	**16**
Breaching 62 Day Target	**18**	**14**	**13**	**19**	**18**	**14**	**10**	**14**	**19**	**15**	**15**
% Treated Within Target	**54%**	**52%**	**61%**	**57%**	**62%**	**58%**	**67%**	**60%**	**56%**	**63%**	**52%**

Closed Pathways - Nov 24 - suspicion to treatment days of wait band (target within 62 days)

HealthBoard	0-14 days	15 to 28 days	29-62 days	63-104 days	105-200 days	over 300 days	Total
Aneurin Bevan UHB	2	1	4	4	2		13
Betsi Cadwaladr UHB		1	1				2
Cwm Taf Morgannwg UHB					2	1	3
Hywel Dda UHB	1		6		1		8
Swansea Bay UHB		2	3	3	1		9
Total	3	4	14	7	6	1	35





NHS Executive Key Performance Indicator Trajectories – Submitted May 2024

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

At the start of 2024/25 financial year NHS Executive wrote to all health boards and trusts setting out a requirement for improved waiting times, this to drive improvements in patient care and experience. Five areas were highlighted, and minimum access targets provided. As a health board PTHB provided trajectories to meet or exceed these minimum planned care targets to achieve the targets.

The below table contains submission trajectories and is colour and icon coded dependant on compliance, please note that:
- Value cell shading red/green, this denotes compliance to health board submitted trajectory as a key performance indicator
- Value cell icon either green tick ✓ or red cross ✗ denotes compliance against the NHS Performance Framework target.

Ministerial Priority Measures			Baseline		Month										
Measure	NHS Performance Target	KPI Improvement Target	Mar-24		Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
Number of patients waiting more than 52 weeks for a new outpatient appointment	Zero	40% reduction by end of September 2024 Zero by March 2025	0	Performance trajectory	55	65	55	45	20	8	5	0	0	0	0
				Actual	✓ 0	✓ 0	✓ 0	✗ 1	✗ 1	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0
Number of patients waiting more than 104 weeks for referral to treatment	Zero	Zero end of December 2024	1	Performance trajectory	0	0	0	0	0	0	0	0	0	0	0
				Actual	✓ 0	✗ 1	✗ 2	✗ 3	✗ 3	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0
Number of patients waiting over 8 weeks for a specified diagnostic	Zero	95% to be zero by December 2024	116	Performance trajectory	230	200	150	75	30	0	0	0	0	0	0
				Actual	✗ 140	✗ 171	✗ 157	✗ 155	✗ 140	✗ 124	✗ 107	✗ 83	✗ 84	✗ 70	✗ 79
Number of patients who spend 12 hours or more in all major and minor emergency care facilities from arrival until admission, transfer or discharge	Zero	20% reduction by September 2024 Further 20% reduction by March 2025	0	Performance trajectory	0	0	0	0	0	0	0	0	0	0	0
				Actual	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0
Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS for people age under 18 years	80%	80% by December 2024	97.7%	Performance trajectory	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%
				Actual	✗ 80.0%	✓ 86.5%	✓ 83.7%	✓ 93.1%	✓ 90.0%	✓ 87.5%	✓ 92.1%	✓ 89.2%	✓ 92.9%	✓ 86.7%	✓ 91.2%
Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS for adults age 18 years and over	80%	80% by December 2024	91.1%	Performance trajectory	85.6%	85.6%	85.6%	85.6%	85.6%	85.6%	85.6%	85.6%	85.6%	85.6%	85.6%
				Actual	✓ 95.2%	✓ 95.3%	✓ 93.0%	✓ 95.10%	✓ 87.50%	✓ 91.7%	✓ 92.3%	✓ 98.3%	✓ 95.6%	✗ 79.0%	✓ 96.2%

Mental Health performance improvement trajectories 2024/25 – Submitted May 2024

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

At the start of 2024/25 financial year Welsh Government policy and performance leads requested trajectories to support internal NHS Wales delivery assurance process for the operational delivery of mental health performance, forming part of routine mental health touchpoint meetings with Health Board colleagues as well as Integrated Quality, Planning and Delivery meetings between Health Boards, Welsh Government and the NHS Executive.

The below table contains key elements for the submitted trajectories and is colour and icon coded dependant on compliance, please note that:

- Value cell shading red/green, this denotes compliance to health board submitted trajectory as a key mental health performance indicator
- Value cell icon either green tick ✓ or red cross ✗ denotes compliance against the NHS Performance Framework target.

Policy Lead Priority Measures				Month										
Age Group	Measure	Target		Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
Under 18's	Mental Health Measure Part 1a - % of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral	80%	Performance trajectory	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%
			Actual	✓ 98.0%	✓ 98.1%	✓ 100.0%	✓ 94.6%	✓ 100.0%	✓ 100.0%	✓ 100.0%	✓ 100.0%	✓ 100.0%	✓ 100.0%	✓ 100.0%
	Mental Health Measure Part 1b - % of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS	80% by December 2024 (80% monthly is NHS Performance Framework Target)	Performance trajectory	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%	86.0%
			Actual	✓ 80.0%	✓ 86.5%	✓ 83.7%	✓ 93.1%	✓ 90.0%	✓ 87.5%	✓ 92.1%	✓ 89.2%	✓ 92.9%	✓ 86.7%	✓ 91.2%
	Mental Health Measure Part 2 - % of health board residents in receipt of secondary mental health services who have a valid care and treatment plan	90%	Performance trajectory	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%
			Actual	✓ 94.1%	✓ 93.9%	✓ 90.8%	✓ 91.0%	✓ 93.6%	✓ 94.9%	✓ 94.9%	✓ 97.8%	✓ 94.8%	✓ 96.3%	✓ 95.7%
	Neurodevelopmental - % of children and young people waiting less than 26 weeks to start an ADHS or ASD neurodevelopment assessment	80%	Performance trajectory	45.0%	45.0%	45.0%	45.0%	45.0%	45.0%	45.0%	45.0%	45.0%	45.0%	45.0%
			Actual	✗ 45.4%	✗ 45.8%	✗ 39.6%	✗ 42.0%	✗ 37.2%	✗ 34.3%	✗ 30.9%	✗ 30.5%	✗ 27.3%	✗ 24.4%	✗ 25.9%
	SCAMHS - % of patients waiting less than 28 days for a first appointment for sCAMHS	80%	Performance trajectory	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%
			Actual	✓ 98.0%	✓ 92.7%	✓ 93.8%	✓ 100.0%	✓ 100.0%	✓ 100.0%	✓ 100.0%	✓ 100.0%	✓ 97.1%	✓ 100.0%	✓ 100.0%
18 years and over	Mental Health Measure Part 1a - % of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral	80%	Performance trajectory	70.0%	70.0%	70.0%	75.0%	75.0%	75.0%	75.0%	75.0%	80.0%	80.0%	80.0%
			Actual	✗ 44.1%	✗ 54.1%	✗ 69.2%	✗ 74.0%	✗ 45.3%	✗ 46.7%	✗ 58.7%	✗ 71.4%	✗ 78.7%	✗ 58.0%	✓ 85.5%
	Mental Health Measure Part 1b - % of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS	80% by December 2024 (80% monthly is NHS Performance Framework Target)	Performance trajectory	86%	86%	86%	86%	86%	86%	86%	86%	86%	86%	86%
			Actual	✓ 95.2%	✓ 95.3%	✓ 93.0%	✓ 95.1%	✓ 87.5%	✓ 91.7%	✓ 92.3%	✓ 98.3%	✓ 95.6%	✗ 79.0%	✓ 96.2%
	Mental Health Measure Part 2 - % of health board residents in receipt of secondary mental health services who have a valid care and treatment plan	90%	Performance trajectory	80%	83%	86%	88%	90%	90%	90%	90%	90%	90%	90%
			Actual	✗ 89.0%	✓ 90.4%	✓ 91.3%	✓ 91.5%	✓ 90.6%	✗ 89.6%	✗ 88.6%	✗ 84.1%	✗ 78.6%	✗ 79.1%	✗ 79.8%
	Psychological Therapies - % of patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult Mental Health	80%	Performance trajectory	80.0%	83.0%	85.0%	88.0%	90.0%	93.0%	95.0%	95.0%	95.0%	95.0%	95.0%
			Actual	✗ 75.1%	✗ 69.4%	✗ 75.2%	✗ 76.9%	✗ 78.7%	✗ 79.9%	✗ 72.9%	✗ 67.0%	✗ 63.1%	✗ 66.4%	✗ 68.2%

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

Agenda item: 5.3

Delivery and Performamce Committee	**01 May 2025**
Subject:	**Progress Against the Integrated Plan (Delivery Plan 2024-2029) end of year report January to March 2025**
Approved and presented by:	Executive Director of Planning, Performance & Commissioning
Prepared by:	Assistant Director of Planning/Planning Managers
Other Committees and meetings considered at:	Executive Committee 16th and 23rd April 2025

PURPOSE:

This report provides the Delivery and Performance Committee with an update of the progress made against the Integrated Plan as an end of year report January to March 2025.

The report has been considered at the Executive Committee where Executive leads collectively moderated, prior to submission to Delivery and Performance Committee.

Following consideration at Delivery and Performance Committee, this report will be provided to PTHB Board and subsequently submitted to Welsh Government, as a formal report of Progress against Plan for Q4.

It will also feed into the PTHB Annual Report 2024-2025.

RECOMMENDATION(S):

The Delivery and Performance Committee are asked to:

- **CONSIDER** the report ahead of submission to PTHB Board and take **ASSURANCE** that there is a process in place for monitoring progress against plan.

Approve/Take Assurance	Discuss	Note
Y	Y	N

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	Y	
2. Provide Early Help and Support	Y	
3. Tackle the Big Four	Y	

4. Enable Joined up Care	Y	
5. Develop Workforce Futures	Y	
6. Promote Innovative Environments	Y	
7. Put Digital First	Y	
8. Transforming in Partnership	Y	

EXECUTIVE SUMMARY:

This report provides the Delivery and Performance Committee with an update of the progress made against the Integrated Plan at the end of year January to March 2025. This is the cumulative output of the reviews carried out by each Executive Lead on their respective areas for the whole year.

This information is particularly important at year end as part of the review and appraisal of progress against plan that contributes to the Annual Report (which will give a fuller picture of achievements and learning from the year, and how this has informed the forward plan and planning practice going forward).

Once considered by the Delivery and Performance Committee, this will then be submitted to PTHB Board and finally to Welsh Government as a formal report of Progress against Plan for the Quarter 4 period.

It will also feed into the PTHB Annual Report 2024-2025.

This is an important component of the health board's assurance and performance management regime. This is particularly relevant in the context of the Health Board's escalation status of 'Level 4' for strategy, finance and planning. Improvements have been made continuously to this report to enable sufficiently detailed yet concise reporting of the PTHB Integrated Plan.

BACKGROUND

This report provides the Delivery and Performance Committee with an update of the progress made against the Integrated Plan for the Quarter 4 period (January to March 2025).

<u>1) Development of Progress Report against Plan</u>

Each of the 27 Strategic Priorities set out within the Integrated Plan have been reviewed and a commentary provided by Executive Leads on key achievements and challenges, where required for Quarter 4.

An additional explanation including mitigating action is also included where any items are **RAG** rated as Red. Executive leads were also asked to reassess their delivery confidence ratings with current confidence levels compared to that of the start of the year. Improvements have been made continuously to this report to enable sufficiently detailed yet concise reporting of progress against the PTHB Integrated Plan.

This is an important component of the Health Board's monitoring, assurance and performance management regime. This is particularly relevant in the context of the Health Board's escalation status of 'Targeted Intervention' for strategy, finance and planning.

Executive Lead sign off has been maintained, to ensure that the report reflects the appraisal carried out within Directorates and is given as part of the Executive Leads accountability for their portfolio and strategic priorities.

The information provided in this report is also part of the wider review and appraisal of progress and performance across the year, as part of the production of the Annual Report 2024 – 2025, which is currently being drafted. This latter document will give a fuller picture of achievements and learning from the year, and how this has informed the forward plan and planning practice going forward.

2)Progress Summary at Q4

The report shows the progress made with delivery of the actions and priorities in the Plan as reported at the end of the year.

Of the 215 key deliverables identified for completion in 2024/25, 149 have been completed (Blue), this represents 72% of the plan as being complete, as at year end. The remaining key deliverables have been categorised as behind schedule (26) or at risk (31) representing 28% of the plan and therefore havent been delivered in year. A number of these have been identified as key areas to inform year 2 (2025/26) of the Health Board's 5-year plan.

Achievements to date

- Enhanced coordination for those in Powys who are most frail, or at risk of frailty. There has been an enhanced focus on the end of life, with improved care planning and streamlined clinical pathways for example those for the management of Cellulitis and Urinary Tract Infections.
- Referral management for those with musculoskeletal conditions, enhancing patient care and service efficiency. This initiative is implementing evidence and value-based interventions including clinical review and triage, specialised leadership for Orthopaedics, and the joint appointment of an Orthopaedic Consultant for Upper Limb services.
- Major investment in modernising diagnostic services and enhancing patient care, through the X-Ray replacement programme. Welshpool, Llandrindod Wells and Ystradgynlais have successfully re-opened with state-of-the-art equipment.
- Successful implementation of the Single Point of Access for Mental Health as part of '111 Press 2'. This marks a major achievement in improving access to care and is a transformative step in enhancing mental health support and access.

- The Children and Adolescent Mental Health Services Crisis Hub is now fully operational, providing a dedicated, purpose-built sanctuary for children and young people experiencing mental health distress. The alignment of Rapid Response and Outreach with Crisis Response has also improved out-of-hours support.
- Powys is the first region in Wales to establish a pathway integrating a jointly operated Integrated Autism Service (IAS) alongside a newly developed Attention Deficit Hyperactivity Disorder (ADHD) service. Further work is also in train to address long waits in neurodevelopment services following a comprehensive appraisal of the challenges and opportunities.
- The successful Phase 1 implementation of Powys 'DigiFLO' is a major advancement in digital patient flow management across Powys community hospitals.
- A focus on delays in pathways of care has seen a 13% decrease in the last quarter, reflecting improvements in tracking and co-ordinating responses to patient flow.
- Approval of Digital Maternity Cymru business case, with programme progressing to implementation stage, anticipated completion by end March 2026.
- Completion of the Maternity Assurance and Safety Improvement Plan.
- Neurodevelopmental strategic action plan in place, informed by co-production and multi-agency collaboration shaped by future demand aligned to best practice.
- Patient Story agenda progressing with the recruitment of a Peoples Experience lead expected in June 2025
- Work underway to complete the People Experience Maturity Matrix following the release of the Peoples Experience Framework
- Effective delivery of all health board-led population level health improvement programmes
- Successful implementation of the Outpatient Transformation Plan, supporting service modernisation and improved patient experience
- Expanded availability and utilisation of Point of Care Testing across Powys, enhancing timely diagnostics
- Ongoing implementation and annual evaluation of the 'Improving Cancer journey' in Powys
- Strengthened strategic workforce planning capabilities through enhanced managerial knowledge and skills development
- Effective onboarding and development of new recruits through the Aspiring Nure Programme

- On going delivery of the National Nurse Retention Plan
- Implementation of Full the Speaking Up Safley framework
- Completion of the Virtual Consultation project, resulting in an award directed to Attend Anywhere to ensure ongoing business continuity.
- Approval of the Electronic Prescribing and Medicines Administration (EPMA) business case, with the programme now progressing into the implementation stage
- Implementing the technology to support Telephony Welsh Language functionality, enhancing bilingual service provision within the health board
- Reduction in the length of stay in Community Hospitals achieved since December 2024
- Successful roll out of PROMs in the Mental Health acute inpatient settings
- As part of the Mental Health Network, PTHB hosted a Mental Health Knowledge Exchange event that received outstanding feedback from attendees. The event showcased the triage and assessment project, along with the implementation of the Mental Health Single Point of Access (SPOA). It served as a precursor to a three-day international knowledge exchange held in Cardiff, where Powys was recognised as a leader in the development and delivery of the Mental Health SPOA.

Further analysis has identified the items below as behind schedule.

The table below shows the areas of delivery with a RAG rating of red at year end and an explanation for the reason for delay/action for recovery.

Items Behind Schedule

The table below summarises areas of delivery which remain with a red BRAGG rating at the end of Quarter 4.

The main areas relate to specific schemes in Community Services and Planned Care, the Major Conditions Plan and Mental Health (which is being reviewed as part of the reshaping of the Transformation Programme), and some Digital schemes due to the interdependency with national programmes. There are also items that have been rolled over into the new year.

Strategic Priority	**Area of delivery**	**Deliverables**	**Reason for delay / action for recovery**	**Delivery confidence assessment at Q3**
Early Help and Support				
Improve Access to Primary and	General Medical Services	Engagement with patients and stakeholders on perception and	This deliverable was paused due to the implementation of the	Low

Community Care		experience of access Q4	national Access T&F Review Group	
	Optometry	Pre-registration Optometrist between primary and secondary care in Cluster(s) Q2	Recruitment and supervision challenges	Low
		School vision and eyecare access improvements Q2	School Vision will sit under the Womens Family and Children services going forward and become part of the school's programme	Low
	Dental	Increase capacity of Llandrindod Wells contract Q2	Issues within the practice, practice is open but offering very limited GDS offer via a Dental Therapist	Medium
Design and Deliver a phased Frailty and Community Model	Improve coordination of the Last Year of Life	Commence implementation including liaison with out of county providers Q3-Q4	As outlined in Q3, the liaison work with out of county providers has not taken place	Low
Deliver the Planned Care & Diagnostic Programme	GIRFT Recommendations	Seek Consultant Urologist sessions to scope community urology service Q2-Q4	PTHB were unsuccessful in the Planned Care Transformation fund for speciality consultant sessions	Low
	Key Strategic Relationships	Recruitment for jointly funded or regional post Q3	Plans to recruit a jointly funded post through the delivery of the MSK Triage solution has been reviewed, the posts would be better managed through a Service Level Agreement	High
		Evaluation of jointly funded or regional post Q4	As Above	Medium
	Referral Management Solutions	Subject to approval implementation of interface triage solution for Orthopaedic Referrals; Evaluation Q3-Q4	Recruitment for key roles are currently being progressed, with the band 7 physiotherapist in its second week of advert. The band 8a physiotherapist job has been approved through the job matching panel and scheduled to go out to advert imminently. The band 6 physiotherapist role has been approved and	High

			advertised with interviews scheduled. The workspace for the 2 Band 3 admin roles has been confirmed as Newtown. The initial mapping design document for single point of access for Orthopaedic referral management has been drafted and discussed with the clinical and admin teams for ratification. This has been taken into Q1-Q2 2025/26 Deliverables.	
		Develop referral management solution for dentistry in relation to oral cancer Q2	Scoping of opportunities in dental to be taken forward in Annual Plan 2025/26	Low
Tackling the Big Four				
Develop and Deliver a Major Conditions Plan	Development of a Transformative Major Conditions Plan	<u>Development of a phased major conditions transformation plan</u> to develop: a less siloed approach; streamline appointments, diagnostics, assessments, care and treatment plans, reviews and polypharmacy; and to improve co-ordination in the last year of life Q1- Q3 development of the plan	An SRO was not identified for the work programme and it has therefore been unable to progress as planned	Low
Deliver the Mental Health Transformation Programme	Transformation of Adult and Community Model Phase 1 (includes alignment of Duty and Assessment Model)	Refining the baseline. Refining the modelling for the new model. Continuous engagement Q1	This work has been rescheduled for Q1-Q2 2025-26 as part of the Community model redesign work	High
		Public engagement and consultation Q2	Public engagement and consultation has not been required.	High
		Phase 1 implementation Q4	Implementation into Q1 2025-26, potentially aligned with accelerated work	High

			for the Mental Health Community Model.	
Workforces Futures				
A Great Place to Work	Develop a Pilot for Tier 2	Develop the Tier 2 programme Q2	This has been delayed to Q1 2025/26	Medium
Digital First				
Citizen centred care and support	Improve awareness and access to their digital appointment	Introduce patient portal for managing appointments Q4	Issues with cyber assurance, exploring alternative solutions	Low
Leadership, Partnership and Alliances	Continue engagement with NHS England to improve clinical cross border pathways	Improve data flows of clinical information into our All Wales architecture to support delivery of care Q2	The Cross border programme has been escalated the time for completion has slipped to May 2025.	Low
	Scope requirements for Integrated Shared Care Record	Enable front line staff to access digital clinical information across multiple disciplines Q4	Reliant on the Connected Care National Programme which is not progressing as expected.	Low
Enabling Efficiency and effectiveness	Whole system application review to standardise digital system access and improve efficiencies	Ensuring the system gaps are fully understood to meet the needs of the health board and standardise the approach to recording Q2	This internal work has slowed down due to conflicting priorities and waiting for the direction nationally and the application roadmap for national all Wales solutions	Low
	Finalise cross border clinical records sharing project	Improve data flows of clinical information into our All Wales architecture to support delivery of care Q2	This has slipped due to Digital Health and Care Wales (DHCW) and Testing activities	Low
	Review replacement of WCCIS	Implement a replacement community system that supports the delivery and recording of patient care Q4 (NB - Change in Timescale from Q1-Q4)	Connected Care programme and WCCIS replacement has not progressed. There is no confirmation of WG funding, and the National Business Case has not been re-submitted following comment from key stakeholders	Low
Infrastructure and Security	Continue to improve cyber security posture	Replace and update Firewall authentication technology across the Health Board and migrate applications Q4	This could not progress due to not being able to receipt the equipment needed. This will move to FY 25/2026	Low

Big Data and Artificial Intelligence	Accelerate use of Robotic Processing Automation	Plan and deliver a 'RPA Framework' and Operating Model across the HB Q4	This has not progressed due to capacity and resource	Low
	Adopt Machine learning toolkit (predictive analysis on current data sets)	Design and deliver a framework to adopt Machine Learning models Q3	This has not progressed as expected due to resource and capacity constraints	Low
Innovative Environments				
Property	Integrated Hubs/Agile Working	Develop Spa Road, Llandrindod Wells as Integrated Hub Q3	Confidence of agreement and future creation of Integrated Hub is high for within 2025-26	Medium

3) Conclusion

This report provides the Delivery and Performance Committee with an update of the progress made against the Integrated Plan for the end of year 2024/25 (January to March 2025.)

Following consideration at this Committee, this report will be provided to PTHB Board and Welsh Government as a formal report of Progress against Plan for Quarter 4 in line with national reporting requirements**.**

The information provided in this report is also part of the wider review and appraisal of progress and performance across the year, as part of the production of the Annual Report 2024 – 2025, which is currently being drafted. This latter document will give a fuller picture of achievements and learning from the year, and how this has informed the forward plan and planning practice going forward.

NEXT STEPS:

Following consideration at this Committee, this report will be provided to PTHB Board and Welsh Government as a formal report of Progress against Plan for Quarter 3 in line with national reporting requirements**.**

It will also feed into the PTHB Annual Report 2024-2025.

IMPACT ASSESSMENT – NOT REQUIRED FOR THIS REPORT

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Integrated Plan Progress Report

Quarter 4 2024/ 2025

January to March 2025

BRAGG Key

Blue - Complete
Red - Behind schedule
Amber - At risk/issues present
Green - On track
Grey – Not due yet

PLAN ON A PAGE 2024 - 2029

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

Plan on a page 2024 - 2029

Better Together for a Sustainable Model of Care

Whole System Approach to Wellbeing & Prevention	Faster, effective diagnosis and treatment	Working together across Major Conditions, Physical and Mental Health	Home first and back home fitter and faster
• Develop a whole system prevention plan *across the life course* [blue] • Deliver a Health Protection response *including Vaccination* [blue]	• Improve access to Primary and Community Care [blue] • Design and Deliver a phased Frailty and Community Model [dark red] [blue] [orange] • Deliver the Planned Care and Diagnostics Programme [blue] [grey]	• Develop and deliver a Major Conditions Plan *respiratory & circulatory health (cardiac, diabetes, stroke) and cancer* [grey] • Deliver the Mental Health Transformation Programme [light green]	• Improve pathways of care *focused on system flow* [orange] [dark red] • Deliver the Six Goals Plan for Urgent and Emergency Care *focusing on what works for the Powys population* [dark red]

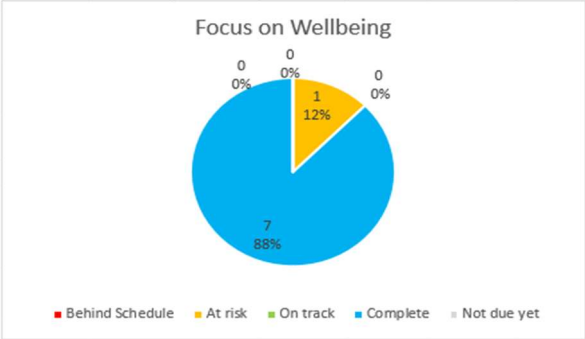
Key:

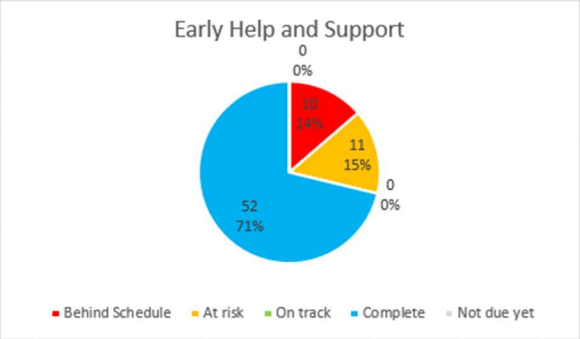
- [blue] WG TEMPLATE Primary & Community Care
- [orange] WG TEMPLATE Enhanced Care in the Community (Pathways of Care)
- [grey] WG TEMPLATE Planned Care & Cancer
- [light green] WG TEMPLATE Mental Health
- [dark red] WG TEMPLATE Urgent and Emergency Care / Six Goals

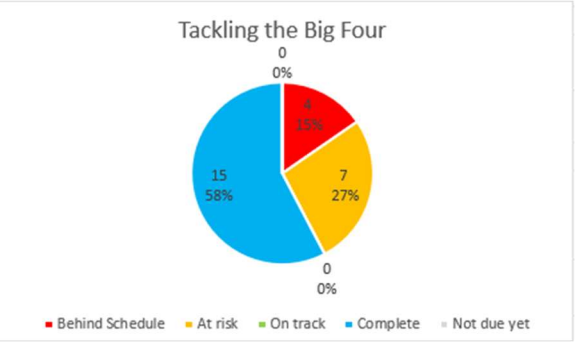
Quality is the golden thread across the whole plan

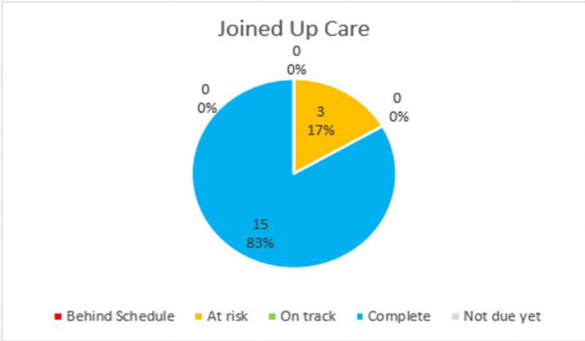
- Underpinned by the Quality Standards: Safe, Timely, Effective, Efficient, Equitable, Person-Centred (STEEEP)
- Delivery of Duty of Quality and Duty of Candour Action Plans
- Interdependencies across the plan in relation to a **Value** based approach and effective **Governance**

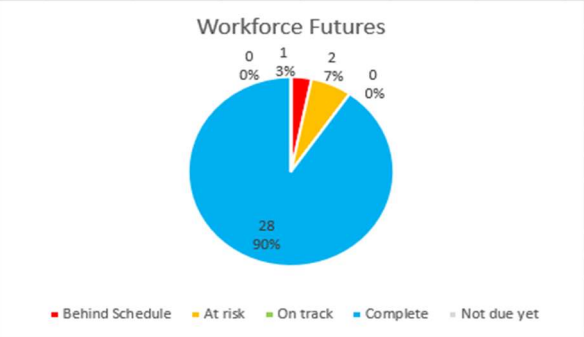
CONSOLIDATED YEAR TO DATE SUMMARY

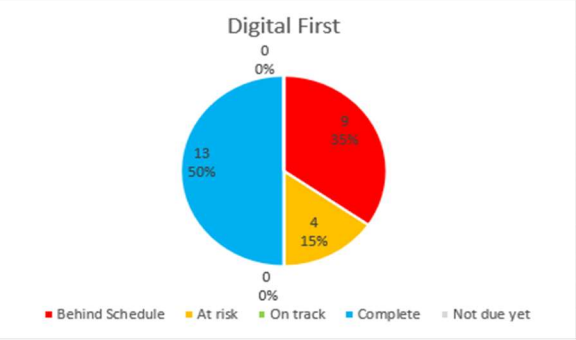


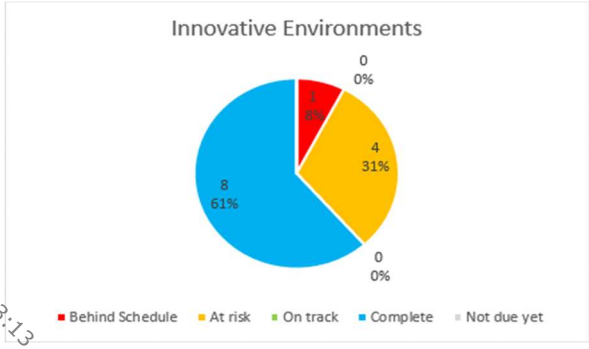


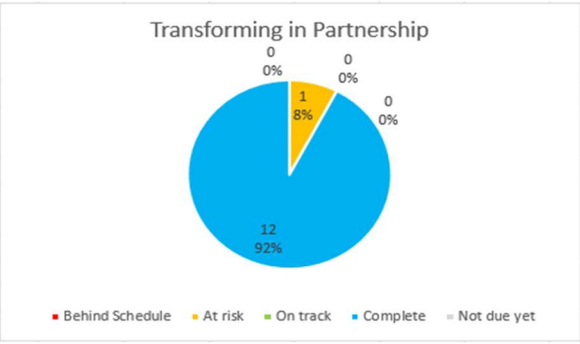


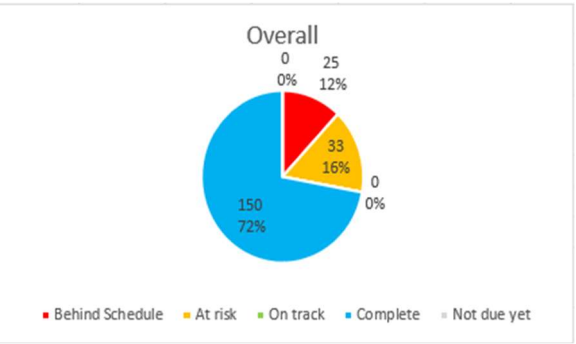












Role:	Acronym
Chief Executive Officer	CEO
Deputy Chief Executive Officer	DCEO
Executive Director of Primary Care, Community and Mental Health	ED PCC&MH
Executive Director of Finance, Capital and Support Services	ED FC&SS
Executive Director of People and Culture	ED P&C
Executive Director of Public Health	ED PH
Executive Director of Nursing, Quality, Women and Family Health	ED NQW&FH
Executive Director of Allied Health Professions, Health Sciences and Digital	ED AHPHS&D
Executive Medical Director	EMD
Executive Director of Planning, Performance and Commissioning	ED PP&C
Director of Corporate Governance / Board Secretary	DCG
Director of Strategic Improvement and Transformation	DSI&T
Associate Director of Estates, Facilities and Support Services	ADEF&SS

Focus on Wellbeing

Strategic Priority 1: Develop a whole system prevention plan across the life course

Executive Lead – Executive Director of Public Health

Intended Outcome/ Impact

- A vision for a joined-up preventative approach is developed
- Conditions are being created that support people to maintain a healthy weight
- Work towards meeting national smoking cessation targets

Commentary on Progress in this Quarter:

- **1.1)** A whole system approach framework for prevention has been developed, setting the foundation for further promotion and engagement with partners in 2025/26 to 'shift left'.
- **1.2)** Powys Whole System Approach to Healthy Weights Action Plan continues to be implemented through partnership working, including:
  - Powys Breastfeeding Welcome Scheme was launched in August 2024 with the health board and Powys County Council. To date, 226 settings across Powys have registered.
  - Introduction to Solid Foods ('weaning') training has been updated and provided to staff, along with resources updated for parents.
  - The Powys Gold Standard Healthy Snack Award has been developed and promoted to early years' settings, alongside the provision of training sessions and individualised support. To date, 7 settings have been successful in achieving the award.

- **1.3)** Smoking cessation work is focusing on building on earlier successes and embedding work to improve awareness of and access to services, including:
  - Providing individualised support to community pharmacy staff to build their confidence in delivering support to smokers.
  - Engagement being undertaken with professionals to improve identification of smokers and to ensure embedding of referral pathways and NRT protocols, so that smokers are signposted/referred to the specialist support available to quit. A focus has been on Midwifery to increase CO monitoring and referral rates of pregnant smokers.
  - Continuously promoting the range of services available through a communication and engagement plan, which has included the launch and extensive distribution of a regular Powys Smokefree newsletter. Q3 data showed 4% of smokers made a quit attempt through smoking cessation services, therefore on track to achieve 5% target by year end.

Commentary on red rated actions: N/A

Progress against key actions and milestones													
Key Areas of Delivery	*Key Deliverables*	*Lead Executive*	*Status*				*Year End Delivery Confidence Assessment 0 = Original*						
			Q1	**Q2**	**Q3**	**Q4**	**0**	**Q1**	**Q2**	**Q3**	**Q4**		
Work with partners to develop a whole system approach to address common modifiable risk factors	1.1) Framework for whole system approach developed Q4	ED PH				Blue	M	M	M	M	High		
Delivery of health board-led population level health improvement programmes	1.2) Implement the Powys Whole System Approach to Healthy Weights action plan, working in partnership Q1-Q4		Green	Green	Green	Blue	H	H	H	H	High		
	1.3) Improve awareness of and access to NHS Stop Smoking services Q1-Q4		Green	Green	Green	Blue	H	H	H	H	High		

Formal change request (Please tick as applicable and provide explanation below)			
Change in Scope	N/A	**Change in Timescale**	N/A

Executive Director Sign Off	Mererid Bowley (Executive Director of Public Health)

Strategic Priority 2: Deliver a Health Protection response, including vaccination

Executive Lead – Executive Director of Public Health

Intended Outcome/ Impact

- PTHB is able to provide a local health protection response that aligns with the Communicable Disease Outbreak Plan for Wales
- Eligible Powys population is offered vaccination, narrowing the uptake in inequities between groups

- Screening uptake rates are above targets

Commentary on Progress in this Quarter:

- Revised Major Incident and Emergency Response Plan and Corporate Business Continuity Plan approved by PTHB Board in July 2024.
- Revised Pandemic Framework was approved by the Executive Committee in May 2024; this forms part of an interim review until updated national pandemic strategy and guidance is published.
- Revised Severe Weather Arrangements approved by the PTHB Executive Team in January 2025.
- Regular internal and external communications tests have taken place, at local and regional levels.
- Operational major incident response walkthroughs across hospital sites with Minor Injury Units, and a number of operational walkthroughs of the Health Board's pathway for patients with suspected Mpox took place during 2024.
- The Health Board responded to a Welsh Ambulance Service Trust (WAST) 'major incident declared' notification for the Talerddig train collision on 21st October 2024. Lessons identified following the response have been submitted and approved at Executive Committee.
- The Heath Board continues to be engaged in national emergency planning, resilience and response preparedness activities that have taken place with multi-agency partners within the Dyfed Powys Local Resilience Forum and at a national level, this includes engagement in a range of planning, training and exercising activities.
- The Health Boad has participated in a number of multi-agency coordination group meetings that have been activated during 2024/2025, including its response to Storm Darragh, December 2024.
- **2.2) Health Protection** responses made for incidents and outbreaks to prevent spread and control spread of infections including ARIs, Scabies, diarrhoea and vomiting. Other work included supporting care homes around winter preparedness, and Hepatitis B and C elimination.
- **2.3) Vaccination programmes** were planned and delivered in line with national directives/guidance. Uptake continuously monitored to guide mitigating actions. For influenza, engagement occurred with GPs to encourage further vaccination sessions; Public Health Wales led communication campaign was supported by local communications team through health board channels, amplified through local networks. To improve access, more local clinics were scheduled using community hospitals; also hybrid approach adopted with support provided for booking and call handling by Vaccination Team to GP practices to deliver vaccination clinics.
    - Covid-19 2024 autumn campaign started in October and, by the end of February 2025, 728 care home residents were vaccinated (uptake of 82.73%); over 29,000 doses administered in the rest of the eligible population achieving an uptake of 51.4% (highest in Wales). Despite the mitigating actions, uptake in the autumn campaign has reduced significantly from the 2023/24 campaign, reflecting a national trend in vaccine uptake reduction being reported.
    - Flu vaccination programme as at end February: Uptake in 2 and 3 year olds of 53.1% (highest in Wales); 65 year olds and over uptake of 69.2% (4th in Wales); clinical risk group uptake 40.9% (highest in Wales). Staff vaccination uptake of 38.6%.
    - MMR Catch-up programme completed and the health board achieved the national target of reaching over 90% for 2 MMR vaccines in both primary and secondary schools.

- New RSV vaccination programme planned and developed and commenced September 2024 with maternal programme and older adult routine programme, followed by older adult catch up campaign running January to August 2025.

Commentary on red rated actions: N/A

Progress against key actions and milestones

Key Areas of Delivery	*Key Deliverables*	*Lead Executive*	*BRAG ('not due' already greyed out)*				*Year End Delivery Confidence Assessment* *0 = Original*				
			Q1	**Q2**	**Q3**	**Q4**	**0**	**Q1**	**Q2**	**Q3**	**Q4**
Ensure PTHB emergency preparedness and organisation resilience and compliance against Civil Contingencies Act	2.1) Review of civil contingency response plans. Implement required actions, including participation in training and exercises Q1-Q4	ED PH	Green	Green	Green	Blue	H	H	H	H	High
Provide Health Protection response to all hazards in line with Communicable Disease Outbreak Plan for Wales	2.2) Continue transition to a regional health protection service to enable a local response to health protection threats and contribute to Health Protection, Framework, in partnership with Powys County Council and Public Health Wales Q3				Amber	Amber	M	M	M	M	High
Implement respiratory vaccination programme in line with Welsh Government directives	2.3) Plan and deliver respiratory vaccination programmes Q1, Q3, Q4		Green		Green	Blue	H	M	H	H	High
Implement immunisation schedule in line with National Immunisation Framework and Welsh Health Circulars	2.4) Plan and deliver vaccination programmes Q4					Blue	H	M	M	H	High
Promote uptake of national screening programmes in partnership with Public Health Wales	2.5) Analyse data published and develop and implement action plan Q4					Blue	H	H	H	H	High

Formal change request (Please tick as applicable and provide explanation below)			
Change in Scope	N/A	**Change in Timescale**	N/A
Executive Director Sign Off	Mererid Bowley (Executive Director of Public Health)		

Early Help and Support

Strategic Priority 3: Improve Access to Primary and Community Care

Executive Leads - Executive Director of Primary Care, Community and Mental Health / Executive Medical Director /Executive Director of Nursing, Quality, Women and Family Health

Intended Outcome/ Impact

- Improved outcomes through earlier, targeted interventions for those in need of support
- Quality, timely services provided closer to home
- Resilient and sustainable rural primary and community care services that meet the needs of the Powys population

Commentary on Progress in this Quarter:

- **3.19)** – Optometry - Welsh General Ophthalmic Service (WGOS) 4 glaucoma filtering launched in February 25. Admin, IG and digital concerns have all progressed to move forward glaucoma monitoring. High probability that WGOS 4 Glaucoma Monitoring/ Medical Retina Filtering/ Medical Retina Monitoring will all launch in Q1 25/26
- **3.37)** The Digital Maternity Cymru business case has been submitted to Welsh Government for consideration following Health Board approval.
- **3.38)** The workforce plan has been commenced in Children's Nursing and the final interim senior post is within the job evaluation process. The Workforce plan for Maternity Services will be address by the Director of Midwifery
- **3.41)** Following significant improvements within the Neurodevelopment delivery model, further transformation of wider Children's services is required inclusive of Community Paediatrics to ensure a sustainable model for the future.

Commentary on red rated actions:

- **3.9 General Medical Services)** – This deliverable was paused due to the implementation of the national Access T&F Review Group. National review continues to inform the national and local approach. Request to remove as a key deliverable for 24/25.
- **3.14 Optometry)** – Cluster projects to support a pre-registration Optometrists have been reviewed and ceased. Recruitment and supervision challenges, alongside potential issues with indemnity has proven challenging. Furthermore, the changing recruitments of the Optometry pre-registration year to a Clinical Learning In Practice (CLIP) period has changed the requirements of the initial proposals. Academy supporting with future workforce plans, alongside Health Education and Improvement Wales (HEIW), looking towards longer-term sustainability and including Optical Assistants and Dispensing Opticians, alongside Optometrists.
- **3.16 Optometry)** - School Vision services sits under W&C Directorate. Previously included in Optometry due to scoping a COVID catch up programme. Request to remove as routine service via W&C back in place as part of the school's programme
- **3.21 Dental)** – The Dentist currently suspended; however practice is open but offering a very limited GDS offer via a Dental Therapist

Progress against key actions and milestones

Key Areas of Delivery	*Key Deliverables*	*Lead Executive*	*BRAG ('not due' already greyed out)*				*Year End Delivery Confidence Assessment 0 = Original*				
			Q1	Q2	Q3	Q4	0	Q1	Q2	Q3	Q4
Accelerated Cluster Development	3.1) Collaborative engagement and develop maturity Q1-Q4	ED PCC&MH	Amber	Amber	Green	Blue	H	M	M	H	High
	3.2) Continue to develop reporting and governance arrangements with RPB Executive (Pan Cluster Planning Group) Q3				Amber	Amber	H	H	H	M	Medium
	3.3) Implementation of Dental Collaborative (pending national negotiation outcome) Q2			Amber	Amber	Amber	M	M	L	L	Low
	3.4) Develop the Professional Nursing Collaborative Q2			Red	Amber	Amber	H	H	M	M	Low
	3.5) Develop the Optometry Collaborative Q1		Green	Blue	Blue	Blue	H	H	M	H	High
	3.6) Continue to identify services best delivered at cluster or pan-cluster level Q4					Amber	H	H	H	H	Medium

General Medical Services	3.7) Annual Programme of Primary and Community Care Academy – training and support for all contractors; identifying funding opportunities; support for GMS (General Medical Services) PLT (Protected Learning Time); evaluation Q1		Green	Blue	Blue	Blue	H	H	H	H	High
	3.8) GMS Practice Sustainability analysis, review, and action planning Q2			Green	Blue	Blue	H	H	H	H	High
	3.9) Engagement with patients and stakeholders on perception and experience of access Q4					Red	H	H	H	L	Low
	3.10) Development of workforce model in line with Strategic Programme for Primary Care/ Primary Care Strategic Workforce Plan & PTHB Frailty and Community Model Q3				Green	Blue	H	H	H	M	High
	3.11) Roll out multi-professional workforce tool Q3				Amber	Blue	M	M	M	M	High
Optometry	3.12) Systematic tracking of core hour provision Q2			Green	Blue	Blue	H	H	H	H	High
	3.13) Support and track access in relation to IPOS (Independent Prescribing Optometrists) Q1		Green	Green	Green	Blue	H	H	H	H	High
	3.14) Pre-registration Optometrist between primary and secondary care in Cluster(s) Q2			Red	Red	Red	M	M	M	L	Low
	3.15) Establish inter-practice referral for urgent cases Q1		Blue	Blue	Blue	Blue	M	H	H	H	High
	3.16) School vision and eyecare access improvements Q2			Red	Red	Red	L	L	L	L	Low
	~~3.17) Scope Special School Primary Care Eyecare Q1~~		Red	Red	Red		L	L	L	L	Low
	3.18) Publicise occupational health services offer Q1		Red	Blue	Blue	Blue	M	H	H	H	High
	3.19) Implement pathways with outreach Ophthalmology Services, clusters and Optometry practices for Glaucoma and Medical Retina pathways Q1-Q2		Amber	Green	Green	Blue	M	M	M	M	Medium
Dental	3.20) Maintain urgent access in General and Community Dental Service to balance of demand and capacity Q1	ED PCC&MH	Green	Green	Green	Amber	H	H	H	H	Medium
	3.21) Increase capacity of Llandrindod Wells contract Q2			Blue	Blue	Red	H	M	H	M	Low

	3.22) Secure future dental access in Newtown Q2			Green	Green	Blue	M	L	H	H	Medium
	3.23) Rural enhancement offer for Foundation Dentists Q4					Blue	L	L	L	M	High
	3.24) Continue to transfer patients from the dental waiting list to salaried General Dental Practitioner (GDP) in line with contract reform Q1		Blue	Blue	Blue	Blue	H	H	H	H	High
	3.25) Undertake dental waiting list cleansing to support accurate waiting list numbers Q1		Green	Blue	Blue	Blue	H	H	H	H	High
	3.26) Recruit additional dental officer for sedation by end of Year 1 Q4					Blue	M	M	M	L	High
	3.27) Rescope mobile dental services in areas with limited or no access Q1		Blue	Blue	Blue	**Blue**	H	H	H	H	High
	3.28) Develop undergraduate dental therapy placement programme with Cardiff Dental School Q4					Blue	M	M	M	L	High
Community Pharmacy	3.29) Further development of Assurance Framework; Annual programme of contract monitoring – and targeted visits (50% of pharmacies in Year 1); implement contract breach process by year end Q4					Blue	H	H	H	H	High
	3.30) Ensure access and monitor provision of Clinical Community Pharmacy Service (CCPS) and "additional pharmacy services". Q1-Q4 Ongoing (monthly)	EMD	Green	Green	Green	Blue	H	H	H	H	High
	3.31) Review and update of service specifications for locally commissioned services Q4					Blue	H	H	H	H	High
	3.32) Review pharmacy 'rota services' to ensure that they are delivering value to our population Q4					Amber	H	M	M	L	Low
	3.33) Work with Welsh Government to address challenges that are unique to Powys (e.g. implementation of 56-day prescribing in dispensing practices) Q4					Amber	L	L	L	L	Low

	3.34) Work with contractors to improve the quality of Datix reporting and ensure that learning is shared as appropriate Q1-Q4 Ongoing		Green	Green	Green	Blue	H	H	H	H	High
	3.35) Continue to encourage Pharmacists to train as independent pharmacist prescriber (IPPs) and monitor provision of IPP services across Powys Q1-Q4 Ongoing		Green	Green	Green	Blue	H	H	H	H	High
Women & Children's - Maternity	3.36) Delivery of the Maternity Assurance and Safety Improvement Plan Q1-4	ED NQW&FH	Blue	Blue	Blue	Blue	H	H	H	H	High
	3.37) Implementation of Digital Maternity Cymru (DMC) appropriate to PTHB Q1-4		Amber	Amber	Amber	Blue	M	M	M	M	High
	3.38) Review workforce and implement the revised workforce review Q1-4		Green	Green	Amber	Amber	H	M	M	M	Medium
	3.39) Implementation of Health Inspectorate Wales recommendations including birth centre environments Q1-4		Green	Green	Green	Blue	M	L	L	L	Medium
Women & Children's – Women's Health	3.40) Assessment and local delivery of All Wales policy and plan requirements, adapted to PTHB context Implement plans for Women's Health and Sexual Health Improvement; HIV and All Wales Women's Health Implementation Group Priorities Q1-4		Green	Green	Green	Blue	M	M	M	M	Medium
Women & Children's – Pathway Development	3.41) Implementation of key service / pathway developments: - Develop and deliver Community Paediatric Remodel action plan - Implementation of the multi agency Neurodevelopment Strategic Action Plan for Powys - Develop an Additional Learning Needs Strategy for Powys including partnership delivery plan Q1-4		Amber	Amber	Amber	Blue	M	H	H	H	High

Formal change request (Please tick as applicable and provide explanation below)

Change in Scope	N/A	**Change in Timescale**	N/A

Change in Scope and Timescale

- 3.17 - Special School Primary Care Eyecare (SPEC) is dependent upon national clinical pathways, led by national clinical leads and has been assigned lower priority versus other clinical pathways. Scope of service has not been communicated to HBs so cannot progress this action. No indication this pathway is imminent during 24/25 – request to remove as a key deliverable for 24/25. Change request approved at Executive Committee 22.01.2025.

Executive Director Sign Off	Elaine Lorton (Executive Director of Primary Care, Community and Mental Health) Kate Wright (Executive Medical Director) Claire Roche (Executive Director of Nursing, Quality, Women and Family Health)

Strategic Priority 4 - Design and Deliver a phased Frailty and Community Model

Executive Lead - Executive Director of Primary Care, Community and Mental Health

Intended Outcome/ Impact

- A sustainable approach to frailty and community care, improving equity of access
- Risk stratification of the population to deliver effective support for those with greatest need and at greatest risk of ill health
- Joined up support for physical and cognitive frailty and improved co-ordination at end of life particularly the last year of life
- Associated reduction in emergency admissions/ prevention of avoidable deterioration in health such as deconditioning and fractures

Commentary on Progress in this Quarter:

- **4.1) Continuous Engagement in sharing the challenge and understanding Discovery findings; shaping and refining ideas Q1-4:** Building on the previous joint Better Together / Sustainable Powys sessions back in February and March 2024, further joint sessions between PTHB and Powys County Council were held with Town and Community Councils in Q3 and the final one took place in Newtown in Q4 (it was previously delayed due to bad weather). The health board has also developed its Case for Change document during Q4 which was shared with staff for their feedback between 13/02/2025 and 09/03/2025, with an updated Case for Change document due to be published for further engagement with patients, the public and wider stakeholders in Spring 2025.
- **4.4) Minimum 12 Week Consultation for areas of significant service change Q3-4:** As outlined in 4.1) above, the health board has also developed its Case for Change document during Q4 which was shared with staff for their feedback between 13/02/2025 and 09/03/2025, with an updated Case for Change document due to be published for further engagement with patients, the public and wider stakeholders in Spring 2025. Work to identify the steps to consultation have been developed in readiness for 2025/26.

- **4.7) Review access to Fracture Liaison Service Q3-Q4:** The Task & Finish Group has remained in place to finalise the business case, including the preferred option to improvement patient outcomes, experience and cost through ensuring better access to Fracture Liaison Services for Powys patients. Work has continued with national colleagues to understanding if resource may be available to help support the development of a PTHB service to support access to Fracture Liaison Services for Powys patients.
- **4.8) Implement National Community Nursing Framework in Powys Q1-Q4:** Following the self-assessment against elements of the Community Nursing Standards in Q2, the resultant action plan continues to be implemented to prioritise the areas where further development is needed, recognising what can be successfully and safely delivered in a rural county.
- **4.13) Review the impact of the PTHB-element of the National Cellulitis Improvement Programme Q4:** The individual commenced in post on 01/11/2024 in the National Cellulitis Improvement Programme in the national team, with links to the local PTHB Lymphoedema & Cellulitis Team established and being developed operationally. Recognising the short period of time, work has taken place to identify the impact and benefits delivered to date, with positive signs. It is proposed a fuller evaluation will take place towards the end of 2025/26 to inform the next steps.

Commentary on red rated actions:

- **4.10) Commence implementation including liaison with out of county providers Q3-Q4:** As outlined in Q3, the liaison work with out of county providers has not taken place. It was anticipated that the National Service Specification for Palliative and End of Life Care in Wales would be finalised towards the end of 2024/25, however the recent consultation by the NHS Wales Executive on the draft service specification has been delayed. Similarly, the nationally-led Joint Commissioning Committee work to look at a different commissioning model for hospice services has not yet been finalised. Whilst awaiting these national pieces of work, PTHB has been able to roll out a revised Treatment Escalation process in the community in Powys, including related training for staff and the development of a patient-information leaflet which will be published in Q1 2025/26.

Progress against key actions and milestones

Key Areas of Delivery	*Key Deliverables*	*Lead Executive*	*BRAG ('not due' already greyed out)*				*Year End Delivery Confidence Assessment 0 = Original*				
			Q1	Q2	Q3	Q4	0	Q1	Q2	Q3	Q4
Continue development of tiered community model	4.1) Continuous Engagement in sharing the challenge and understanding Discovery findings; shaping and refining ideas Q1-4	ED PCC&MH	Green	Green	Green	Blue	H	H	H	H	High

	4.2) Next phase of design including configuration of tiered community model, outpatient, daycase and admitted patient care Q2-3			Green	Amber	Amber	M	M	H	H	High
	4.3) Identification of service development Q3				Amber	Amber	M	M	M	H	High
	4.4) Minimum 12 Week Consultation for areas of significant service change Q3-4				Green	Blue	M	M	M	M	Medium
Continue to implement Frailty Model, including optimisation and join up for frailty of memory	4.5) Develop Frailty scoring Q1-Q3		Green	Amber	Blue	Blue	M	M	M	M	High
	4.6) Develop the approach to Comprehensive Geriatric Assessment and care planning Q1-Q3		Green	Green	Blue	Blue	M	M	M	M	High
	4.7) Review access to Fracture Liaison Service Q3-Q4				Green	Blue	H	H	H	H	High
	4.8) Implement National Community Nursing Framework in Powys Q1-Q4		Green	Green	Amber	Amber	M	M	M	M	Medium
Improve coordination of the Last Year of Life	4.9) Finalise approach to planning for the Last Year of Life with major conditions Q1-Q2		Green	Blue	Blue	Blue	H	H	H	H	High
	4.10) Commence implementation including liaison with out of county providers Q3-Q4				Red	Red	M	M	M	L	Low
Review and refine the Community Hospital model	~~Scope an improved approach to cognitive impairment on general wards Q1-Q2~~ see change in box below		Green	Red			M	M	L		Select
	~~Pilot the approach Q3-Q4~~						M	M	L		Select
Support Admission Avoidance	4.11) Subject to approval, support the National Cellulitis Improvement Programme with a Powys-related post Q1-Q3		Green	Green	Blue	Blue	H	H	H	H	High
	4.12) Scope phase 1 Urinary Tract Infection (UTI) pathway transformation and commence implementation Q2–Q3			Green	Blue	Blue	H	H	H	H	High
	4.13) Review the impact of the PTHB-element of the National Cellulitis Improvement Programme Q4					Blue	H	H	H	H	High

Powell Bethan 01/05/2025 10:03:13

Formal change request (Please tick as applicable and provide explanation below)			
Change in Scope	N/A	**Change in Timescale**	N/A

Change in Timescale

- Review and refine the community hospital model – due to the Temporary Service Change to co-locate patients this area of delivery has been reprioritised. Change request approved in Quarter 2.

Executive Director Sign Off	Elaine Lorton (Executive Director of Primary Care, Community and Mental Health)

Strategic Priority 5 - Deliver the Planned Care & Diagnostics Programme

Executive Leads – Executive Director of Primary Care, Community and Mental Health / Executive Director of Planning, Performance and Commissioning / Executive Director of Allied Health Professions, Health Sciences and Digital

Intended Outcome/ Impact

- As many patients treated in Powys as possible – delivery of Rural Regional Centres and North Powys Wellbeing Programme
- Improved resilience of provider services and greater utilisation of provider services capacity/ system assets
- Getting It Right First Time is the default method of operation with associated improvements in quality, governance and assurance

Commentary on Progress in this Quarter:

- **5.1) -** The GIRFT implement support sessions are complete for Ophthalmology, Orthopaedics, General Surgery, Gynaecology and Urology. GIRFT has now been replaced by optimisation frameworks which will be launched at the end of March 2025 and recommendations delivered through a long-term plan.
- **5.13) -** Work is ongoing to increase clinic capacity, with weekly sessions now being held in Brecon and Llandrindod Wells. There is ongoing discussion with neighbouring health boards for the development of nurse led WET AMD service in North Powys and discussions around pre assessment and biometric pathways for cataract patients. Work will continue as part of the 2025/26 long term delivery planning.

- **5.15) -** Virtual appointments are part of clinic templates across Orthopaedics/ENT/Colorectal/Urology/Rheumatology specialities. Discharge is the preferred patient outcome, but Patient Initiated Follow Ups and SOS pathways are well established. For advice patients have access to the Waiting Well Programme. This work will continue into 2025/26 delivery planning. Work will continue as part of the 2025/26 long term delivery planning.
- **5.18) -** Phase 1 complete -Ystradgynlais, Welshpool and Llandrindod have completed the x-ray replacement phase and now back fully operational, Phase 2 - Newtown x-ray equipment has been delivered and expected to be installed and fully operational by 31st March. There is a delay on the Brecon delivery of the x-ray equipment but is on track to be installed before the end of March, but it will not go live until April 18th which will then see phase 2 complete.
- **5.20) –** Point Of Care Testing (POCT) co-Ordinator supporting the following areas on adding POCT into their clinical pathways: Mental Health Pochi for FBC in Clozapine monitoring: Living Well Service - metabolic function monitoring for GLP-1 prescribing pathway: Women & Childrens - All Wales NEWTT2 pathway for neonates: MIU - T&F for MIU development. Opportunities identified with South Cluster on CRP pathway to improve the pathway and relationship with Primary Care. Internal Audit underway around Medical Devices Contract Monitoring.

Commentary on red rated actions:

- **5.2) Seek Consultant Urologist sessions:** PTHB were unsuccessful in the Planned Care Transformation fund for speciality consultant sessions resulting in PTHB not being able to progress with Consultant Urologist sessions.
- **5.4) & 5.5) -** Plans to recruit a jointly funded post through the delivery of the MSK Triage solution has been reviewed, the posts would be better managed through a Service Level Agreement.
- **5.9) -** Recruitment for key roles are currently being progressed, with the band 7 physiotherapist in its second week of advert. The band 8a physiotherapist job has been approved through the job matching panel and scheduled to go out to advert imminently. The band 6 physiotherapist role has been approved and advertised with interviews scheduled. The workspace for the 2 Band 3 admin roles has been confirmed as Newtown. The initial mapping design document for single point of access for Orthopaedic referral management has been drafted and discussed with the clinical and admin teams for ratification. This has been taken into Q1-Q2 2025/26 Deliverables.
- **5.11) Dental:** The proposal to purchase high quality cameras to allow good clinical photography in Dental service is currently paused until the outcome and evaluation is complete for the Dermatology pilot. Dermatology pilot was evaluated as successful - scoping of opportunities in dental to be taken forward in Annual Plan 2025/26.

Progress against key actions and milestones

Key Areas of Delivery	*Key Deliverables*	*Lead Executive*	*BRAG ('not due' already greyed out)*				*Year End Delivery Confidence Assessment* *0 = Original*				
			Q1	**Q2**	**Q3**	**Q4**	**0**	**Q1**	**Q2**	**Q3**	**Q4**

GIRFT Recommendations	5.1) Continue implementation of GIRFT recommendations for General Surgery, Orthopaedics and Ophthalmology to include repatriation of low complexity day cases Q1-Q4		Green	Green	Green	Blue	H	H	H	H	High
	5.2) Seek Consultant Urologist sessions to scope community urology service Q2-Q4			Red	Red	Red	M	L	L	L	Low
Key Strategic Relationships	5.3) Explore Opportunities for jointly funded or regional post Q1		Blue	Blue	Blue	Blue	H	H	H	H	High
	5.4) Recruitment for jointly funded or regional post Q3				Amber	Red	H	M	M	H	Medium
	5.5) Evaluation of jointly funded or regional post Q4					Red	H	M	M	M	Medium
Referral Management Solutions	5.6) Scope a (Provider) interface triage pilot for Orthopaedic Referrals Q1	ED PCC&MH	Blue	Blue	Blue	Blue	H	H	H	H	High
	5.7) Pilot interface triage solution for Orthopaedic Referrals Q2	ED PP&C		Blue	Blue	Blue	H	H	H	H	High
	5.8) Evaluate interface triage solution for Orthopaedic Referrals and any associated Business Case through the Investment Benefit Group Q3				Blue	Blue	H	H	H	H	High
	5.9) Subject to approval implementation of interface triage solution for Orthopaedic Referrals; Evaluation Q3-Q4				Green	Red	H	H	H	H	Select
	5.10) Scope a referral management solution for Dermatology; Pilot subject to any associated Business Case support; Evaluate; begin phased roll-out Q1		Blue	Blue	Blue	Blue	H	H	H	H	High
	5.11) Develop referral management solution for dentistry in relation to oral cancer Q2			Red	Red	Red	H	M	L	L	Low

Improve Value in Key Specialities	5.13) Continued implementation of Wet Age-Related Macular Degeneration (AMD) and Cataracts improvement plan in alignment with GIRFT Q1-Q4	ED PCC&MH ED PP&C	Green	Green	Green	Blue	H	H	H	H	High
Implement the Outpatient Transformation Plan	5.14) Appoint permanent Assistant Medical Director for Planned Care Q1		Blue	Blue	Blue	Blue	M	H	H	H	High
	5.15) Continued implementation of outpatient transformation plan (virtual appointments, access to advice and guidance, modernisation of follow ups including see on symptoms) Q1-Q4		Green	Green	Green	Blue	M	M	H	H	High
Radiology Provision across Powys (enabling implementation of RISP)	5.16) Submit capital business case for replacement of X-ray equipment to enable implementation of RISP Q1	ED AHPHS&D	Blue	Blue	Blue	Blue	M	H	H	H	High
	5.17) Review x–ray provision across Powys as part of work on sustainable model Q1		Blue	Blue	Blue	Blue	H	H	H	H	High
	5.18) Develop x-ray implementation plan and implement phase 1 Q2-Q4			Green	Green	Blue	M	L	H	H	High
Enhance the provision of Point of Care Testing throughout Powys	5.19) Review and develop existing POCT provision and governance: Establish QA Compliance framework, analyse asset registry, monitoring initiation and training development Q1-Q2	ED PCC&MH ED PP&C	Green	Blue	Blue	Blue	H	H	H	H	High
	5.20) Expand availability of POCT provision in support of clinical pathway development and governance: identify opportunities in primary & community care, prepare for internal audit Q3-Q4				Amber	Blue	M	M	M	M	High
	5.21) Identify ongoing funding for the POCT Co-ordinator role Q3-Q4				Blue	Blue	M	M	M	H	High

Formal change request (Please tick as applicable and provide explanation below)

Change in Scope	N/A	**Change in Timescale**	N/A

Executive Director Sign Off	Elaine Lorton (Executive Director of Primary Care, Community and Mental Health) Nicola Johnson (Executive Director of Planning, Performance and Commissioning) Claire Madsen (Executive Director of Allied Health Professions, Health Sciences and Digital)

Tackling the Big Four

Strategic Priority 6 - Develop and Deliver a Major Conditions Plan

Executive Leads - Director of Strategic Improvement and Transformation / Executive Medical Director / Executive Director of Allied Health Professions, Health Sciences and Digital / Executive Director of Planning, Performance and Commissioning / Executive Director of Primary Care, Community and Mental Health

Intended Outcome/ Impact

- A shift to prevention to improve population health and reduce the burden of ill health, with smarter approaches to segment and target those at risk
- Optimising the key pathways of care to improve equity of access and patient experience
- Joined up care across physical and mental health; effective management of long term conditions and a core approach to rehabilitation
- Greater co-ordination of care to improved efficiency, performance and outcomes

Commentary on Progress in this Quarter**:**

- **6.2) Map and develop key optimal pathways for Diabetes**: Mapping of the existing diabetes pathway took place to support a presentation to the Directors of Finance Value Leadership Group on 31/01/2025. Work commenced in Q4 on a business case to scope whether clinics for Powys patients living with diabetes who have hybrid closed loop pumps could be provided closer to home, with the aim of the business case being finalised in 2025/26.
- **6.9) Single Cancer Pathway (SCP):** The Cancer Performance of providers continues to be reviewed regularly and any learning for improvement of pathways is shared. However, in spite of this, due to capacity constraints in commissioned services, the SCP is performance is still challenged.

Commentary on red rated actions:

- **6.1) Development of a phased major conditions transformation plan**: An SRO was not identified for the work programme and it has therefore been unable to progress as planned. Progress has however been made in the background with a focus on High-cost user data modelling which has identified co-morbidities as an

area of higher spend based on patients with more than one condition. Work around how outcomes and experience for Powys patients living with comorbidities in the community can be improved will be taken forwards in 2025/26 and development and delivery of the integrated community model.

Progress against key actions and milestones

Key Areas of Delivery	*Key Deliverables*	*Lead Executive*	*BRAG ('not due' already greyed out)*				*Year End Delivery Confidence Assessment 0 = Original*				
			Q1	**Q2**	**Q3**	**Q4**	**0**	**Q1**	**Q2**	**Q3**	**Q4**
Development of a transformative Major Conditions Plan	6.1) Development of a phased major conditions transformation plan to develop: a less siloed approach; streamline appointments, diagnostics, assessments, care and treatment plans, reviews and polypharmacy; and to improve co-ordination in the last year of life Q1- Q3 development of the plan	DSI&T	Amber	Red	Red	Red	H	H	L	L	Low
Optimal Pathways	6.2) Map and develop key optimal pathways for Diabetes (in liaison with national Value and Sustainability Work) Q2 confirm baseline and gap analysis Q3-Q4 first phase improvement	ED PCC&MH		Amber	Amber	Amber	M	M	L	L	Low
Stroke	6.3) Review National Prescribing indicators in primary care for Atrial Fibrillation; explore improvements Q3	ED PP&C EMD			Amber	Amber	H		H	M	Medium
	6.4) PTHB Clinical engagement in key Strategic Programmes for Stroke (Wales and England particularly Herefordshire & Worcestershire) Q3	DPPP&C EMD			Green	Blue			H	H	High
	6.5) Incorporation of guidelines for stroke rehabilitation Q3	ED AHPHS&D			Green	Blue			H	H	High

Diabetes	6.6) Delivery of All Wales Diabetes Prevention Programme (AWDPP) Q1-Q4	ED PH	Green	Green	Green	Blue	H			H	Select
Cardiac	6.7) Community cardiology Q4	ED PCC&MH / ED PP&C				Amber	H		M		Medium
Cancer Cancer Improvement Plan	6.8) Deliver the PTHB Cancer Improvement Plan Q1- Q4	EMD	Green	Amber	Amber	Amber	M	M	M	M	Medium
Single Cancer Pathway	6.9) Review variation of Single Cancer Pathway performance across secondary care providers and reduction of backlog of those waiting over 62 days for first definitive cancer treatment Q1 – Q4	EMD	Red	Red	Red	Amber	L	L	L	L	Low
Implement improving Cancer Journey	6.10) Implement Improving Cancer Journey Programme Phase 2 Q1-Q4	EMD	Green	Green	Green	Blue	H	H	H	H	High
	6.11) Annual review of PTHB Cancer Improvement Plan and update for 2024-25 at year end Q4					Blue	H	H	H	H	High
Respiratory Ensure equitable and standardised MDT services across the whole of PTHB	6.12) Continue to explore options for medical cover across PTHB Q1-Q3	ED PCC&MH	Amber	Amber	Amber	Amber	M	M	M	M	Medium
	6.13) Provide support to Primary Care to implement Asthma plans for the asthma population Q2-Q4			Green	Green	Blue	M	M	M	M	High

Formal change request (Please tick as applicable and provide explanation below)			
Change in Scope	N/A	**Change in Timescale**	N/A

Q3 Change in Executive Lead

6.2) Map and develop key optimal pathways for Diabetes – Change request to remove DSI&T and transfer to ED PCC&MH. Change request approved at Executive Committee 22.01.2025. 6.6) Delivery of All Wales Diabetes Prevention Programme (AWDPP) Q1-Q4 – Change request to remove DSI&T as Exec Lead. Change request approved at Executive Committee 22.01.2025.	
Executive Director Sign Off	Lucie Cornish (Director of Strategic Improvement and Transformation) Kate Wright (Executive Medical Director) Claire Madsen (Executive Director of Allied Health Professions, Health Sciences and Digital) Nicola Johnson (Executive Director of Planning, Performance and Commissioning) Elaine Lorton (Executive Director of Primary Care, Community and Mental Health)

Tackling the Big Four

Strategic Priority 7 - Deliver the Mental Health Transformation Programme

Executive Lead – Executive Director of Primary Care, Community and Mental Health

Intended Outcome/ Impact

- Delivery of equitable and quality mental health care that meets the needs of the population
- Increased efficiency and integration of services to improve sustainability and user experience with clear navigation, access and referral
- Improved co-ordination and care planning with reduction in avoidable urgent and emergency attendances and out of county care

Commentary on Progress in this Quarter:

- **7.3) Workforce design and further consultation Q3:** The alignment of Powys Dementia Home Treatment Teams to create a sustainable pan-Powys team, improving equity and consistency across Powys is progressing, (though progress affected by staff sickness). A proposed pan-Powys DHTT pathway, refined staff model and working pattern have been drafted and are due for signoff via Mental Health SMT and Transformation Programme Board. A meeting is in place to review proposed operational process with digital team colleagues to ensure best use of available electronic systems and reporting functionality. A task & finish group is in place to

review outcome measures and work with the Information team to develop a DHTT BI dashboard. OD are advising regarding required organisational change process during Q1 25-26, with new operational policy planned to be rolled out late Q1.

- Following preliminary transformation work with partners including North Powys Wellbeing Programme, PTHB Mental Health Services, Social Care and 3rd Sector colleagues, the redesign of the Mental Health community model for Powys has progressed during Q4. The redesign aims to ensure the provision of equitable, quality care, in line with national strategies, that meets the needs of the Powys population. This work has been identified as a priority for the 2025-26 integrated Plan, linked to the Community Model for physical health and will also include the phase 3 work for Mental Health Single Point of Access (SPOA). Following a joint workshop in January 2025, including Social Care and NHS Executive colleagues, a draft vision, outline model and principles for the Mental Health community model have been drafted. All or part of the community model will be accelerated within Q1-Q2 2025-26, linked to the community model for physical health, which will also inform work around the inpatient model (bedded care) for Powys.
- **7.5)** Refine baseline including urgent referral information. Continuous engagement. Scope expansion of "front door" role including development to align other referral processes. Q1: Scoping for Single point of access (SPOA) phases 1 & 2 was completed during Q2.
- **7.6)** Develop phased delivery plan Q2: Delivery plan developed in Q2.
- **7.7)** Phase 1 implementation including administrative single point of access Q3, & 7.8) Phase 2 implementation including commencing development of referral routes for Secondary Care referrals Q4: The Mental Health Single Point of Access (SPOA) phase 1 (refinement of previous email administration hub) and phase 2 (implementation of Triage team), went live successfully in Q2, utilising WG 'pump prime funding' from the 'Six goals' project. Following a successful business case submission to the Investment Benefit Group (IBG) in Q4, for continued funding, preparation work is underway to develop a holistic assessment (phase 3), close to 'the front door'. A joint workshop with PCC Social Care took place in January to scope the Assessment phase (phase 3), which identified the opportunity for Social Care to link to the MH Services 'front door'. This workshop also highlighted the integration required of the SPOA within the MH Community model. Q4 has seen the Single Point of Access (SPOA) process refinement activities and staffing challenges, despite which scoping work has continued, which will now progress alongside development of the MH Community Model, linked with the Physical Health Community Model, (which may be accelerated for Q1-2 2025-26, pending Executive Committee decision).
- **7.9)** Engagement with children and young people, families, and carers (i)Workforce design Q1: A Child and Adolescent Health Services (CAMHS) Crisis Hub is now fully operational, providing access to sanctuary for children in a safe, friendly, built for purpose environment.
- **7.10)** Recruitment Q2, & **7.11)** Implementation of rapid response and outreach service Q3-Q4: A new Rapid response & Outreach Team (RRO) has been recruited with working hours aligned to the adults CRHTs, enabling a greater out of hours (OOH) for CYP. The Hub uses a multidisciplinary team (MDT) approach to supporting young people and their families in mental health distress. Engagement with families is ongoing with young people supporting the ongoing development of the project. This facility is increasingly diverting children and young people from attending A&E, or acute mental health wards, whilst offering intensive home treatment and assertive outreach service. Numbers of appointments/ contacts are increasing month on month, with a 25% reduction in average monthly Welsh emergency department attendances (0-17yr olds), throughout 2024/25 from an average of 7.2 attendances per month in 2023/24 to 5.4 attendances per month in 2024/25 from April – August, (6 Goals for Urgent & Emergency Care 2021-2026). This successful project is yet to secure 2025/26 funding.

- **7.19)** A revised pathway for neurodiversity pathway Q1-Q4: This deliverable has to date been led within the MH Learning Disabilities and Neurodiversity Teams. Powys is the first region in Wales to now have an ND pathway which includes a jointly operated Integrated Autism Service (IAS) working alongside a new ADHD service. New working practices have been embedded, with the pathway undergoing service evaluation and further development. Sustainability work is underway due to fragility of current specialist workforce comprised of temporary seconded posts. This service remains a priority going forwards.

Commentary on red rated actions:

- **7.1) Refining the baseline. Refining the modelling for the new model.** Continuous engagement Q1: 2023/24 MH Baseline data approved by MH Senior Team 16/3/25 and will be taken forward to MH Transformation Board 25.4.25. Preliminary modelling work was ongoing throughout Q3, undertaken by North Powys Wellbeing Team. A meeting between MH Senior Management Team and external modelling resource in January 2025 determined that scoping and vision was required for MH services prior to further modelling work. This work has been rescheduled for Q1-Q2 2025-26 as part of the Community model redesign work.
- **7.2) Public engagement and consultation Q2:** Public engagement and consultation has not been required.
- **7.4)** Dementia Home Treatment Team (DHTT): Resource has been diverted due to staff absences. Also, as part of organisational change process, this project will include a 4- week staff consultation, taking implementation into Q1 2025-26, potentially aligned with accelerated work for the Mental Health Community Model.

Progress against key actions and milestones

Key Areas of Delivery	*Key Deliverables*	*Lead Executive*	*BRAG ('not due' already greyed out)*				*Year End Delivery Confidence Assessment 0 = Original*				
			Q1	**Q2**	**Q3**	**Q4**	**0**	**Q1**	**Q2**	**Q3**	**Q4**
Transformation of Adult and Community Model Phase 1 (includes alignment of Duty and Assessment Model)	7.1) Refining the baseline. Refining the modelling for the new model. Continuous engagement Q1	ED PCC&MH	Amber	Red	Red	Red	H	M	M	H	High
	7.2) Public engagement and consultation Q2			Amber	Red	Red	M	H	M	H	Low
	7.3) Workforce design and further consultation Q3				Blue	Blue	M	M	M	H	High
	7.4) Phase 1 implementation Q4					Red	M	M	M	H	Low
	7.5) Scope model. Refine baseline including urgent referral information. Continuous engagement. Scope expansion of "front		Green	Blue	Blue	Blue	M	H	M	H	High

Expand capacity to extend single point of access including Next Phase of Development offer alignment with 111P2 for Duty and Assessment Model	door" role including development to align other referral processes. Q1											
	7.6) Develop phased delivery plan Q2			Blue	Blue	Blue	M	H	H	H	High
	7.7) Phase 1 implementation including administrative single point of access Q3				Blue	Blue	M	M	H	H	High
	7.8) Phase 2 implementation including commencing development of referral routes for Secondary Care referrals Q4					Blue	M	M	H	H	High
Ensure access to provision for sanctuary for children	7.9) Engagement with children and young people, families, and carers (i)Workforce design Q1	ED PCC&MH	Blue	Blue	Blue	Blue	H	H	H	H	High
	7.10) (ii) Recruitment Q2			Blue	Blue	Blue	M	H	H	H	High
	7.11) (iii) Implementation of rapid response and outreach service Q3-Q4				Green	Blue	M	H	H	M	High
Develop access to provision for sanctuary for adults	~~7.12) i) Through collaboration with stakeholders, staff and partners, design a sustainable model for a highly rural setting Q3-4~~				Red		M	M	M	L	Select
	7.13) (ii) Assess impact of right care, right person 7.14) Q3 Year 2 Phased Delivery Plan				Amber	Amber	H	H	H	H	Low
Take forward the next phase of work to enable access to a step-down solution for those with complex needs	~~7.15) Continuous engagement Q1-Q4~~		Green	Red	Red		M	H	L	L	Select
	~~7.16) Explore and develop advisory options appraisal Q1~~		Red	Red	Red		L	L	L	L	Select
	~~7.17) Design and workforce planning Q2~~			Red	Red		M	L	L	L	Select
	~~7.18) Preparation for procurement Q3-Q4~~				Red		M	L	L	L	Select

Next phase of neurodiversity pathway development	7.19) A revised pathway for neurodiversity pathway Q1-Q4		Amber	Blue	Blue	Blue	H	L	M	H	High

Formal change request (Please tick as applicable and provide explanation below)

Change in Scope	N/A	**Change in Timescale**	N/A

Change in Timescale

- 7.12) **Develop access to provision for sanctuary for adults:** This programme has been suspended due to lack of evidence for rural areas. It is not a current priority for 2024/2025. Change request approved at Executive Committee 22.01.2025.
- 7.15 – 7.18) **Step-down solution:** This project was paused and is not a current priority. Change request approved at Executive Committee 22.01.2025.

Executive Director Sign Off	Elaine Lorton (Executive Director of Primary Care, Community and Mental Health)

Joined Up Care

Strategic Priority 8 – Improve pathways of care focused on system flow

Executive Lead - Executive Director of Primary Care, Community and Mental Health

Intended Outcome/ Impact

- People Home Fitter and Faster
- Co-ordinated and effective pathways of care which deliver an efficient flow across health and care systems
- Associated elimination of pathways of care delays and reduction in avoidable bed utilisation / average length of stay

Commentary on Progress in this Quarter:

- **8.4) Review and refine Digital Patient Flow System, begin to strengthen beyond minimum viable product Q4:** The review and refinement of the Digital Patient Flow System has been achieved, with the basic functionality performing well. Recent developments have focused on enhancing user-friendliness, improving operational utility, and introducing 'quality of life' improvements for users. Further enhancements are planned to continue into FY 2025/26
- **8.5) Reduce the number of service users experiencing Pathways of Care Delays (POCDs) through escalation and tracking Q1-Q4:** Total numbers of Pathways of Care Delays have increased in Q4. Number of POCDs within recent 3-month data (Dec '24 – Feb '25) demonstrate a 9% increase compared with the 3-month prior (176

[Sep-Nov]: 192 [Dec-Feb]) and a 15% increase when compared with the same period in the previous year (167 [2023]: 192 [2024]). Assessment Issues and Care Home Placement arrangements remain the highest contributing causes, making up 49% and 18% of total POCDs for this period respectively. However, the February position does represent a 25% decrease compared with the March 2024 baseline established as part of national monitoring and intervention (74 [Mar '24]: 56 [Feb '25]). The total number of days delayed as a result of Pathways of Care Delays has reduced (2308 [Avg. Dec-Feb]) representing 14% decrease when compared with the 3-month prior (2693 [Avg. Sep-Nov]: 2308 [Avg. Dec-Feb]) and a 15% decrease compared to the March 2024 baseline (2710 [Mar]: 2308 [Avg. Dec-Feb]) To reduce the number of service users experiencing Pathways of Care Delays, a Pathway of Care Delay Action Plan remains in place. Implementation is monitored through the POCD sub-group which reports into Care Action Committee. Efforts to continue to reduce the number of service users experiencing Pathways of Care Delays (POCDs) through escalation and tracking are planned to continue into FY 2025/26.

- **8.6) Reduce the number of super-stranded patients through escalation and tracking Q1-Q4:** The number of super-stranded patients has remained stable (12 [Dec '24]: 12 [Feb '25]). However, this continues to represent a 20% when compared with the previous Q4 baseline (12 [Feb '25]: 15 [Q4,23/24]. This will continue to be monitored through the Power BI dashboard to enhance monitoring of super-stranded patients, as well as monitoring through the POCD sub-group which reports into Care Action Committee. Efforts to continue to reduce the number of super-stranded through escalation and tracking are planned to continue into FY 2025/26.
- **8.8) Consider Expansion of Discharge Liaison Officer Q3-Q4:** Recruitment for the Mid Powys DLO role, funded through the Six Goals for Urgent and Emergency Care, was initially unsuccessful. The post was subsequently readvertised, and interviews are scheduled for the final week of Q4. Recruitment is now anticipated early in Q1.
- **8.9) Reduce average length of stay throughout Powys, through escalation and tracking Q1-Q4:** Average length of stay has remained stable (42.80 [Dec '24]: 42.84 [Feb '25]). However, this represents a 22% reduction when compared with the same period of the previous year (54.88 [Feb '24]: 42.84 [Feb '25]). Efforts to continue to reduce the average length of stay throughout Powys, through escalation and tracking are planned to continue into FY 2025/26.

Commentary on red rated actions: N/A

Progress against key actions and milestones

Key Areas of Delivery	*Key Deliverables*	*Lead Executive*	*BRAG ('not due' already greyed out)*				*Year End Delivery Confidence Assessment 0 = Original*				
			Q1	**Q2**	**Q3**	**Q4**	**0**	**Q1**	**Q2**	**Q3**	**Q4**
Implement a Digital Patient Flow System	8.1) Complete test and pilot phases of newly developed Digital Patient Flow System Q1	ED AHPHS&D	Blue	Blue	Blue	Blue	H	H	H	H	High
	8.2) Launch and roll-out of Digital Patient Flow System Q2			Blue	Blue	Blue	H	H	H	H	High
	8.3) Embed Digital Patient Flow System into standard practice and broaden user operability Q3				Amber	Blue	H	H	H	H	High

	8.4) Review and refine Digital Patient Flow System, begin to strengthen beyond minimum viable product Q4					Blue	H	H	H	H	High
Improved Approach to Pathways of Care Delays (POCD)	8.5) Reduce the number of service users experiencing Pathways of Care Delays (POCDs) through escalation and tracking Q1-Q4	ED PCC&MH	Green	Amber	Amber	Amber	H	H	M	M	Medium
	8.6) Reduce the number of super-stranded patients through escalation and tracking Q1-Q4		Green	Amber	Green	Blue	H	H	M	M	Medium
Improved Approach to Supporting People to Leave Hospital Fitter and Faster	8.7) Embed discharge liaison officer posts throughout Powys Q1-Q2		Green	Blue	Blue	Blue	H	H	H	H	High
	8.8) Consider Expansion of Discharge Liaison Officer Q3-Q4				Amber	Blue	H	H	H	H	High
	8.9) Reduce average length of stay throughout Powys, through escalation and tracking Q1-Q4		Green	Amber	Green	Blue	H	H	M	M	Medium

Formal change request (Please tick as applicable and provide explanation below)			
Change in Scope	N/A	**Change in Timescale**	N/A

Executive Director Sign Off	Claire Madsen (Executive Director of Allied Health Professions, Health Sciences and Digital) Elaine Lorton (Executive Director of Primary Care, Community and Mental Health)

Strategic Priority 9 – Deliver the Six Goals Plan for Urgent and Emergency Care focusing on what works for the Powys population

Executive Lead - Executive Director of Primary Care, Community and Mental Health / Executive Director of Allied Health Professions, Health Sciences and Digital

Intended Outcome/ Impact

- People home fitter and faster
- A co-ordinated and evidence based Urgent and Emergency Care offer across complex health and care systems used by the Powys population

- Effective and efficient locally provided services including optimised minor injuries provision and bed utilisation to ensure patient flow

Commentary on Progress in this Quarter:

- **9.2) Broadening the knowledge and skills of MIU staff in Powys Q1-Q4:** The training needs analysis led by the Urgent and Emergency Care Clinical Transformation Lead is ongoing. Other scheduled training remains on track, with no further changes to planned timelines. Overall, progress towards broadening the knowledge and skills of MIU staff remains on schedule, with efforts to continue to broaden the knowledge and skills of Minor Injuries Unit (MIU) staff planned to continue into FY 2025/26.
- **9.6) Review of SOP and operational model including PROMS to inform the way forward Q4:** System challenges have prevented the implementation of an optimised model at the Glan Irfon site, with further work is needed to enhance collaborative working with partners. Work is underway to enhance partnership working and move toward a more optimal model for delivery of care. However, the scope of the expansion of Therapy Led Rehabilitation throughout PTHB has expanded in-year through the implementation of Rehabilitation Units as part of the Colocation Temporary Service Changes. These changes have introduced a new SOP, aligned to the 2023 Community Rehabilitation Standards to establish clear guidelines and procedures that promote high-quality rehabilitation care, including supporting patients to: maintain and improve function, compensate for lost function, prevent or slow the loss of function, self-manage their condition and maintain a better quality of life. New PROMS have been developed and introduced to support the evaluation of these changes, with efforts to continue to expand Therapy Led Rehabilitation are planned to continue into FY 2025/26, through the evaluation of the Rehabilitation Units as part of the Colocation Temporary Service Change evaluation.
- **9.8) Improve data quality and confidence of D2RA Measure reporting Q3-4:** There have been positive improvements in data quality and confidence for D2RA Measure reporting throughout Q4, with compliance trends showing steady progress. Measure 1, allocation within one day of admission, improved from 0% in January to 24% in February and 44% to mid-March. Measure 2, allocation at the point of Clinical Optimisation, increased from 50% in January to 66% in February and 83% to mid-March. Measure 3, allocation at the point of discharge, rose from 33% in January to 38% in February and 72% to mid-March.
- **9.9) Expansion of dedicated pathway capacity Q1-4:** The existing reablement service has been redesigned to create a more integrated and effective community rehabilitation service that aligns with the Allied Health Professional (AHP) Rehabilitation Standards. This transformation includes the development of two clearly defined pathways, enabling Powys Teaching Health Board (PTHB) and PCC to ensure individuals are triaged and placed on the appropriate Discharge to Recover then Assess (D2RA) pathway in a timely manner, aligning with the objectives of Goal 6: Six Goals for Urgent and Emergency Care. The refreshed service model will offer a robust PTHB community rehabilitation provision, delivered by a suitably skilled workforce, with well-established step-up and step-down pathways for individuals requiring support at home. It fosters a culture of rehabilitation and positive risk-taking and strengthens collaboration between PTHB and Powys County Council (PCC) through clearly defined service criteria, reducing duplication and inefficiency. The PCC Enablement Service will focus on rightsizing care packages and promoting enablement, helping to reduce dependency on long-term domiciliary care. Through the delivery of timely care, these services it will support to prevent deconditioning and ensure pathways are used appropriately, improving outcomes for individuals across Powys.

Commentary on red rated actions: N/A

Progress against key actions and milestones

Key Areas of Delivery	*Key Deliverables*	*Lead Executive*	*BRAG ('not due' already greyed out)*				*Year End Delivery Confidence Assessment 0 = Original*				
			Q1	**Q2**	**Q3**	**Q4**	**0**	**Q1**	**Q2**	**Q3**	**Q4**
Implement Enhanced Community Care Phase One, including the Rapid Response in the community	9.1) Scope the need for a Rapid Response service Q1	ED PCC&MH	Amber	Amber	Amber	Amber	H	H	H	H	High
	9.2) Broadening the knowledge and skills of MIU staff in Powys Q1-Q4		Green	Green	Green	Blue	H	H	H	H	High
Expand Therapy Led Rehabilitation	9.3) Embed new Standard Operating Procedure (SOP) and Key Performance Indicators (KPIs) for Therapy Led Rehabilitation at Mid-Powys Intermediate Care Centre (Glan Irfon) Q1	ED AHPS&D	Blue	Blue	Blue	Blue	H	H	H	H	High
	9.4) Enhance partnership and collaboration to ensure targeted patient referral and access, as well as appropriate service utilisation Q2			Blue	Blue	Blue	H	H	H	H	High
	9.5) Implement optimised model as part of winter response strategy Q3				Amber	Amber	H	H	H	M	Medium
	9.6) Review of SOP and operational model including PROMS to inform the way forward Q4					Blue	H	H	H	H	High
Enhance and expand D2RA Pathway utilisation	9.7) Commence monthly aggregate reporting of D2RA Measures Q1-Q3	ED PCC&MH	Green	Green	Blue	Blue	M	H	H	H	High
	9.8) Improve data quality and confidence of D2RA Measure reporting Q3-4				Green	Blue	H	H	H	H	High
	9.9) Expansion of dedicated pathway capacity Q1-4		Green	Green	Green	Blue	M	M	M	H	High

Formal change request (Please tick as applicable and provide explanation below)			
Change in Scope	N/A	**Change in Timescale**	N/A

Executive Director Sign Off	Claire Madsen (Executive Director of Allied Health Professions, Health Sciences and Digital)

	Elaine Lorton (Executive Director of Primary Care, Community and Mental Health)

Workforce Futures

Strategic Priority 10: Transformation and Sustainability

Executive Lead – Executive Director of People and Culture

Intended Outcome/ Impact

- Strategic workforce planning with creative, innovative and effective approaches
- Sustainable workforce model with associated reduction in vacancies, agency usage and a greater pipeline of potential recruits
- Home grown capability in rural healthcare, with associated improvements in patient care and experience

Commentary on Progress in this Quarter:

- **10.1)** The People & Culture (P&C) Directorate deployed an intensive piece of work to roll out workforce planning training to senior managers and leaders earlier last year to ensure there was adequate support available for developing the skills and capabilities of our staff to drive the development and delivery of strategic workforce plans. Workforce planning (WFP) training is available for managers to access through multiple modalities, such as 1-hour information and awareness session, through to more detailed training accessed via online or face to face classroom-based training. The P&C Business Partnering team have undertaken a gap analysis to understand who has undertaken the training to date and who, from those identified as a senior leader who should attend, has yet to complete the training. Targeted discussions with Assistant Directors have taken place with an identified list of senior managers to prioritise in relation to training delivery. 39 senior managers have completed the full training to date with leadership teams from across Mental Health, Women's & Childrens, Digital and Corporate Nursing receiving the 1-Hour awareness sessions. Our training approach has continued to develop based around service needs and has included the development of a bespoke awareness session and more recently, targeted practical follow up sessions to explore the 6-step toolkit in more detail.

- **10.2)** During this financial year 2024/25, we have recruited 3 cohorts (6 x Registered Nurses per cohort) of Adult Field Internationally Educated Nurses (IENs). The first cohort joined Newtown hospital in Aug 2024, the 2nd cohort joined the team in Machynlleth hospital in November 2024, and the third cohort joined Brecon hospital in February 2025. This most recent cohort in Brecon are currently undergoing OSCE training and due to take their OSCE exam on 25th March. An additional 6 Registered Mental Health IENs are also due to arrive before the end of the 2024/25 financial year and join and subsequently join PTHB. Two of these RMNs are already in country and currently undergoing OSCE training in Swansea Bay University Health Board (SBUHB), due to take their OSCE exam on

18th Mar and then move to Llandrindod Wells to work in Llandrindod Wells hospital. The remaining four RMNs travel to Wales on 20th March will and undertake their OSCE training in SBUHB and are scheduled to take their OSCE exam on 24th April. Thereafter, two will go to Ystradgynlais hospital, and the other two to Bronllys hospital to join the Mental Health teams.

- **10.5/10.6)** Aspiring Nurse Programme: Our newest cohort (Sept 2024) of Aspiring Nurses saw the recruitment and onboarding of 19 new recruits and they are now well into the first year of their learning pathway. Of the original 19 recruited, 4 have unfortunately withdrawn from the course due to personal circumstances. Currently, there are 12 working in the adult general wards and 3 in the Mental Health Wards. This cohort will complete the first year of the course with Llandrillo College, and if successful, will progress onto Year 2 of the degree programme with the Open University. The September 2023 cohort of 17 Aspiring Nurses all progressed successfully into year 2 last September and are now studying full time with Bangor University. They are currently undertaking full time academic study and clinical placements. HEIW have confirmed that they are committed to supporting PTHB with the ongoing success of the Aspiring Nurse Programme with further ongoing funding. Recruitment to the September 2025 cohort will begin in May 2025 with onboarding planned for August 2025. There is a current bank recruitment campaign ongoing, encouraging potential aspiring nurse applicants to join our Temporary Staffing Unit to build knowledge and experience that will help to support their applications to the programme.

Commentary on red rated actions: N/A

Progress against key actions and milestones

Key Areas of Delivery	*Key Deliverables*	*Lead Executive*	*BRAG ('not due' already greyed out)*				*Year End Delivery Confidence Assessment* 0 = Original				
			Q1	Q2	Q3	Q4	0	Q1	Q2	Q3	Q4
Grow the knowledge and capabilities of managers to develop strategic workforce plans aligned to the Accelerated Model of Care	10.1) Cohort of managers (who are required to) who have completed training Q2 & Q4	ED P&C		Green		Blue	H	M	M	H	High
On board a further 3 cohorts of internationally trained Adult Nurses targeting areas with high variable pay spend	10.2) On board Cohorts 1, 2 and 3 for 24/25 Q2 & Q4			Green		Blue	H	H	H	H	High
	10.3) Scope opportunities from national programmes for international recruitment for Mental Health Q3				Green	Blue	H	H	H	H	High

Explore the potential to recruit internationally trained Mental Health Nurses and Medics												
Launch a second cohort of the Aspiring Nurse Programme with HEIW and University partners (improving access for Powys based pre-registered students to the Nurse Degree Programme)	10.4) Agreed plans and funding arrangements in partnership with HEIW and FE/ HEI providers Q2			Blue	Blue	Blue	H	H	H	H	High
	10.5) Report on the recruitment rates of the programme Q4					Blue	H	H	H	H	High
	10.6) Ensuring there is an opportunity for a Welsh essential recruitment offer Q4					Blue	H	H	H	H	High
Generate interest from the younger generation in a rural health and care career through the Academy Career and Education Enterprise Scheme (ACEES)	10.7) Evaluate the Academy Careers and Education Enterprise Scheme (ACEEs) and develop plans for 2024/25 academic year Q1		Blue	Blue	Blue	Blue	H	H	H	H	High
	10.8) Report on the development plans for 2024/25 academic year Q3				Blue	Blue	H	H	H	H	High

Formal change request (Please tick as applicable and provide explanation below)			
Change in Scope	N/A	**Change in Timescale**	N/A
Executive Director Sign Off	Debra Wood Lawson (Executive Director of People and Culture)		

Strategic Priority 11: A Great Place to work

Executive Lead – Executive Director of People and Culture

Intended Outcome/ Impact

- The health board is a great place to work, with positive organisational and team climates, high levels of staff satisfaction, engagement and wellbeing
- Associated improvements in recruitment and retention and reductions in workplace absences

- Staff are able to raise concerns and speak up safely and there is clarity on standards of behaviour and role expectations

Commentary on Progress in this Quarter:

- **11.6)** Embed the Speaking Up Safely framework. The thirteen actions within the speaking up safely framework have been reviewed and completed, or transferred into business-as-usual operations, with an ongoing commitment by PTHB continue to develop a culture of speaking up safely. This has included the provision of the 'Our Voice' portal as a mechanism for people to speak up, and the formation of a quarterly Speaking Up Safely Steering Group who will review any current data, hear from the experiences of those who have spoken up, understand barriers and also agree further organisational actions to be undertaken. The roll out of Speaking Up Safely development sessions has also started with 9 attendees on the first formal session following the previous pilots.
- A review paper to be agreed by Executive Committee that closes the initial action plan and transfers the requirements set out in the Speaking Up Safely Framework to business–as-usual, has been produced and will be approved in Q1 2025/26.

Commentary on red rated actions:

- **11.8)** A pilot tier 2 programme has been developed but due to service pressures and uncertainty around resource funding to deliver, this has been delayed to Q1 2025/26.

Progress against key actions and milestones

Key Areas of Delivery	*Key Deliverables*	*Lead Executive*	*BRAG ('not due' already greyed out)*				*Year End Delivery Confidence Assessment* 0 = Original				
			Q1	Q2	Q3	Q4	0	Q1	Q2	Q3	Q4
Deliver the actions set out in the national Nurse Retention Plan	11.1) Complete the nurse retention self-assessment tool Q1	ED P&C	Blue	Blue	Blue	Blue	H	H	H	H	High
	11.2) Undertake a gap analysis and deep dive of data and intelligence, to understand retention and priorities Q2			Blue	Blue	Blue	H	H	H	H	High
Ensure a clear mechanism for staff to raise concerns and support a culture of psychological safety, so staff feel able to speak up.	11.3) Introduce the Speaking Up Safely 'Your Voice' Portal on staff intranet Q1		Blue	Blue	Blue	Blue	H	H	H	H	High
	11.4) Introduce team activities/briefings Q2			Amber	Blue	Blue	H	H	H	H	High

	11.5) Refresh the Chat2Change plan Q2			Green	Blue	Blue	H	H	H	H	High
	11.6) Embed the Speaking Up Safely Framework Q4					Blue	H	H	H	H	High
Roll out Tier 1 of clinical leadership programme	11.7) Deliver the Tier 1 programme at a rate of 1 course per month Q1-2		Blue	Blue	Blue	Blue	H	H	H	H	High
Develop a pilot for Tier 2	11.8) Develop the Tier 2 programme Q2			Amber	Amber	Red	H	H	M	M	High
	11.9) Pilot Tier 2 programme Q3				Amber	Blue	H	M	M	M	High
Design a Charter with leadership expectations of managers responsibilities in setting standards of behaviour, engaging with staff and creating a great place to work	11.10) Develop draft Charter and resources for consultation and feedback Q1		Blue	Blue	Blue	Blue	H	H	H	H	High
	11.11) Consult with Executive team, Trade Unions and Chat2Change group Q2			Blue	Blue	Blue	H	H	H	H	High
	11.12) Launch Charter Q3				Blue	Blue	H	H	H	H	High

Formal change request (Please tick as applicable and provide explanation below)			
Change in Scope	N/A	**Change in Timescale**	N/A

Executive Director Sign Off	Debra Wood Lawson (Executive Director of People and Culture)

Strategic Priority 12: Employee Health and Wellbeing

Executive Lead – Executive Director of People and Culture

Intended Outcome/ Impact

- Staff report positively about their health and wellbeing at work, feel supported and have access to wellbeing initiatives that meet their needs

- Staff across the organisation demonstrate compassionate leadership in their everyday work
- Managers are able to utilise workforce policy and guidance to support staff to remain in/return to work

Commentary on Progress in this Quarter:

- **12.1)** Wellbeing Roadshows. Roadshows have been undertaken across 14 sites including all of the main hospitals. 356 staff were engaged with out of a potential 436 available on those days (81%). Further Road Runs have been undertaken to visit the smaller sites with 141 staff engaged with so far.
- **12.2)** Compassionate Leadership. Within Q4 5 Introduction to Compassionate Leadership Behaviour sessions were run, 3 open to all and 2 specifically to capture those attending CLIP. In total 46 attendees completed this activity.
- **12.3 & 4)** Working in partnership, a reviewed managing attendance at work toolkit was developed and launched aimed at providing a range of supporting information to assist in managing attendance, this has included reviewing our approaches in relation to temporary redeployments and the development of a "my health passport" to assist in discussions regarding reasonable adjustments. We have an active and ongoing offer of training to support managers in the deployment of policy and have continued to undertake targeted work in relation to our interventions, which also includes support to long term absence over 6 months or complex cases. This is reflected in the health board sickness absence performance which demonstrates a sustained reduction in sickness absence levels.
- **12.5)** Team Climate. Due to service demands no large service area undertook the Team Climate Survey. However, the Integrated Autism Service did complete it as part of Team Intervention work.

Commentary on red rated actions: N/A

Progress against key actions and milestones

Key Areas of Delivery	*Key Deliverables*	*Lead Executive*	*BRAG ('not due' already greyed out)*				*Year End Delivery Confidence Assessment* 0 = Original				
			Q1	Q2	Q3	Q4	0	Q1	Q2	Q3	Q4
Regular access to wellbeing roadshows and initiatives which support health	12.1) Undertake a series of wellbeing roadshows across the county Q4	ED P&C				Blue	H	H	H	H	High
Embed Compassionate Leadership model to underpin approach to staff wellbeing	12.2) Deliver two Compassionate Leadership courses per month Q1-Q4 Quarterly Update		Green	Green	Green	Blue	H	H	H	H	High

Develop the capability of managers in relation to Managing Attendance at work policy to support staff to return to work or stay in work	12.3) Review and republication of the managing attendance at work toolkit Q1		Blue	Blue	Blue	Blue	H	H	H	H	High
	12.4) Delivery of targeted / bespoke sessions to managers Q1-Q4 Ongoing		Green	Green	Green	Blue	H	H	H	H	High
Undertake regular Team Climate surveys and feedback to service managers to identify ways they can support the wellbeing of their staff	12.5) Undertake surveys targeting one service per quarter Q1-Q4 Quarterly Update		Green	Amber	Green	Blue	H	H	H	H	High

Formal change request (Please tick as applicable and provide explanation below)			
Change in Scope	N/A	**Change in Timescale**	N/A

Executive Director Sign Off	Debra Wood Lawson (Executive Director of People and Culture)

Strategic Priority 13: Equalities and Welsh Language

Executive Lead – Executive Director of People and Culture

Intended Outcome/ Impact

- The health board is dynamic in promoting and achieving equality as an employer and employees report positive experiences and support
- The health board takes a pro-active wider role as an anchor institution in the community, leveraging its importance in the Foundational Economy
- There is an 'Equality Friendly' culture with a well trained workforce and effective utilisation of assistive technology, translation and interpretation

Commentary on Progress in this Quarter:

- **13.3)** This activity is partially complete, an audit of all main hospital sites has been undertaken to assess the current assistive hearing technology available and its utilisation. This identified that whilst most sites had at least some technology available it was underutilised and/or people were unaware of how to use, with only one site making good use. As a result of this assessment, training is going to be delivered in relation to the use of the equipment however, we were unable to schedule this in Q4 due to availability and we anticipate this will take place in Q1 2025.

- **13.4)** This project has been completed with the exception of the delivery of the training associated with the equipment. This was not able to be scheduled within Q4 due to availability of the Outpatients teams. The training day has been scheduled for 2nd May.
- **13.5)** This information will be included in the Directors report to the next People and Culture Committee meeting.

Commentary on red rated actions: N/A

Progress against key actions and milestones

Key Areas of Delivery	*Key Deliverables*	*Lead Executive*	*BRAG ('not due' already greyed out)*				*Year End Delivery Confidence Assessment* 0 = Original				
			Q1	Q2	Q3	Q4	0	Q1	Q2	Q3	Q4
Continue the rollout of the Gender Awareness programme	13.1) Updates on Gender Awareness provided in Equality Annual Report Q4	ED P&C				Blue	H	H	H	H	High
Integration of Welsh Language into the wider Managers' Training Programme	13.2) Continuous programme of training Q4					Blue	H	H	H	H	High
Commence the implementation of the objectives set out in the Strategic Equality Plan	13.3) Achieve workplace certifications for Age-Friendly Employer, Disability Confident and Hate Crime Charter Q4					Amber		H	M	L	High
	13.4) Sensory loss work: deployment of assistive technologies & Sign Live Q4					Amber	H	H	M	M	High
Continue to monitor the use and uptake of Online translation to reduce costs and improve access to BSL and foreign language interpretation	13.5) Provide an update in relation to the use of online translation Q2-Q4			Green	Green	Blue	H	H	H	H	High
Begin work on the new Welsh in Healthcare Strategy including the introduction of the new Welsh Language recruitment assessment system.	13.6) System designed and functionality finalised Q1		Green	Green	Green	Blue	H	H	H	H	High

Formal change request (Please tick as applicable and provide explanation below)			
Change in Scope	N/A	**Change in Timescale**	N/A
Executive Director Sign Off	Debra Wood Lawson (Executive Director of People and Culture)		

Digital First

Strategic Priority 14: Citizen centred care and support

Executive Lead - Executive Director of Allied Health Professions, Health Sciences and Digital

Intended Outcome/ Impact

- Efficient and effective digital approaches used to improved citizen centred care and support – with improved patient engagement, access and control
- Digital enables patients and service users to take an active part in their own health & wellbeing
- Greater communication at all points of access and delivery in a rural healthcare system

Commentary on Progress in this Quarter:

- **14.2)** We have been engaged with the NHS Wales app team to work with them in prioritising cross border pathways, however there more to do in facilitating wider uptake from GP Clusters to register patients in Powys on the NHS Wales App
- **14.3)** Virtual Consultation has completed with an award directed to Attend Anywhere to ensure Business Continuity.

Commentary on red rated actions:

- **14.1)** Due to the supplier not meeting the cyber assurance requirements for the patient portal, we can not proceed and will seek to look at an alternative supplier/solution

Progress against key actions and milestones

Key Areas of Delivery	*Key Deliverables*	*Lead Executive*	*BRAG ('not due' already greyed out)*				*Year End Delivery Confidence Assessment 0 = Original*				
			Q1	**Q2**	**Q3**	**Q4**	**0**	**Q1**	**Q2**	**Q3**	**Q4**
Improve awareness and access to their digital appointment	14.1) Introduce patient portal for managing appointments Q4	ED AHPHS&D				Red	H	H	L	L	Low
Improve awareness of and access to the NHS Wales App	14.2) Support the development of the NHS Wales App to include Cross Border pathway Q4					Amber	M	M	L	L	Low
Transition to an alternative virtual consultation platform	14.3) Provide a replacement virtual consultation platform across Powys Q3				Green	Blue	H	H	M	H	High

Formal change request (Please tick as applicable and provide explanation below)			
Change in Scope	N/A	**Change in Timescale**	N/A

Executive Director Sign Off	Claire Madsen (Executive Director of Allied Health Professions, Health Sciences and Digital)

Strategic Priority 15: Leadership, Partnership and Alliances

Executive Lead - Executive Director of Allied Health Professions, Health Sciences and Digital

Intended Outcome/ Impact

- Digital First supports leadership and partnership planning and decision making
- Well led Digital Teams providing excellent services and support for staff and patients, to support and improve the delivery of care
- Increased efficiency and optimisation of system use to reduce administrative and repetitive tasks

Commentary on Progress in this Quarter:

- **15.1)** the Target Operating Model was completed with the transition of the S33 ICT Schedule to PTHB. This model of IT Service and support is complete and will continue to be evaluated as part of continuous service improvement
- **15.4)** Draft Business Case complete to implement a Training Function, next steps are to take the case through IBG

Commentary on red rated actions:

- **15.2)** The Cross border programme has been escalated to Executive level, the time for completion has slipped to May 2025.
- **15.3)** Reliant on the Connected Care National Programme which is not progressing as expected. The programme is changing in scope from a Mental Health, Social Care and Community Care replacement to defining an Integrated Shared Care Record. This has created a risk for our WCCIS system, which is contracted with the supplier until 2027 however the platform will be unsupported by Microsoft in 2026

Progress against key actions and milestones

Key Areas of Delivery	*Key Deliverables*	*Lead Executive*	*BRAG ('not due' already greyed out)*				*Year End Delivery Confidence Assessment* *0 = Original*				
			Q1	Q2	Q3	Q4	0	Q1	Q2	Q3	Q4
Transition of ICT Service Support; Digital Clinical partnership with Experience Level Agreements (XLA)	15.1) Target Operating Model Implementation Q3	ED AHPHS&D			Blue	Blue	H	H	M	H	High
Continue engagement with NHS England to improve clinical cross border pathways	15.2) Improve data flows of clinical information into our All Wales architecture to support delivery of care Q2			Red	Red	Red	L	L	L	L	Low
Scope requirements for Integrated Shared Care Record	15.3) Enable front line staff to access digital clinical information across multiple disciplines Q4					Red	M	M	M	L	Low
Provide opportunities to improve Digital literacy across the HB	15.4) Upskill, train and support staff to improve confidence in using digital systems Q4					Amber	H	H	H	L	Medium

Formal change request (Please tick as applicable and provide explanation below)

Change in Scope	N/A	**Change in Timescale**	N/A
Executive Director Sign Off	Claire Madsen (Executive Director of Allied Health Professions, Health Sciences and Digital)		

Strategic Priority 16: Enabling Efficiency and effectiveness

Executive Lead - Executive Director of Allied Health Professions, Health Sciences and Digital

Intended Outcome/ Impact

- Improved efficiency and streamlining – to support decision making and delivery of safe and timely care
- Improved staff / user and patient experience; greater engagement and associated improvements in healthcare system utilisation (e.g. Reduced DNAs)
- Centralised maintenance and a reduction in the carbon footprint

Commentary on Progress in this Quarter:

- **16.2)** and **16.3)** Electronic Prescribing and Medicines Administration (EPMA) case has moved to the implementation phase following successful approval of the business case

Commentary on red rated actions:

- **16.1)** This internal work has slowed down due to conflicting priorities and waiting for the direction nationally and the application roadmap for national all
- Wales solutions
- **16.4)** This has slipped due to Digital Health and Care Wales (DHCW) and Testing activities
- **16.5)** Connected Care programme and WCCIS replacement has not progressed. There is no confirmation of WG funding, and the National Business Case has not been re-submitted following comment from key stakeholders

Progress against key actions and milestones

Key Areas of Delivery	*Key Deliverables*	*Lead Executive*	*BRAG ('not due' already greyed out)*				*Year End Delivery Confidence Assessment* *0 = Original*				
			Q1	Q2	Q3	Q4	0	Q1	Q2	Q3	Q4
Whole system application review to standardise digital	16.1) Ensuring the system gaps are fully understood to meet the needs of the health board and standardise the approach to recording Q2	ED AHPHS&D		Amber	Red	Red	M	M	M	L	Low

system access and improve efficiencies												
Complete ePMA (Electrotonic Prescribing and Medicines Administration) pre-implementation phase	16.2) Completion of a Business case to roll out (inpatient & outpatient) Q2			Blue	Blue	Blue	M	M	H	H	High
Award ePMA contract	16.3) Develop, build, test and implement the ePMA system Q4					Blue	M	M	H	M	Medium
Finalise cross border clinical records sharing project	16.4) Improve data flows of clinical information into our All Wales architecture to support delivery of care Q2			Red	Red	Red	M	M	L	L	Low
Review replacement of WCCIS	16.5) Implement a replacement community system that supports the delivery and recording of patient care Q4 (NB - Change in Timescale from Q1-Q4)		Amber	Red	Red	Red	H	M	M	L	Low
Implement print management solution	16.6) Replace and deliver new multi-functional devices across the HB Q1		Blue	Blue	Blue	Blue	H	H	H	H	High
Introduce digital clinical appointment letters	16.7) Adoption across all services using WPAS to digitally engage with patients Q4					Blue	M	M	M	L	High

Formal change request (Please tick as applicable and provide explanation below)			
Change in Scope	N/A	**Change in Timescale**	N/A

Executive Director Sign Off	Claire Madsen (Executive Director of Allied Health Professions, Health Sciences and Digital)

Strategic Priority 17: Infrastructure and security

Executive Lead - Executive Director of Allied Health Professions, Health Sciences and Digital

Intended Outcome/ Impact

- Improved reliability and supportability of digital infrastructure
- Reduce and where possible remove single points of failure in the digital estate; reduce likelihood of single component outages
- Improved cyber security posture

Commentary on Progress in this Quarter:

- **17.1)** Substantial progress has and continues to be made to upgrade core infrastructure across the Health Board
- **17.2)** The Telephony Welsh Language functionality will be configured and completed before the year end
- **17.3)** Resilience improvements are completed and will continue to be monitored
- **17.5)** This has made substantial progress and is on track for completion

Commentary on red rated actions:

- **17.4)** This could not progress due to not being able to receipt the equipment needed. This will move to FY 25/2026

Progress against key actions and milestones

Key Areas of Delivery	*Key Deliverables*	*Lead Executive*	*BRAG ('not due' already greyed out)*				*Year End Delivery Confidence Assessment* *0 = Original*				
			Q1	Q2	Q3	Q4	0	Q1	Q2	Q3	Q4
Improve network Connectivity and reliability	17.1) Upgraded core infrastructure across all areas in the Health Board Q4	ED AHPHS&D	Amber	Green	Green	Blue	M	L	M	M	Medium
Improve telephony and collaboration tools	17.2) Procure and implement new telephony system Q4		Amber	Green	Blue	Blue	M	H	H	M	High
Improve application availability and resiliency	17.3) Implement enterprise level availability technologies to support resilience across the Health Board Q2			Blue	Blue	Blue	M	L	H	H	High

Continue to improve cyber security posture	17.4) Replace and update Firewall authentication technology across the Health Board and migrate applications Q4		Red	Red	Red	Red	M	L	H	L	Low
Align and upgrade legacy operating systems	17.5) Removal of legacy and unsupported operating systems to support resilience Q3				Green	Blue	H	M	H	H	High

Formal change request (Please tick as applicable and provide explanation below)			
Change in Scope	N/A	**Change in Timescale**	N/A

Executive Director Sign Off	Claire Madsen (Executive Director of Allied Health Professions, Health Sciences and Digital)

Strategic Priority 18: Big Data and Artificial Intelligence

Executive Lead - Executive Director of Allied Health Professions, Health Sciences and Digital

Intended Outcome/ Impact

- Increased access, quality and trust in health and care data available in near real time, promoting complete transparency of data
- Data collected consistently, cutting down manual/paper processes and releasing administration time
- 'Cloud first' approach with robust, advanced and secure reporting solutions; use of Data Platform Machine Learning and predictive modelling

Commentary on Progress in this Quarter:

- **18.1)** This work is progressing well and will be ongoing as more dashboards are made available to meet the changing needs of the organisation
- **18.3)** Complete and data sets continue to transfer from Ifor to the new platform
- **18.4)** This is progressing, and needs user acceptance testing for ease of use
- **18.5)** This is scheduled to complete by the end of the FY
- **18.7)** This is being prioritised in collaboration with the clinical informatics function

Commentary on red rated actions:

- **18.6)** This has not progressed due to capacity and resource

- **18.8)** This has not progressed as expected due to resource and capacity constraints

Progress against key actions and milestones

Key Areas of Delivery	*Key Deliverables*	*Lead Executive*	*BRAG ('not due' already greyed out)*				*Year End Delivery Confidence Assessment 0 = Original*				
			Q1	Q2	Q3	Q4	0	Q1	Q2	Q3	Q4
Onboard services to new Business Intelligence platform and adopt single source of truth for data	18.1) Provide the necessary tools to allow staff to access a 'Data Self-Service' to review a single source of data Q3	ED AHPHS&D			Green	Blue	M	M	M	H	High
Creation of a Health & Care Data Platform	~~18.2) Develop and implement a secure & robust Platform Q3~~				Red		M	M	M	L	Low
Modernise data processes	18.3) Plan and deliver a data collection framework Q2			Blue	Blue	Blue	M	M	H	H	High
Introduce a Data Catalog to enable users to discover, understand, and use the data they need to make informed decisions	18.4) Create a Data Catalog that is accessible by the entire Health Board Q2			Amber	Amber	Amber	M	M	H	M	Medium
Migration of legacy reports and data processes from IFOR to the cloud	18.5) Commence transition from the IFOR Reporting platform to a cloud hosted platform Q3, Q4				Green	Blue	M	M	H	H	High
Accelerate use of Robotic Processing Automation	18.6) Plan and deliver a 'RPA Framework' and Operating Model across the HB Q4					Red	H	H	H	L	Low
Improve the accuracy, completeness, of data quality using advanced technologies and best practices	18.7) Identify required resource and approach to improve Data Quality Q4	ED AHPHS&D				Amber	H	H	H	L	Medium
Adopt Machine learning toolkit (predictive analysis on current data sets)	18.8) Design and deliver a framework to adopt Machine Learning models Q3				Red	Red	H	H	M	L	Low

Formal change request (Please tick as applicable and provide explanation below)			
Change in Scope	N/A	**Change in Timescale**	N/A

Change in Timescale

- Develop and implement a secure & robust Platform Q3 – currently on hold due to other priorities and system replacement within Powys Council Social Care Services (procurement complete and contract awarded) - will need to move to 2025/26. Change request approved at Executive Committee 22.01.2025.

Executive Director Sign Off	Claire Madsen (Executive Director of Allied Health Professions, Health Sciences and Digital)

Innovative Environments

Strategic Priority 19: Strategic Capital

Executive Lead - Associate Director of Estates, Facilities and Support Services

Intended Outcome/ Impact

- Delivery of Capital Programme enhancements to the estate including compliance improvements
- Strategic capital programme progressed to support delivery of 'A Healthy Caring Powys' and PTHB Integrated Plan / Strategic Priorities
- Programme of works to address urgent compliance risks and infrastructure improvements

Commentary on Progress in this Quarter:

- **19.1) North Powys Wellbeing Programme**: phased approach has been agreed to progress the Integrated Hub element as phase 1. Application for funding for fees to progress SOC/OBC business case submitted to IRCF. Presented at panel in February awaiting approval.
- **19.2) Llandrindod Wells Rural Regional Centre**: £3M funding obtained to undertake part of Phase 2 programme which includes replacement windows, roofs, external access improvements and refurbishment of Westdene accommodation unit. This phase of the work is on track for completion within financial year. Business case for remaining phases will be developed in 2025/26
- **19.3) Discretionary Programme / EFAB**: progressing well with largest overall programme of activity for many years but some resource gaps in Capital team.

Commentary on red rated actions: N/A

Progress against key actions and milestones

Key Areas of Delivery	*Key Deliverables*	*Lead Executive*	*BRAG ('not due' already greyed out)*				*Year End Delivery Confidence Assessment 0 = Original*				
			Q1	**Q2**	**Q3**	**Q4**	**0**	**Q1**	**Q2**	**Q3**	**Q4**
North Powys Wellbeing Programme	19.1) Outline Business Case Development for campus Q2	ADEF&SS		Amber	Amber	Amber	L	M	M	M	Medium
Llandrindod Wells Rural Regional Centre	19.2) Business Case submission in format as outlined by Welsh Government as part of endorsed Programme Business Case Q3	ADEF&SS			Amber	Amber	L	M	H	M	Medium
Discretionary Capital Programme including Estates Funding Advisory Board (EFAB), etc.	19.3) Discretionary Capital Programme (circa 25 projects) Q1-Q4	ADEF&SS	Amber	Green	Green	Blue	H	M	M	M	High
	19.4) EFAB Brecon Fire Q4	ADEF&SS				Blue	H	H	H	M	High
	19.5) EFAB Machynlleth Fire Q4	ADEF&SS				Blue	H	H	H	H	High
	19.6) Building Management Systems Ystradgynlais Q4	ADEF&SS				Amber	H	H	H	H	Medium
	19.7) Waste Compounds pan-Powys Q4	ADEF&SS				Blue	H	H	H	H	High
Development of Strategic Capital Plan, project pipeline	19.8) Health and Social Care, Integration and Rebalancing Capital Fund (IRCF); capital project programme Q2	ADEF&SS		Green	Blue	Blue	H	M	H	H	High

Formal change request (Please tick as applicable and provide explanation below)

Change in Scope	N/A	**Change in Timescale**	N/A

Change in Scope and Timescale

- **19.1)** North Powys: scope now changed to phased approach with submission of SOC/OBC for Integrated Hub / Front Door element only in Q3 2025/26. Change request approved at Executive Committee 22.01.2025.
- **19.2)** Llandrindod: Welsh Government Capital Prioritisation Process has put business case submissions on hold. Progression in year of £3M element of larger Phase 2 programme. Change request approved at Executive Committee 22.01.2025.

Executive Director Sign Off	Wayne Tannahill (Associate Director of Estates, Facilities and Support Services)

Strategic Priority 20: Estates Strategy

Executive Lead - Associate Director of Estates, Facilities and Support Services

Intended Outcome/ Impact

- Structured plan for future estate development / health and care needs

Commentary on Progress in this Quarter:

- **20.1)** Work continues to be aligned and dependant on Better Together outcomes – specific 'Site Review' task and finish group has been set up under Better Together with work ongoing and incorporating consideration of Regional Partnership Board IRCF Integrated Hubs as part of activity.

Commentary on red rated actions: N/A

Progress against key actions and milestones

Key Areas of Delivery	*Key Deliverables*	*Lead Executive*	*BRAG ('not due' already greyed out)*				*Year End Delivery Confidence Assessment 0 = Original*				
			Q1	**Q2**	**Q3**	**Q4**	**0**	**Q1**	**Q2**	**Q3**	**Q4**
Draft Estates Strategy	20.1) Estates Strategy; initial draft for review Q1	ADEF&SS	Amber	Amber	Amber	Amber	M	M	M	M	Medium

Formal change request (Please tick as applicable and provide explanation below)

Change in Scope	N/A	**Change in Timescale**	N/A

Change in Scope and Timescale

- **20.1)** Estates Strategy has interdependency on the Better Together activity which will define 'where do we want to be' in terms of the Service Strategy – the Estates Strategy will respond to this and enable change. Timeline currently uncertain. Change request approved at Executive Committee 22.01.2025.

Executive Director Sign Off	Wayne Tannahill (Associate Director of Estates, Facilities and Support Services)

Strategic Priority 21: Environmental Management and Decarbonisation

Executive Lead - Associate Director of Estates, Facilities and Support Services

Intended Outcome/ Impact

- Reduction in Carbon emissions and ambition for public sector Net Zero by 2030
- Enhancement and protection of biodiversity and development of community group activity
- Improved energy efficiency and carbon reduction

Commentary on Progress in this Quarter:

- **21.1)** Actions in response to the Climate Emergency and subsequent Decarbonisation Strategic Delivery Plan remain on track with no new Red Flags escalated by the Environment & Sustainability Group. A major refresh of the Plan and incorporation of Climate Adaptation as a priority is expected to be published by Welsh Government in Q1 25-26.
- **21.2)** Biodiversity protection and enhancement has continued to see growth largely as a result of the ability and skills of the Community Liaison Officer to develop plans, coordinate and share longer-term plans for sustainable partnership working with green spaces to create a formal referral pathway for the Health Board, with major achievements with community integration of green spaces formalised at Bro Dyfi and Bronllys hospitals.
- **21.3)** The four year-long Re:Fit programme has finally entered the Construction Phase, which is seeing large-scale £4.2M energy efficiency measures implemented through the Health Board's partner, Vital Energi. This is a major stepping stone to decarbonise the Health Board and will reduce carbon emissions, improve patient and staff comfort levels, enhance energy resilience and provide revenue savings. Programme remains on track with contract end in Q2 25-26.

Commentary on red rated actions: N/A

Progress against key actions and milestones

Key Actions	*Key Milestones*	*Lead Executive*	*BRAG ('not due' already greyed out)*	*Year End Delivery Confidence Assessment* *0 = Original*

			Q1	Q2	Q3	Q4	0	Q1	Q2	Q3	Q4
Decarbonisation	21.1) Decarbonisation Strategic Delivery Plan – actions as set out for 2024/2025 Q1-Q4	ADEF&SS	Green	Green	Green	Blue	H	H	H	H	High
Biodiversity	21.2) Enhancement and protection of biodiversity including community group engagement Q1-Q4		Green	Green	Green	Blue	H	H	H	H	High
Energy efficiency	21.3) Implementation of energy efficiency interventions pan-Powys: Re:fit programme / Invest to Save Q4					Blue	M	M	H	H	High

Formal change request (Please tick as applicable and provide explanation below)			
Change in Scope	N/A	**Change in Timescale**	N/A

Executive Director Sign Off	Wayne Tannahill (Associate Director of Estates, Facilities and Support Services)

Strategic Priority 22: Property

Executive Lead - Associate Director of Estates, Facilities and Support Services

Intended Outcome/ Impact

- Integrated Working in agile environments to maximise space efficiency

Commentary on Progress in this Quarter: N/A

Commentary on red rated actions:

- **22.1)** Detailed design and study work has been completed to identify the space requirements for a Council-led team's co-location within the building to create an Integrated Hub. Revenue-costed plans have been developed and shared with the Council leads but delay in Council approval has led to programme slipping past Q3 and subsequent Q4 deadlines. However, confidence of agreement and future creation of Integrated Hub is high for within 2025-26.

Progress against key actions and milestones													
Key Actions	*Key Milestones*	*Lead Executive*	*BRAG ('not due' already greyed out)*				*Year End Delivery Confidence Assessment 0 = Original*						
			Q1	Q2	Q3	Q4	0	Q1	Q2	Q3	Q4		
Integrated Hubs / Agile Working	22.1) Develop Spa Road, Llandrindod Wells as Integrated Hub Q3	ADEF&SS			Amber	Red	H	M	M	M	Low		

Formal change request (Please tick as applicable and provide explanation below)			
Change in Scope	N/A	**Change in Timescale**	N/A

Executive Director Sign Off	Wayne Tannahill (Associate Director of Estates, Facilities and Support Services)

Transforming in Partnership

Strategic Priority 23: Key Strategic Partnerships

Executive Leads - Executive Director of Public Health / Director of Corporate Governance / Board Secretary / Executive Director of Planning, Performance and Commissioning

Intended Outcome/ Impact

- Whole system approach to health and wellbeing to leverage benefit of collaborative working for population of Powys (and wider region as appropriate)
- Whole system value and effectiveness – best use of public purse for population
- Effective partnership governance and oversight

Commentary on Progress in this Quarter:

- **23.1)** A Partnership Assurance and Governance Framework has been developed in line with the agreed revised timeframe (development Quarter 4 and operationalisation Q1 2025/26). The Framework sets out the purpose and legislative background; a classification of statutory partnerships and "partnerships by choice" and "partnership" as a way of working. For the 14 main partnerships and Joint Committees involving PTHB it sets out for each - the partnership type, legislation and delegation, terms of reference, key subgroups, leadership (including the designated PTHB lead), budget, plan, existing assurance arrangements, reporting process and cycle, key issues. It recommends a regular highlight report to the PPPH Committee as part of operationalisation in 25/26 and a process for keeping the schedule of partnerships up to date. (In addition, the development and implementation of an Evaluation, Prioritisation and Assurance Framework for the RPB was completed in Q3 and applied to existing revenue funding - in order to help inform RPB decision making in January 2025.)

Commentary on red rated actions: N/A

Progress against key actions and milestones

Key Actions	*Key Milestones*	*Lead Executive*	*BRAG ('not due' already greyed out)*				*Year End Delivery Confidence Assessment* *0 = Original*				
			Q1	Q2	Q3	Q4	0	Q1	Q2	Q3	Q4
PTHB Partnership Assurance and Governance Framework to be developed	23.1) Framework to be developed by Q4, operationalised in Q1 of 25/26.	DCG/ ED PP&C			Red	Blue	M	M	L	L	High

Formal change request (Please tick as applicable and provide explanation below)

Change in Scope	N/A	**Change in Timescale**	N/A

Change in Timescale

23.1) Framework to be developed, agreed and operationalised Q3 – Timescale change to Q4. Change request approved at Executive Committee 22.01.2025.

Executive Director Sign Off	Helen Bushell (Director of Corporate Governance / Board Secretary) Nicola Johnson (Executive Director of Planning, Performance and Commissioning)

Powell Bethan 01/05/2025 10:03:13

Strategic Priority 24: Commissioning, Performance, Planning

Executive Lead - Executive Director of Planning, Performance and Commissioning

Intended Outcome/ Impact

- Integrated commissioning, performance and planning delivering 'A Healthy Caring Powys' and the PTHB Integrated Plan
- Effective mechanisms in place for strategic planning, commissioning assurance and performance management
- Supporting value, effectiveness, efficiency, quality and resilience of provider and commissioned services for Powys residents

Commentary on Progress in this Quarter:

- **24.3)** Portfolio of commissioning and performance activity as noted - at risk in terms of NHSW providers not delivering required RTT and cancer performance; and due to financial pressures mainly in NHSE providers and Specialised Services.

Commentary on red rated actions: N/A

Progress against key actions and milestones

Key Actions	*Key Milestones*	*Lead Executive*	*BRAG ('not due' already greyed out)*				*Year End Delivery Confidence Assessment 0 = Original*				
			Q1	**Q2**	**Q3**	**Q4**	**0**	**Q1**	**Q2**	**Q3**	**Q4**
Delivery of Annual Strategic Planning Cycle	24.1) Quarterly Reporting cycle (progress against plan and strategic change) Q1-Q3	ED PP&C	Green	Green	Green	Blue	H	H	H	H	High
	24.2) Annual Plan Review & Development Q3-Q4				Green	Blue	H	H	H	H	High
Delivery of Immediate / Short / Medium and Long Term Commissioning and Performance Work Programme	24.3) Portfolio of commissioning and performance activity as noted Q1-Q4		Green	Green	Amber	Amber	H	H	H	H	Low

Formal change request (Please tick as applicable and provide explanation below)

Change in Scope	N/A	**Change in Timescale**	N/A

Executive Director Sign Off	Nicola Johnson (Executive Director of Planning, Performance and Commissioning)

Strategic Priority 25: Governance

Executive Lead - Director of Corporate Governance / Board Secretary

Intended Outcome/ Impact

- Decisive and effective decision making supported by assurance, oversight and effective management of risks
- Appropriately skilled, trained and informed Board
- Excellent Board and Executive administration and governance advice and support

Commentary on Progress in this Quarter:

- **25.1) Board Assurance Framework** – Framework is in place, core risk element of the framework in place. Next phase of assurance dashboards in development.
- **25.2) Board and Committee plans** -delivered, all scheduled committees and Boards delivered with additional meetings also supported. Work plans fully monitored.
- **25.3)** Board Development programme fully delivered
- **25.4)** Risk Management Framework revised and approved by Board in March 2025
- **25.5)** Corporate business systems continue to mature across the team

Commentary on red rated actions: N/A

Progress against key actions and milestones

Key Actions	*Key Milestones*	*Lead Executive*	*BRAG ('not due' already greyed out)*				*Year End Delivery Confidence Assessment 0 = Original*				
			Q1	**Q2**	**Q3**	**Q4**	**0**	**Q1**	**Q2**	**Q3**	**Q4**

Board Assurance Framework	25.1) Board Assurance Framework (BAF) is an integrated part of every Board meeting Q1	DCG	Green	Green	Amber	Blue	H	H	M	M	High
Board and Committee work plans aligned to the plans Board Assurance Framework and Corporate Risk Register	25.2) Board and Committee work plans are agreed, delivered and evaluated. Q1-Q4		Green	Green	Green	Blue	H	H	H	H	High
Board Development programme that underpins the High Performing Board programme	25.3) Board development programme x6 sessions; board briefings x12 sessions Q1-Q4		Green	Green	Green	Blue	H	H	H	H	High
Review Boards Risk Management Framework further embedding effective risk management	25.4) Risk management framework reviewed and fully implemented Q4					Blue	H	H	L	M	High
Corporate business systems maximising efficiency and effectiveness	25.5) Corporate business systems clearly defined and in place Q1		Green	Green	Green	Blue	H	H	H	H	High

Formal change request (Please tick as applicable and provide explanation below)			
Change in Scope	N/A	**Change in Timescale**	N/A

Executive Director Sign Off	Helen Bushell (Director of Corporate Governance / Board Secretary)

Strategic Priority 26: Effective systems and delivery of engagement and communication

Executive Lead - Director of Corporate Governance / Board Secretary

Intended Outcome/ Impact

- Clear and effective communication and engagement between the health board and the population it serves
- Communication activity supports strategic priorities and focuses on the management of principal risks
- Increased coherency across partners with a shared approach to public voice and insight to drive positive change

Commentary on Progress in this Quarter:

Whilst recognising that the key actions within this ongoing objective relate to ongoing programmes of engagement, communication, and co-production, the specific actions identified for 2024/2025 are on schedule and work is under way to develop the priority programme for 2025/26. The focus of work has remained under ongoing review and reprioritisation particularly to reflect emerging requirement relating to the development of the future shape of safe and sustainable health services.

- Focus support for the consideration of potential areas of in-year cost improvement including in relation to the potential waiting list measures which were subsequently discounted at a meeting in public of the Board in January 2025.
- Continued engagement and communication support for temporary service changes implemented during Q3.
- Establishment of a new co-production journey tracker through the Powys Engagement and Insight Network (a joint sub-group of the Public Services Board and Regional Partnership Board) as well as prepatory work towards the Q3 and Q4 People and Communities Insight Report.
- Promotion of flu and COVID vaccination has continued to be a key focus during Q4, alongside wider winter response. Further adverse weather events have required significant reactive comms support to reduce risk and impact for the organisation and for communities.
- Planning and delivery of the Better Together programme including delivery of a focused phase of staff engagement during February & March 2025, and planning towards a phase of patient, public and stakeholder engagement expected early in Q1 2025/26 to help shape the future of safe, quality health services for Powys.
- Launch of the 2025 Staff Excellence Awards Commentary on red rated actions

Commentary on red rated actions: N/A

Progress against key actions and milestones

Key Actions	*Key Milestones*	*Lead Executive*	*BRAG ('not due' already greyed out)*				*Year End Delivery Confidence Assessment* *0 = Original*				
			Q1	Q2	Q3	Q4	0	Q1	Q2	Q3	Q4
Design and delivery of a programme of marketing and communication	26.1) Design and deliver annual programme of communication and marketing activity focusing on those issues offer the most strategic benefit and management of principal risks Q1-Q4	DCG	Green	Green	Green	Blue	H	H	H	H	High
Design and delivery of a programme of continuous and targeted engagement	26.2) Design and deliver compliant programmes of engagement and/or consultation reflecting the requirements of the health board (e.g. Better Together), local partnerships (e.g. Sustainable Powys), regional programmes (e.g. cross-border / commissioning changes)		Amber	Green	Green	Blue	H	H	H	H	High

	and national programmes (e.g. all-Wales and specialised services). Q1-Q4										
Delivery of shared PSB/RPB Engagement and Participation Plan priorities	26.3) Design and deliver a shared approach to coproduction across public sector partners in the Regional Partnership Board and Public Services Board Q1-Q4		Green	Green	Green	Blue	H	H	H	H	High

Formal change request (Please tick as applicable and provide explanation below)			
Change in Scope	N/A	**Change in Timescale**	N/A

Executive Director Sign Off	Helen Bushell (Director of Corporate Governance / Board Secretary)

Strategic Priority 27: Quality and Safety

Executive Lead - Executive Director of Nursing, Quality, Women and Family Health

Intended Outcome/ Impact

- Delivery of Quality care that meets the needs of the Powys population
- A mature and effective approach to quality embedded throughout the organisation

Commentary on Progress in this Quarter:

- **27.1)** The IQR and IQPD reporting framework provides updates on the progress and implementation of the Duty of Quality, this is in readiness for the updated regulation expected late 2025, a scoping exercise is underway to establish the impact this will have PTHB Corporate Q&S Services.
- Patient stories agenda has progressed with resource to recruit to a Patient Experience Lead and to implement the new Peoples Experience Framework.

Commentary on red rated actions: N/A

Progress against key actions and milestones

Key Actions	*Key Milestones*	*Lead Executive*	*BRAG ('not due' already greyed out)*				*Year End Delivery Confidence Assessment* *0 = Original*				
			Q1	**Q2**	**Q3**	**Q4**	**0**	**Q1**	**Q2**	**Q3**	**Q4**
Year 2 Maturity Plan (building on Year 1 of Duty of Quality and Candour Implementation Plan)	27.1) Duty of Quality and Candour Maturity Plan Q1-Q4	ED NQW&FH	Green	Green	Green	Blue	H	H	H	H	High

Formal change request (Please tick as applicable and provide explanation below)			
Change in Scope	N/A	**Change in Timescale**	N/A

Executive Director Sign Off	Claire Roche (Executive Director of Nursing, Quality, Women and Family Health)

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 5.5

Delivery and Performance Committee	**Date: 01 May 2025**
Subject:	**Health & Safety Q4/Annual Report 2024-25**
Approved and presented by:	Debra Wood-Lawson, Executive Director People & Culture
Prepared by:	Deputy Director People & Culture Senior Health & Safety Officer
Other Committees and meetings considered at:	Executive Committee – 23 April 2025 who supported the paper.

PURPOSE:

The Annual Health and Safety report presents a comprehensive overview of performance during Quarter 4, alongside a full-year summary covering the financial period from 1 April 2024 to 31 March 2025.

The purpose of this report is to provide the Delivery and Performance Committee with assurance on the Health Board's compliance with statutory health and safety requirements. It also highlights key are of performance, areas for improvement, and summarises the key activities and progress made throughout the year.

RECOMMENDATION(S):

The Delivery and Performance Committee is asked to:

- **CONSIDER** the content within the report and to **REVIEW** for the purposes of **ASSURANCE** the performance, training and incident information and where appropriate, any further actions required.
- **ENDORSE** the report to be submitted to the Board in May 2025.

Take Assurance	Discuss	Note
Y	Y	N

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	Y	The continued investment in H&S across the health board and training of staff, is critical to ensuring a proactive approach and positive H&S culture, and ultimately the safety and wellbeing of its employees.
2. Provide Early Help and Support	Y	
3. Tackle the Big Four	N	
4. Enable Joined up Care	N	

5. Develop Workforce Futures	Y	
6. Promote Innovative Environments	Y	
7. Put Digital First	N	
8. Transforming in Partnership	N	

EXECUTIVE SUMMARY:

This report presents a detailed update on Health and Safety performance for Quarter 4 and provides a year-end overview for the financial year 2024/2025. It outlines key trends and developments in accident and incident reporting, highlights areas of significant risk, and provides an update on training compliance and delivery. The report also reflects on the progress made in implementing internal audit recommendations and enhancing governance arrangements across the Health Board.

Governance and Policy Development

Significant progress has been achieved in response to the findings of the Internal Audit review, which concluded with an overall assurance rating of *Reasonable*. Actions to address the audit recommendations have been effectively progressed, demonstrating a strengthened commitment to continuous improvement and robust governance in Health and Safety.

All Health and Safety policies remain current, reflecting the Health Board's proactive approach to policy management. In addition, a comprehensive review of the Corporate Health and Safety Policy is currently underway. This review aims to ensure continued alignment with best practice and health board needs. The revised policy is scheduled for completion and formal approval in Quarter 1 of 2025/2026, alongside updated Terms of Reference and membership proposals for the Health and Safety Group. As part of wider governance reforms, the Group will be formally established as a sub-committee of the Executive Committee, enhancing its visibility and strategic oversight.

Accident and Incident Reporting

During 2024/2025, there has been a slight increase in the number of RIDDOR-reportable incidents compared to the previous year. However, analysis indicates no recurring underlying causes, and importantly, no enforcement action has been taken by the Health and Safety Executive (HSE). This suggests that while incidents have occurred, they have been appropriately managed, with effective responses in place.

Similarly, there has been a modest rise in the total number of reported accidents and incidents across the health board. Despite this increase, overall figures remain relatively low and consistent with previous years, indicating a stable risk profile across the Health Board.

Violence and Aggression

One area of heightened concern during the reporting period has been the increase in incidents which fall under violence and aggression. A total of 70 more incidents were reported compared to 2023/2024, with the majority of the increase linked to cases of inappropriate behaviour and verbal assault, such as swearing or threatening language. While this trend is concerning and underscores the continued importance of protecting

staff, it is reassuring that the number of incidents involving physical assault (i.e., physical contact) has decreased by 21% compared to the previous year.

Efforts to address this challenge are ongoing. The Prevention and Management of Violence and Aggression (PMVA) Adviser is actively rolling out targeted training on de-escalation techniques and personal safety. These sessions are designed to support staff in managing challenging behaviours and reducing the frequency and severity of incidents. The reduction in physical assaults suggests early signs of impact, and this remains a strategic priority for the Health Board moving forward.

Training Delivery and Compliance
Training compliance across core Health and Safety subjects has remained relatively stable throughout the year. There have been slight, but encouraging, improvements in manual handling training rates, reflecting positive engagement from services and staff. However, there has been a slight decline in compliance levels for PMVA training, particularly in relation to Module D. To address this, a programme of targeted engagement and support will be rolled out during 2025/2026, working closely with service areas to monitor compliance levels and provide additional opportunities for staff to complete mandatory training. The Health Board remains committed to ensuring that all staff are equipped with the necessary skills and knowledge to work safely and confidently in their respective environments.

As part of the review of the corporate Health and Safety policy a risk-based approach is being adopted to identify those supervisors/managers who should form part of a wider training offer for managers.

ASSESSMENT & CURRENT SITUATION:

<u>Internal Audit</u>:
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 health and safety training as 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.

Reasonable 	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

It is expected that following the review and approval of the health board's corporate H&S policy HSP-001, which is currently in progress, all outstanding items from the 2023 Audit will have been completed, this includes the items below:

Health and Safety Governance:
Health and Safety Governance and reporting streams are currently being reviewed and discussed by Senior Management from Corporate Governance, People and Culture and Estates. This is to ensure where responsibilities sit within other departments, these are aligned and report through the correct mechanisms and committees for scrutiny. Once agreed, this will be included in the reviewed and updated Health and Safety Policy.

Standard Operating Procedures (SOP) & Other Procedures / Guidance:
In the last 12 months the H&S team have developed and implemented and SOP for the Reporting of Injuries, Diseases and Danger Occurrences Regulations 2013 (RIDDOR). This document is designed to assist and guide Managers and Supervisors in

identifying and understanding the types of incidents need to be reported to the HSE in line with the Regulations.

Policies

The current H&S policy position is as follows:

Number	Policy Title	Status
PTHB- HSP001	Health & Safety Policy	Under Review
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 Persons and New Mothers Policy	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 - HSP018	First Aid at Work Policy	Current
PTHB - HSP025	Personal Protective Equipment Policy	Current

All H&S policies were updated in Q2 of 2024/25 to reflect the changes in portfolio and structure that have taken place in the last twelve months. Which involved the Health and Safety team moving from the Support Services Directorate to the People and Culture Directorate.

Policies due for their 3-year review and updated in 2024/25, included:

- HSP008 – The Management of Contractors Policy
- HSP018 – First Aid at Work Policy
- HSP001 – The health baord's Health and Safety Policy

Both the Management of Contractors (HSP008) and First Aid at Work (HSP018) policies have been reviewed, revised and approved at HSG. These are now live via both the corporate policy pages and H&S pages of the intranet.
The main Health and Safety Policy (HSP001) is still under review. This is due to the outstanding audit items identified above which have taken time to resolve and also to encompass the new Terms of Reference of the Health and Safey Group.

Health and Safety Executive Activity

The Health and Safety Executive (HSE) aim to influence change and help health boards manage risks at work. This includes:

- 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.

The Current Enforcement Record for PTHB since 2019

Type of HSE Enforcement Action	2019	2020	2021	2022	2023	2024/25 Q1	2024/25 Q2	2024/25 Q3	2024/25 Q4
Prosecution									
Prohibition Notice									
Improvement Notice									
Fee for Intervention (FFI)									

There has been no enforcement action by the Health and Safety Executive in the financial year 2024/25.

Previous Interventions by the HSE.

HSE Interventions	Reason
2019	HSE Letter of Contravention in relation to the prevention and management of violence & aggression and Manual Handling. This resulted in Fee for Intervention (FFI).

2019	HSE Improvement Notices associated with Legionella. This resulted in Fee for Intervention (FFI).
2021	HSE Improvement Notices associated with Hand Arm Vibration (HAVS). This resulted in Fee for Intervention (FFI).
2022	PTHB Prosecution by the HSE in relation to Hand Arm Vibration.

Ionising Radiation

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 annual update from the Radiation Lead is as follows:

A combined briefing summarizing the key points from both the Radiography Service Exception Report (Q4 2025) and the RPC Executive Annual Report (2024), focusing on the 12-month period leading into Q1 2025:

1. Capital Equipment Replacement:

- £1.7 million programme to replace digital X-ray equipment has progressed significantly.
    - Phase 1 (Welshpool, Llandrindod, Ystradgynlais) completed.
    - Phase 2 to complete early 2025; Brecon is the final site, set to go live 24th April 2025.
- All new equipment is IRMER compliant and underwent critical examination by Medical Physics before going live.
- Standardised QA programmes for new machines have been drafted; final ratification expected 17th April 2025.

2. Radiation Incidents & Risk Management:

- Six radiation-related Datix incidents were recorded in Q4 2025; two were formally reportable to Medical Physics:
    - Common issues: wrong patient ID, decontamination lapse, wrong laterality, and repeated exposure.
    - None exceeded radiation dose thresholds; all were contained and reviewed with learning reflections and team discussions.

- A reportable incident in Brecon (Oct 2024) was escalated to HIW but deemed not clinically significant. Awaiting formal closure confirmation from HIW.

3. Compliance & Training:

- IRMER updates being integrated:
    - RAD 004 is being rewritten to reflect the Oct 2024 IRMER update.
- All staff have undergone application training on the new equipment.
- Annual entitlement to refer under IRMER confirmed for NMRs.
- Safety documentation and H&S files are current.
- Radiation safety training and RPS updates delivered (Oct–Nov 2024); now included in the Electronic Staff Record (ESR).

4. RPA & QA Monitoring:

- Regular QA testing and equipment audits carried out:
    - Dose audits flagged some imaging for further review; suggested local Diagnostic Reference Levels (DRLs).
    - Environmental radiation monitoring across all sites showed no safety concerns.
    - QC strategies pending for new ultrasound and image reporting workstations (Welshpool/Cardiology).

5. Radon Monitoring:

- All PTHB sites remain under the 300 Bq/m3 safety limit.
- A 5-year maintenance contract with RPW Radon Wales is active.
- Estates teams received training; Knighton Hospital may need future mitigation depending on usage.

6. PACS/RIS Implementation:

- Scheduled go-live: April 2025.
- Risk: Philips will not migrate 3 years of historical data.
    - Workaround: 18-month migration under review to maintain continuity of care.

7. Governance & Risks:

- 12 risks managed locally; five were escalated, most now resolved.
    - Ongoing issue: obstetric ultrasound staffing.

- SOPs for consent, clinical audits, and QA ratified and stored centrally on SharePoint.

Next Steps & Actions (as of early 2025)

- Ratify QA standardisation and RAD 004 update.
- Complete installation and compliance approval of final radiography sites (Brecon, Newtown).
- Address historical data gap for PACS/RIS.
- Continue staff training and monitor radon levels and imaging dose compliance.

Asbestos

Given the age and historical development of the Powys Teaching Health Board estate, asbestos-containing materials (ACMs) are present across a number of our buildings and facilities. The management of asbestos compliance is overseen by the Estates team, with dedicated responsibility held by the appointed Asbestos Manager.

Compliance is monitored through established procedures and is reported annually to the Board via the Innovative Environment Group. This is done through the formal submission of the Annual Asbestos Report, which outlines key findings, actions taken, and the current status of asbestos management across the estate. A copy of the most recent report is included as **Appendix 1** for reference.

Work-Related Stress

To proactively support staff wellbeing, the Health and Safety team has implemented a comprehensive **Stress Management Policy (HSP-011)**, which is complemented by a practical **Stress Management and Wellbeing Toolkit**. These resources, along with additional guidance and information, are readily accessible through the Health and Safety intranet site. Ongoing support is also available via the **Occupational Health Department** and the **People and Culture Directorate**.

During the year, the People and Culture Directorate undertook a detailed analysis of workforce absence data to identify any patterns or areas requiring additional interventions related to stress. The findings were presented to both the **Executive Committee** and the **Health and Safety Group**. While stress, anxiety, and depression continue to be the leading reasons recorded in ESR for staff absence, the review did not reveal any significant trends or hotspots requiring action beyond the current support measures in place.

Accidents and Incidents

The data is taken from the Once for Wales - Datix system and can be subject to change where the reporting of accidents and incidents is delayed.

For Note - The slips trips and falls being reported within this report do not include patients falls which are reviewed by a patient fall group.

General Incidents/Accident Data - Q4 January - March 2025

		Jan 2025	Feb 2025	Mar 2025	Total
Accident, Injury	Burns or scalds	0	1	0	1
	Contact with needles or medical sharps	0	0	2	2
	Contact with object or animal	1	0	2	3
	Contact with or exposure to hazardous substance	1	0	0	1
	Entrapment / Drawn in	0	0	0	0
	Manual Handling - Non patient/service user handling	2	0	1	3
	Manual Handling - Patient/service user handling	4	1	1	6
	Patient injury	0	0	0	0
	Road traffic collision	0	0	0	0
	Slip, trip or fall	4	1	1	6
	Struck against or by an object	2	1	1	4
	Total	14	4	8	26
Equipment, Devices	Manual Handling - Equipment	0	0	0	0
	Manual Handling - Patient/service user handling	0	0	0	0
	Medical devices	0	1	0	1
	Non-medical equipment	1	2	2	5
	Total	1	3	2	9
Total		15	7	10	32

General Incidents/Accident Data - Q4 Trends and Themes

There has been a very slight increase in accidents and incidents in Q4 compared to those reported in Q3. A total of 28 or were reported in Q3 and 32 have been reported in Q4, an increase of 4 incidents. These numbers remain generally low with a total of 60 reported the last two quarters, in comparison to Q1 and Q2 there were a total of 59 accidents and incidents were reported, a difference of one.

The top four categories in Q4 include:

- Slips, trips and falls (6)
- Manual handling – patient and service user handling (6)
- Non-medical equipment (5)
- Struck against or by and object (4)

Slips, trips and falls – this category continues to be in the top reported categories each quarter, increasing from five reported in Q3 to six reported in Q4. None of the six in this period were reportable to the HSE. The slips, trips and falls are the result of various factors, including:

- Community Nursing – An employee was returning to their car when they slipped and fell on the drive injuring their back, head and arm.

- Community Nursing – An employee slipped on a lose brick on the exterior steps causing a sprained ankle and grazing to the wrist.

- Community Nursing – An employee at leg club while delivering care tripped on the lino causing them to fall onto their left knee and then land on their coccyx.

- Brecon Hospital – An employee was carrying notes while ascending a staircase, tripped causing the employee to fall, injuring their head, elbow and leg.

- Newtown Hospital – Employee tripped due to defective carpet under their desk, this defect has been reported on several occasions since 2018, and no action has been taken to address the situation. The office was re-arranged so the defect wasn't in an accessible position then it was moved back to the original configuration again posing a hazard to the workstation user.

- Bronllys Hospital – Trip and fall on level surface, due to hole hidden under the grass being walked on to visit the electrical switch room.

Manual handling – patient and service user handling – In Q4 the following patient and service user handling incidents were reported:

- Llandrindod Hospital (Theatre) – Employee aggravated an existing knee condition when manoeuvring a wheelchair with patient.

- Llandrindod Hospital – While assisting to move a patient the employee injured their back.

- Brecon Hospital (Therapies) – While assisting with the transferring and exercising of a patient aggravated and existing back condition.

- Brecon Hospital – Employee experienced pain of the neck, shoulders and lumber spine after delivering care to a bariatric patient, on a defective bed that could not be raised.

- Community – Employee while delivering care in the community injured their lower back.

- Bronllys Hospital – Employee assisted a patient to the floor who suddenly fell and then had to support the patient on the floor for some time while waiting for assistance, this resulted in them aggravating an existing back condition. This incident was reported to the HSE as an over 7-day injury.

General Incidents/Accident Data - Year 1st April 2024 - 31st March 2025.

		Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Total
Accident, Injury	Burns or scalds	0	0	1	2	0	0	1	0	1	0	1	0	6
	Contact with needles or medical sharps	0	0	2	2	0	0	1	2	1	0	0	2	10
	Contact with object or animal	2	0	1	1	1	0	2	1	1	1	0	2	12
	Contact with or exposure to hazardous substance	0	1	0	1	0	0	0	0	0	1	0	0	3
	Entrapment / Drawn in	0	0	0	0	0	0	0	0	0	0	0	0	0
	Manual Handling - Non patient/service user handling	0	0	0	1	2	0	0	2	0	2	0	1	8
	Manual Handling - Patient/service user handling	2	0	0	1	1	1	2	0	0	4	1	1	13
	Patient injury	0	0	0	0	0	0	0	0	0	0	0	0	0
	Road traffic collision	1	0	0	0	0	1	1	0	2	0	0	0	5
	Slip, trip or fall	3	2	1	6	2	2	2	2	1	4	1	1	27
	Struck against or by an object	0	2	1	0	0	0	1	2	1	2	1	1	11
	Total	8	5	6	14	6	4	10	9	7	14	4	8	95
Equipment/ Devices	Manual Handling – Equipment	0	0	0	0	0	0	0	0	0	0	0	0	0
	Manual Handling - Patient/service user handling	0	0	1	0	0	0	0	0	0	0	0	0	1
	Medical devices	1	0	1	0	2	0	0	0	2	0	1	0	7
	Non-medical equipment	3	0	2	1	0	4	0	1	0	1	2	2	16
	Total	4	0	4	1	2	4	0	1	2	1	3	2	24
Total		12	5	10	15	8	8	10	10	9	15	7	10	119

Annual Trends and Themes from the Accident and Incident data

In the last 12-months a total of 119 reported general accidents and incidents were reported across the health board. This compared to the year 2023/24 where there was a total of 109 is an increase in 10 reported general accidents and incidents.

The top five categories over the last twelve months are as follows:

- Slips, Trips and Falls – 27, which is an increase of 8 incidents on the previous year.
- Manual Handling (patient/service user) – 13, which is an increase of 4 incidents on the previous year.
- Contact with Object or Animal – 12, which is an increase of 3 incidents on the previous year.
- Struck Against or by and Object – 11, which is a reduction of 2 incidents on the previous year.
- Non-medical Equipment -16, which is a reduction of 2 incidents on the previous year.

V&A Incident Data Q4 January – March 2025

	Jan	Feb	March	Total
Abduction	0	0	0	0
Absconding or missing patient/service user	1	4	2	7
Aggressive/threatening behaviour	7	7	5	19
Anti-social behaviour	0	1	0	1
Equality and diversity policy / guidelines	0	0	0	0
Harassment	0	0	0	0
Inappropriate behaviour / attitude	2	2	8	12
Inappropriate use of social media	0	0	0	0
Indecent exposure	0	0	0	0
Patient clinically challenging behaviour	0	0	0	0
Physical assault (physical contact)	8	3	6	17
Privacy and dignity for the patient	0	0	0	0
Protest	0	0	0	0
Restrictive practices	4	2	8	14
Self-harm / self-injurious behaviour	6	5	3	14
Sexual (inappropriate) behaviour	2	2	0	4
Sexual assault	0	0	0	0
Smoking	0	0	1	1
Verbal assault (gender/sexual orientation)	0	0	1	1
Verbal assault (racial abuse)	1	0	1	2
Verbal assault (swearing etc.)	0	1	1	2
Total	**31**	**27**	**36**	**94**

Data shows that Q4 saw a slight reduction across most categories in overall reporting of incidents compared to the 3 previous quarters. Although overall numbers reduced there were no discernible changes in the pattern for the categories where incidents were occurring.

Aggressive/Threating Behaviour remains the highest reported category accounting for 20% of overall reported incidents. However, there was a reduction of 41% in the actual number of incidents of Aggressive/threating behaviour reported compared to Q3.

Physical assault also saw lower reporting numbers compared to Q3 and follows the overall reduction in the number of incidents reported for this category across the year.

V&A Incident Data - Financial Year 1st April 2024 - 31st March 2025.

For the year 2024/25 - **477** Reports were made under the category of Behaviour (including Violence and Aggression).

	Apr 2	May 2	Jun 2	Jul 2	Aug 2	Sep 2	Oct 2	Nov 2	Dec 2	Jan 2	Feb	Mar	Total	23/24
Abduction	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Absconding or missing patient/service	3	3	2	1	5	2	3	1	4	1	4	2	31	13
Aggressive/threatening behaviour	13	16	10	12	11	8	12	14	6	7	7	5	121	117
Anti social behaviour	1	0	2	1	0	0	2	0	1	0	1	0	8	11
Equality and diversity policy / guidelin	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Harassment	0	1	2	0	4	2	4	0	2	0	0	0	15	4
Inappropriate behaviour / attitude	6	3	5	8	9	5	9	8	8	2	2	8	73	36
Inappropriate use of social media	0	0	0	0	0	1	0	1	1	0	0	0	3	2
Indecent exposure	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Patient clinically challenging behaviou	0	1	0	3	3	0	0	0	1	0	0	0	8	14
Physical assault (physical contact)	5	2	3	6	4	13	6	9	10	8	3	6	75	94
Privacy and dignity for the patient	0	0	0	0	0	0	1	0	0	0	0	0	1	0
Protest	0	0	0	0	0	0	1	0	0	0	0	0	1	0
Restrictive practices	3	4	12	3	5	1	3	3	2	4	2	8	50	54
Self-harm / self-injurious behaviour	1	2	2	1	2	1	5	8	15	6	5	3	51	43
Sexual (inappropriate) behaviour	0	0	0	0	1	0	4	0	0	2	2	0	9	4
Sexual assault	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Smoking	0	0	1	0	0	0	0	0	0	0	0	1	2	3
Verbal assault (gender/sexual orienta	0	1	0	0	0	0	0	0	0	0	0	1	2	2
Verbal assault (racial abuse)	0	0	0	0	0	0	0	1	0	1	0	1	3	3
Verbal assault (swearing etc.)	4	4	2	1	3	1	1	4	2	0	1	1	24	5
Total	36	37	41	36	47	34	51	49	52	31	27	36	477	407

In 2024/25 we saw an increase of **17.2%** (70 incidents) in the overall number of incidents reported compared to the previous year. The overall number however remain relatively low.

Increased reports were seen in the following categories:

- Absconding/missing patients – (Increase from 13 to 31)
- Harassment – (Increase from 4 to 15)
- Inappropriate behaviour / attitude (Increase from 36 to 73)
- Verbal assault (swearing) – (Increase from 5 to 24)
- Self-harm – (Small increase from 43 to 51)

Decreased reports were shown for

- Physical assault – (Decrease from 94 to 75)

The 2 categories that contain the largest number of Datix are

i) Aggressive / Threatening behaviour; and
ii) Inappropriate behaviour / attitude.

While it is pleasing to see a reduction in the numbers of physical assaults, which is likely linked to improved de-escalation techniques and distraction, many of these incidents would still be reportable as they would often include an element of intimidation, threats and verbal abuse.

Of the 31 reports of absconding / missing patients:

- 9 were from Felindre, 5 from 1 female attempting to leave through window and once escaping over the roof; others including patients failing to return.

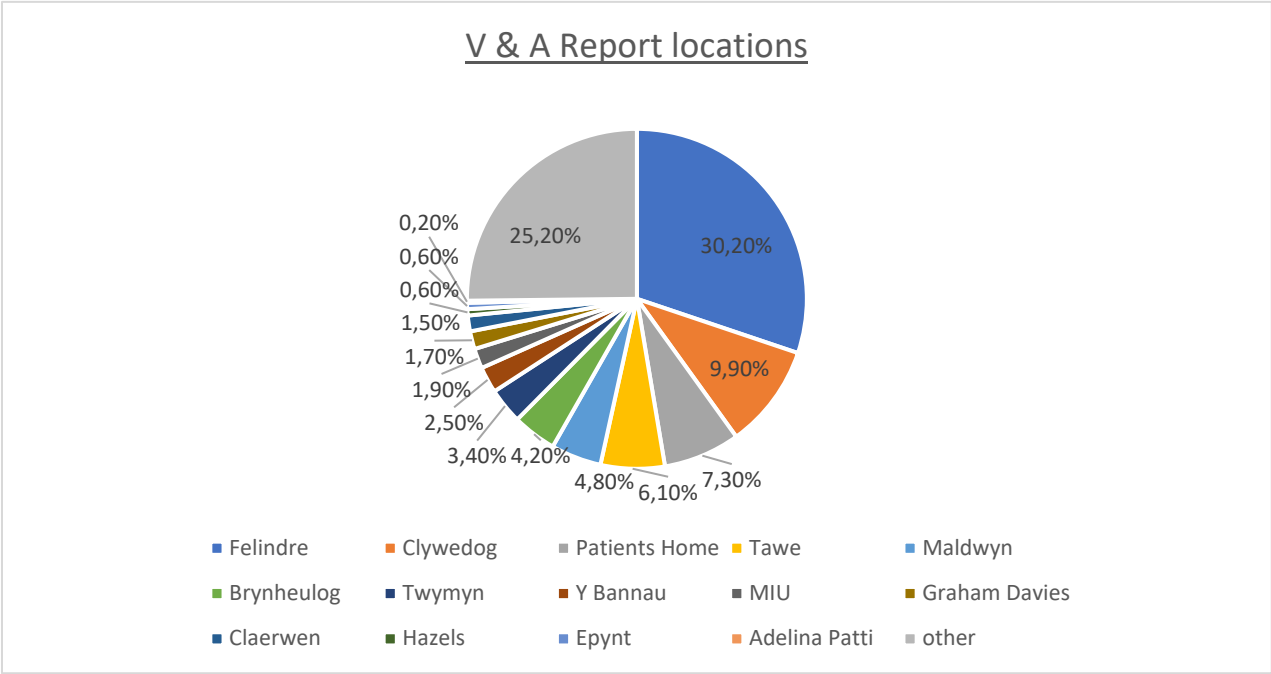
- 9 Reports were from Y Bannau where disorientated patients were using push door release and fire exits to leave, 5 reports were related to 1 male.

- Other reports including missing people who were service users but not formal patients and patients who were late returning from relative visits.

Ward	Q1	Q2	Q3	Q4	Total	%
Felindre	28	24	59	33	144	30.2%
Clywedog	3	25	14	5	47	9.9%
Patients Home	11	8	11	5	35	7.3%
Tawe	5	11	2	11	29	6.1%
Maldwyn	10	2	7	4	23	4.8%
Brynheulog	8	5	3	4	20	4.2%
Twymyn	3	9	3	1	16	3.4%
Y Bannau	2	6	2	2	12	2.5%
MIU	5	2	1	1	9	1.9%
Graham Davies	3	1	3	1	8	1.7%
Claerwen	3	1	3	0	7	1.5%
Hazels	0	1	0	2	3	0.6%
Epynt	3	0	0	0	3	0.6%
Adelina Patti	0	0	1	0	1	0.2%
Other	30	22	43	25	120	25.2%
Totals	**114**	**117**	**152**	**94**	**477**	

Figures have been recorded across the health board and of the 477 Datix reports made in 2024/25:

- 46% were from the 3 MH Wards
- 7% were from patient homes
- 19% were recorded from general wards
- 25% were recorded from unspecified areas which may be related to wards or incorrectly recorded i.e. some Incidents reported as in site grounds have been related to Felindre patients.



Unfortunately, 25% of records were not recorded under specific locations and were recorded under:

- Outpatients
- Clinical Areas
- Non-clinical Areas
- Site grounds
- Residential/ Nursing homes

This may therefore affect some of the data.

2024/25 Data. Discrepancies

Datix Data - Unfortunately Datix records are not always accurately recorded; although category changes are often made by the V & A Advisor at monthly reviews no other data including location would be changed for example:

Of the 152 reports in Q3, 59 (38.8%) were recorded from Felindre, however manual manipulation of data shows this to have been 64 (42%) which demonstrates that some Datix reports related to Felindre may have been recorded away from the ward. 8 reports were also recorded from the Hazels however only 2 of these were recorded under that location.

** It is important that staff try to record reports under the correct location instead of non-clinical (31); clinical (26) and site grounds (13) which equated to 70 of the 477 reports (14.7%).

Overview

Report numbers can be largely affected by individuals on the wards, between December and February one patient on Felindre was attached to at least 25 Datix reports, they then left the ward but soon returned and a further 7 Datix reports were submitted for in March, this relates to over 20% of Felindre's reports in this year.

Violence and aggression incident data shows that violent and aggressive incidents are happening across the health board and are not just related to MH inpatient wards. Data has identified that 7% of incidents have occurred in patient homes, where staff are often attending as lone workers and 19% recorded from general wards where currently staff only receive E-Learning training.

Going forward it is important that Datix reports are checked before submission, to ensure that categories and locations are correct, so data is accurate. It is also important that services and wards undertake a V&A training needs analysis, to assess based on risk the levels of PMVA training their staff require, to ensure we can better equip our employees to safely deal with these types of situations where they manifest themselves.

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)

RIDDOR Incidents Reported by Category

RIDDOR Category	2019	2020	2021	2022	2023	2024 Q1	2024 Q2	2024 Q3	2024 Q4	Total
Specified Injury			1	3	1		1			6
Specified Injury (Public)		1		2			3			6
Over 7-day Injury	4	2	7	4	5	3		2	1	28
Occupational Disease		4	3	3		1	1			12
Dangerous Occurrence					1	1				2
Fatality										0
Total	4	7	11	12	7	5	5	2	1	54

RIDDOR Incidents Reported by Accident Category

Accident Category	2019	2020	2021	2022	2023	2024 Q1	2024 Q2	2024 Q3	2024 Q4	Total
Slips, Trips & Falls	3	1	3	3		1	3			14
Physical Assault	1			1	3		1			6
Manual Handling		1	3	1	1	2		1	1	10
Burns / Scalds										0
Struck by Object			2	1				1		4
Struck Against		1								1
Falls From Height				2						2
Occupational Disease		4	3	3		1	1			12
Needle Stick										0
Electric Shock				1						1
Another Kind of Accident					2					2
Release of a Chemical					1	1				2
Totals	4	7	11	12	7	5	5	2	1	54

RIDDOR - Q4 and year end 2024/25

Q4 - There has only been one RIDDOR reported incident, this relates to people moving and handling – where a patient fell on the ward and during the fall was supported by a member of staff during causing a sprain to the employees back leading to an over 7-day injury. This was investigated by the line manager and advice provided by H&S.

The total number of reported incidents to the Health and Safety Executive in the year 2024/25 was thirteen. Six of which were classified as an over a 7-day injury, this is where the injured person was not able to work or carry out their role without adjustments, for a period of seven consecutive days or more following the injury. Four incidents were reported in the category of specified injury, and included three bone fractures due to slips, trips, falls and one loss of consciousness due to a slip trip or fall.

H&S - Accident / Incident Investigations

The H&S team continually provided advice and support to departments and managers during their investigations of accidents, incidents throughout the year and have undertaken one formal investigation into a RIDDOR reported accident which occurred in July 2024.

This investigation related to an incident where a member of the Estates Department slipped while cutting back foliage on a raised bank to the rear of one the hospitals. The member of staff fell onto the stationary blade of the hedge cutter they were using, resulting in a laceration to two fingers which required emergency intervention at a district general hospital and then surgery to repair tendons in one finger. A report with the findings of the investigation, long with recommendations has been issued to the Estates Department and H&S are awaiting confirmation the recommendations have been implemented. The findings of the investigation, included:

- Issues with the allocation and supervision of work activities / tasks, especially where these are of a higher risk.

- Issues where the generic risk assessments for the task did not cover the equipment being used and access to the risk assessments by the operative on-site proved to be a potential issue.

- Issues with Training and competence to undertake the task safely or in the safe use of grounds maintenance equipment.

- There was no evidence that there was a toolbox talk in place for grounds maintenance work, or the correct equipment identification, selection and safe use is demonstrated or discussed.

- The Personal Protective Equipment (PPE) toolbox talk required updating to cover the need to ensure PPE is risk assessed and to ensure it is fit for the intended purpose.

During the investigation it was also noted that the HAVS tag fitted to the hedge cutter by and external company via plastic cable tie, had been fitted at the base of the front handle. This handle is a safety cut out device, which when released by the operator immediately stops the blades from operating. The positioning and fixing of this tag had the potential for the tag to move around the handle preventing the safety cut out operating correctly. Luckily in this instance this wasn't the case, and safety cut out worked correctly, and the injured person only made contact with a stationary blade. Had the blade continued to operate the injury would have been significantly more serious.

The Estates department were advised to check all equipment and tag fitting, to ensure there were no further instances of incorrect fitting and to ensure the company who fitted the tags were made aware of their error and potential implications of their actions.

Training

During 2025/26 the following training has been delivered via the Health and Safety team, either by the in-house resource, or by external providers.

Health and Safety Training Delivered:

- 3-day IOSH Managing Safely, delivered by an external provider.
- The Level 1 Health and Safety e-learning package which is mandatory for all staff continues to be delivered via ESR.
- All new starters attend Corporate Induction which includes a section on H&S – this includes - H&S Responsibilities, V&A, Manual Handling, Fire Safety, Lone working, Driving for work, DSE assessments and Datix reporting.
- Patient Handling and Object Handling
- Manual Handling for Managers
- PMVA 4-day Foundation and 1-day refresher courses.
- Breakaway Training.
- Personal Safety & De-escalation Training.
- Med Gas training for Porters.
- Hand Arm Vibration Training.
- Face Fit testing – online presentations.

IOSH Managing Safely

Two pilot courses were run with NPTC, and although very successful with good evaluation outcomes, less than 20 employees were able to attend.

Due to the withdrawal of Welsh Government funding, any further courses that are booked with NPTC will now be charged at a rate of £185 per person, with a minimum of 8 persons per course.

As part of the review and update of the corporate Health and Safety Policy, the health and safety training requirements for employees will be reviewed and will be updated to reflect a deliverable and achievable program of training for managers, relevant to their levels of responsibility and the risks within their service.

It is recognised that given the number of managers and supervisors across the health board, it will be a significant undertaking to achieve the training identified in the policy within a short timeframe. Therefore, to ensure training is prioritised, the H&S team will be conducting risk- based a training needs analysis, specifically for health and safety training. This will allow or more structured and planned programme, with a view to achieving compliance within the 3-year term of the updated H&S Policy.

As part of this training review, the H&S team have been investigating various options for training delivery, with a view to try and reduce the impact on services, especially where staff backfilling can be challenging. One of which included utilising an in-house health and safety course, currently being developed by Cwm Taff Health Board, as an alternative to IOSH Managing Safely.

This course has been in development for around two years, and it is hoped once ready will be a more flexible option to the IOSH Managing Safely course, also with the hope in the future it can be accredited. The course is currently still not ready for launch and when it is, it will need to be assessed to ensure it is fit for the needs of PTHB.

Statutory and Mandatory Training rates for Manual Handling & PMVA.

Training compliance rates are reported through several Groups and Committees within the Health Board. The key challenge remains the same as previous years, which continues to be widely reported and this is the ability for departments to release staff to attend training, although these challenges are not supported by factual evidence or data.

The table below shows compliance for the financial year 2024/25, with an increase in compliance in 3 of the 5 categories with only a drop in compliance in both V&A categories, Module B (Online) and Module D. Module D in Q2 of the year had shown an increase of 10% on Q1, but over the twelve-month compliance in this module has dropped by 5.03%.

Competence Name	Assignment Count	Required	Achieved	Compliance %	Situation Against 2023/24
070|LOCAL|Manual Handling for Managers - No Renewal|	220	220	169	76.82%	Up 01.17%
NHS|CSTF|Moving and Handling - Level 1 - 2 Years|	855	855	755	88.30%	Up 04.89%
NHS|CSTF|Moving and Handling - Level 2 - 2 Years|	1607	1607	1275	78.22%	Up 01:03%
NHS|CSTF|Violence and Aggression (Wales) - Module B - 3 Years|	2143	2143	1976	92.21%	Down 01.20%
NHS|MAND|Violence & Aggression Module D - 1 Year|	75	75	38	76%	Up 25.33%

**** Module D performance has be under reported previously due to ESR records for 19 staff who have completed their training not being updated. This is being looked into.**

Manual Handling Training

The manual handling 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.

Moving and Handling training is currently planned and booked on a three-monthly basis. This has been reduced from booking six months in advance, to allow more flexibility to meet the demands of the health board, including delivery of training to bank staff and the new cohorts of internationally educated nurses.

People handling training can only be delivered in two venues, Llanidloes and Bronllys, where the equipment is provided in dedicated training rooms. It was hoped that this would expand in 2024 to a facility in Llandrindod, but this has not come to fruition. As has been well documented and communicated previously, due to block booking of the two dedicated training facilities, this has an impact on manual handling delivery and the available spaces that can be offered.

Going forward during the next 12 months the H&S team are going to trail the use of manual handling assessors in the workplace, a model current used by several health boards in Wales. This method would see staff being assessed within their work environment at the point of their two-year refresher, being assessed in a "live" setting

by trained workplace assessor from within their department. The assessors will be trained and supported by the Manual Handling Trainer/Advisor. With this model staff will only need to return to the classroom every 4 years for formal training, this is unless they fail their workplace assessment.

Moving to this model will potentially free up both training space availability and reduce the need for staff to leave the workplace to attend training. The trail is to take place in both the Therapies and X-ray departments in the first instance and will be evaluated over the next 12 to 24 months. If successful it will be a model that can be rolled out across the health board.

Manual Handling Course Deliver 2024/25.

Moving & Handling Course Breakdown – 1st April 2024 – 31st March 2025		
Course	**Number of courses**	**Number attended**
1 Day Refresher	50	377
2 Day Foundation	53	346
Object/Load	97	549
Managers Module G	16	66
Pool Evacuation	8	52
Totals	**224**	**1429**

Each of the manual handling courses is expected to take 8 candidates, so the offering for the financial year as identified in the table above was 224 courses, delivering 1792 training places, with an attendance of 1429, giving an overall attendance of 80%.

Prevention Management of Violence & Aggression Training (PMVA)

PMVA training is currently being delivered by Aneurin Bevan Health Board under an SLA, this includes.

- The 4-day PMVA Foundation Course
- The 1-Day PMVA Refresher Course

A one-day breakaway course along with a personal safety and de-escalation course are being delivered in-house by the PTHB V&A Trainer/Advisor, with training delivered both on-demand and via scheduled courses.

In Q4 a four-day Foundation course had to be run internally additional to the offering by ABUHB, this was due to extra demand to train bank staff.

PMVA Course Deliver 2024/25

PMVA Courses Breakdown - 1st April 2024 – 31st March 2025		
Course	**Number of courses**	**Number attended**
4 Day Foundation (ABUHB)	16	26
1 Day Refresher (ABUHB)	52	63
4 Day Foundation (PTHB)	1	8
1 Day Refresher (PTHB)	0	0
1 Day Breakaway	9	53
Personal Safety & De-escalation	14	130
Totals	**92**	**280**

Courses Delivered to PTHB by ABUHB
The PMVA course delivery by ABUHB is expected to take 3 candidates but this can vary depending on availability.

The above offering for the 12-month period included 16 four-day foundation courses with a total of 44 training places offered to PTHB and a booked attendance of 26 employees. AB are currently only charging for actual attendance.

There were also 52 one-day refresher courses run by ABUHB, with an offering of 192 training places to PTHB. The attendance of PTHB employees on these courses was 63.

Courses Delivered by PTHB
One 4-day foundation course was run internally by PTHB, utilising our internal trainer supported by an external trainer. This course was to cover a recent increase to Bank staff and for new starters. This course supported 12 training spaces of which 8 attended, an attendance rate of 67%.

PMVA Module D Compliance -
Compliance rates in relation to the Module D training course detailed above are as follows:

Of the 78 Staff listed on ESR requiring Module D PMVA Training, 57 are compliant = 73%. However, there are an additional 23 employees that have completed the training and are now compliant, including Bank staff, CAMHS, some which it is believed should be recorded on ESR as substantive ward staff. This is currently being cross referenced with ESR.

Therefore, of the 101 staff recorded as having completed Module D PMVA Training – 80 are compliant = 79.2%

Non-Compliance – There are currently 21 employees showing as not compliant, including:

- 7 from Tawe Ward
- 8 from Clywedog Ward
- 6 from Felindre Ward

These include employees currently off sick, on maternity leave or have since changed roles where PMVA is no longer required but is still showing against their ESR record. 3 members of staff did not pass their refresher course. Further work is being undertaken in consultation with the staff members and their trade unions to consider options including redeployment to roles where PMVA is not required.

Breakaway training
Breakaway training is run internally with 9 courses were run in the twelve-month period, an offering of 72 spaces (8 per course) and 53 employees attending, an attendance rate of 74%.

Personal Safety & De-escalation Training
This course is run internally with 14 courses being run in the last twelve months, and 130 places available and 130 employees attending, and attendance rate of 100%

Hand Arm Vibration Training
In line with the health board's HAVS Policy and training strategy, the following training was delivered during the last financial year:

Level 3 HAVS Awareness Training –
The level 3 training is delivered by the H&S team, either face to face or online via Teams presentation. This year staff from the works and estates department were due their 3 yearly refresher training in line with the policy and training strategy. This was delivered over several sessions in Q1 and Q2 and included several new members of staff. Level 3 training can be arranged to meet the needs and demands of the services when new employees join the health board.

Level 2 HAVS Awareness Training –
At this time there are no employees having been assessed as requiring the level 2 training. Even though the course has been created, there have been significant difficulties getting the course converted into a format to make it available on-demand via ESR. This will be revised in the next financial year to see if this can be progressed.

Level 1 HAVS Awareness Training –
This level of training is delivered by trained department HAVS Leads, via a Toolbox Talk along with the HSE Document INDG 296 and the staff requiring this training are predominantly in Support Services department. At the refresher point of April 2024 there were approximately 150 plus employees who required training across the county.

The information in the tables below has been provided by the service and demonstrate Support Services staff HAVS compliance South and North.

Compliance South

Location	Staff to Attend	Training Completed	Percentage complete
Ystradgynlais	20	16	80%
Brecon	21	15	71%
Bronllys	23	14	61%
Llandrindod Wells	33	22	67%
Totals	97	67	69%

We are advised there are a number of staff in the South on long term sick at present which is potentially resulting in lower compliance than expected. Further toolbox talks are to be run at the end of April 2025.

Compliance North

Location	Staff to Attend	Training Completed	Percentage complete
Llanidloes	17	17	100%
Newtown	16	15	94%
Machynlleth	17	14	82%
Welshpool	17	17	100%
Totals	67	63	94%

We are advised those who have not completed the training in the North are mainly new starters who are scheduled to complete this training by the end of April.

Face Fit Testing

Staff attendance at the online presentations has been sporadic and some sessions have been delivered with as few as one or two attendees. As can be seen in the table below 243 members of staff attended the 35 sessions, giving an average of attendance of 7 persons per session. Moving forward, and to try and maximise the use of the limited resources, arrangements have been made to replace the face-to-face delivery of the presentation on line, which will be recorded on ESR.

The practical testing sessions have predominantly been taking place at three hubs across the county: Llanidloes, Builth Wells and Bronllys. Testing has also been facilitated on site at four further locations, as listed in the table below.

The tables below indicate both the number of online presentations and practical testing sessions delivered in 2024/25 by the team.

Number of Online Presentations Delivered	Number of Persons Attended	Average Attendees Per Session
35	243	7

Number of Test Days	Location	Appointments Available	Appointments Used	Appointments Un-used
7	Bronllys	112	78	34
8	Builth Wells	128	61	83
9	Llanidloes	144	68	76
2	Ystradgynlais	32	22	10
1	Llandrindod Wells	16	6	10
2	Newtown	32	15	17
2	Welshpool	32	27	5
Totals				
31 Test Days	**7** Test Locations	**496** Available Appointments	**277** Appointment Used	**235** Appointments un-used

A total of 31 face fit testing days were offered during the financial year 2024/25, each of the days was able to deliver 16 test appointments, a total of 496 appointments offered, with a total of 277 appointments attended, this equates to a 56% attendance rate.

Staff who are Face fit tested have this recorded on ESR. However, there is not a comprehensive risk assessment to show who requires testing to enable compliance levels to be reported. Discussion with the Infection, Prevention and Control manager and Public Health are on-going to find a resolution to this. Notably though MIUs were identified as amongst our highest risk areas and compliance in these teams has been 100%.

Health and Safety – Corporate Web Pages

A key element of the role of the health and safety function is to communicate and support managers and local teams in understanding health and safety and raising their awareness in the subject along with their roles and responsibilities.

One of the methods deployed to do this, is through the use of the H&S team's web pages, SharePoint and Powys Announcements. With safety critical issues communicated in safety alerts.

Updates to the corporate health and safety web pages this year include sections on:

- Workplace Inspections – A guide to carrying out workplace inspections along with downloadable inspection templates.
- The Safe Use of Bedrails – Information in the safe use of bedrails.
- Shift Workers -Information for those who are carrying out shift work.
- Bullying – Information on tackling bullying and harassment in the workplace.
- A new Seven Minute Briefing – A quarterly briefing issued by the H&S team, communicating seven bite sized topical H&S messages in each edition.
- Manager and Supervisor Health and Safety Responsibilities – A comprehensive guide for managers and supervisors in relation to their health and safety responsibilities and duties.
- Department Health and Safety File Guidance – A comprehensive guide on putting together a departmental health and safety file.
- Working at Height – a guide to working at height including a video toolbox talk, along with ladder safety awareness for step ladders/extension ladders, ladder inspections and safe working from height.

Staff Side Engagement and Support

During this year staff side have undertaken various workplace inspections, but these have not been in collaboration with the H&S team. It has been recognised that when these inspections are submitted to the employer there is often little response to the findings of the report and actions go un-managed.

To address this situation, the H&S team have developed a process for the employer to manage workplace inspections conducted by staff side. In order to ensure the employer responds appropriately and where actions and recommendations are identified, these are captured, actioned, progressed and tracked to completion where required, with feedback to staff side.

A paper was tabled at the Q3 H&S Group meeting in January 2025, recommending a process for implementation, the proposal was supported and approved. Work is currently being undertaken to formalise the process and recommendations within the paper and move the process forward for implementation.

Workplace Inspections

Powys Teaching Health Board has adopted HSG65 - Managing for Health and Safety, as its H&S Management System, which involves the process of Plan, Do, Check, Act. Premises inspections are part of the "Check" section of the cycle and an active method of monitoring health and safety performance.

The H&S team have a section on the website in relation to workplace inspections and have downloadable templates for Site Co-ordinators, Department Managers and others to use.

The need to conduct inspection has been communicated at various meeting and through the web pages, but to date there has been little evidence any inspection have been undertaken, except those done by the Trade Union Reps.

The failure to undertake regular workplace safety inspections poses a significant risk to the health board. The implementation of regular workplace inspected is a proactive way in ensuring hazards are identified at the earliest opportunity, so risk mitigation can be implemented before they result in injury or harm. The H&S team will review the current process in the next financial year, to see how this can be progressed, ensuring proactive programme of workplace inspections are undertaken.

Corporate Health and Safety Risks

In the financial year 2024/2025 - There were no Health and Safety Risks for the Health and Safety team to escalate to the Health and Safety Group and Corporate Risk Register.

Risks held on local Directorate Risk Registers are reviewed by the Directorate Management teams on a regular basis and those pertaining to health and safety should be escalated to the Health and Safety Group as required for review by the service manager.

NEXT STEPS:

Looking Ahead – 2025-26

1. To finalise the review and update of the Health and Safety Policy (HSP001) and submit this policy for approval at the Q1 meeting in July 2025. This will encompass the final pieces of work currently being done in relation to:

   - Health and Safety Governance.
   - Health and Safety Training.
   - The Terms of Reference for the re-formed Health and Safety Committee.

2. To progress and update the current face fit testing booking progress and implement an online video presentation accessed and recorded on ESR. Which will also require an update of the face fit testing web page and information on the intranet. It is envisaged this will be completed in Q1/Q2.

3. Undertake a 3-yearly review and update of the following policies:

   - Stress Management Policy – to be reviewed in period Q2.
   - Manual Handling Policy – to be reviewed in period Q3.
   - Violence & Aggression Policy – to be reviewed in period Q3.

4. To begin rolling out health and safety Training in accordance with the Training needs analysis and approved H&S Policy.

5. Undertake an interim review of the new manual handling workplace assessor's project – to be reviewed in period Q4.

6. To identify and undertake audits and inspections for the financial year 2025/26 based on the health board's data and current HSE focus areas.

7. Review the current audit and inspection process and identify an electronic version – to be review in period Q4.

The H&S team continue to be committed to ensuring a positive health and safety culture is embedded across the health board. It is hoped that following the training needs analysis, targeted health and safety training will be rolled out on a risk-based approach for managers and supervisors. Attending this training will support and give them the knowledge to discharge their health and safety responsibilities in accordance with their job roles. It will also help to foster and encourage a positive safety culture across the health board**.**

Some progress has been made in trying to reduce non-attendance at both face fit testing and the various training sessions delivered by the H&S team, including Manual Handling and PMVA, but there is more work to do on this, which we will continue in the next year.

It is hoped by changing the process for face fit testing this will improve the situation significantly although there are still issues around the capacity to deliver sessions due to the limited number of testers and availability of suitable rooms to carry out the testing. It is also hoped that a move to workplace assessors for manual handling will improve the situation, although this project may take longer to achieve results.

IMPACT ASSESSMENT

This section must be completed for all strategic organisational decisions including approval of health board policies.

QUALITY:

	No impact	Negative	Positive	Both	
Safe				x	Good H&S is critical to the safe day to day running of the health board and helps to a safety culture for patients, staff and visitors.
Timely				x	
Effective				x	
Efficient				x	
Equitable				x	
Person Centred				x	
Workforce				x	
Leadership				x	
Culture				x	
Information				x	
Learn, Improve, Research				x	
Whole Systems Approach				x	

EQUALITY:

	No impact	Negative	Positive	Both
Age	x			
Disability	x			
Gender reassignment	x			
Marriage / civil partnership	x			
Pregnancy / maternity	x			
Race	x			
Religion or Belief	x			
Gender	x			
Sexual Orientation	x			
Welsh Language	x			
Socio-economic status	x			
Social exclusion	x			
Carers	x			

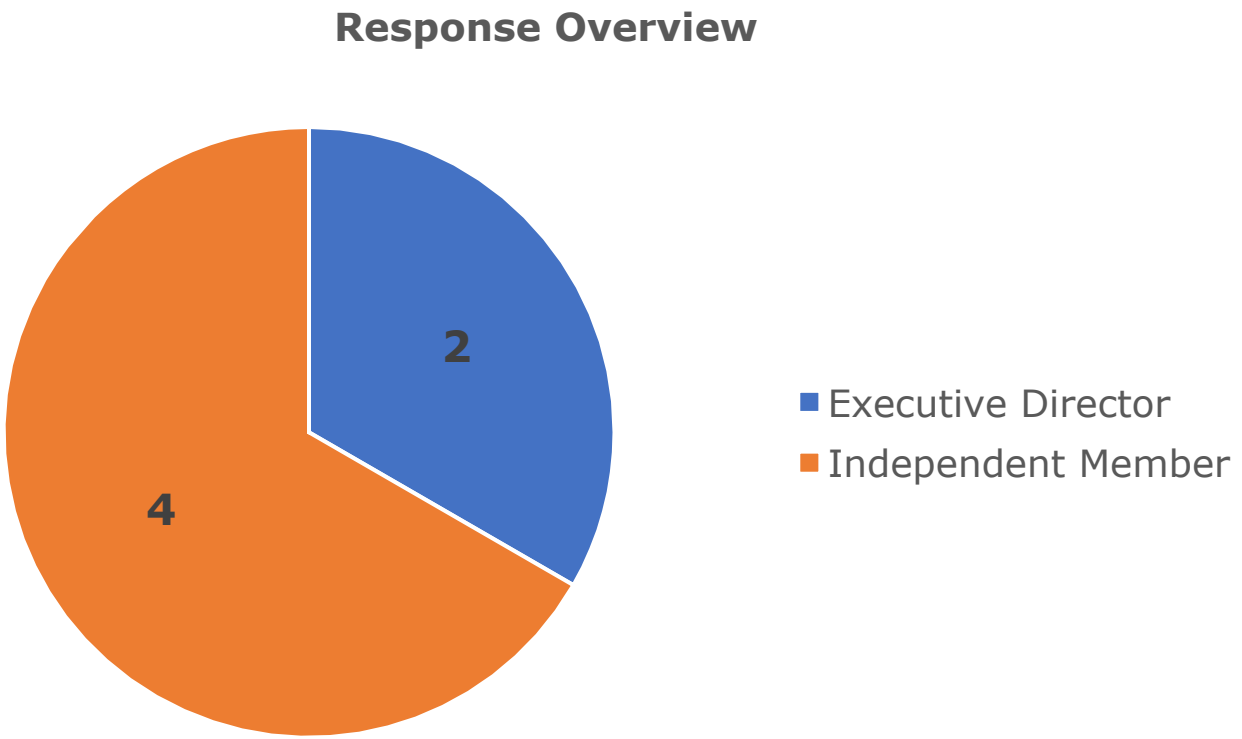
RISK ASSESSMENT:

	Level of risk identified				
	Very Low (0-3)	Low (4-8)	Moderate (9-12)	High (15-25)	
Clinical			x		A lack of H&S compliance within the health board presents a significant risk, through un-safe situations and circumstances leading to the injury to employees, visitors, patients and contractors. This in turn has a significant potential to lead to regulatory intervention by the Health and Safety Executive (HSE). This could have a significant impact, both in sanctions and fines for failing to comply with criminal law along with reputationally. There will also potentially be further financial impact where civil claims are made for injury/damage along with lost time.
Financial			x		
Corporate			x		
Operational			x		
Reputational			x		

Delivery and Performance Committee – 01 May 2025	Agenda Item: 5.7
Subject:	Committee Effectiveness – Delivery and Performance Committee
Approved and Presented by:	Helen Bushell, Director of Corporate Governance/Board Secretary
Author:	Deputy Board Secretary
Purpose:	This presentation provides a summary of the responses received to the Committee Effectiveness questionnaire 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 2024/25 contains a questionnaire followed by discussion at the Committee meeting. The Committee effectiveness questionnaire focuses on the critical themes of: (i) composition and establishment, (ii) effective functioning, (iii) assurance and (iv) leadership and culture.

Section 1 – Response Rate

Response Overview



6 responses in total, no responses from others/external colleagues regularly attending

Section 2 – Composition and Establishment

Overview of ratings 2024/25 – Composition and Establishment

Section 2 - Composition and Establishment					
Question	Strongly Agree	Agree	Unsure	Disagree	Strongly disagree
The Committee understands its role:.	**3** 50%	**3** 50%	0	0	0
The Committee's annual work plan and subsequent agendas enable it to effectively deliver the relevant areas of its Terms of Reference: .	**3** 50%	**3** 50%	0	0	0
The Committee has the membership, authority and resources to perform its role effectively: .	**5** 83.33%	**1** 16.67%	0	0	0
The right people attend meetings of the Committee to enable it to fulfil its role effectively: .	**3** 50%	**2** 33.33%	**1** 16.67%	0	0
Committee members have the collective skills and experience required to fulfil the terms of reference and advise and assure the Board.	**2** 33.33%	**4** 66.67%	0	0	0

KEY THEMES:

- **Agenda length**
- **Risk**

Comments:

- The agenda is very heavily loaded.
- The issue of risk does not feature sufficiently highly.

Section 3 – Effective Functioning

Overview of ratings – Effective Functioning

Section 3 - Effective Functioning					
Question	Strongly Agree	Agree	Sometimes	Disagree	Strongly disagree
Meeting arrangements (frequency, time allocation) allow members individually and collectively to contribute to effective scrutiny and challenge:.	**3** 50%	**2** 33.33%	**1** 16.67%	0	0
Committee meetings are conducted professionally and managed effectively with issues getting the appropriate time and attention proportionate to their importance:.	**5** 83.33%	**1** 16.67%	0	0	0
Committee papers are of a reasonable length, good quality and provide the appropriate level of information to enable the Committee to fulfil its role: .	**1** 16.67%	**3** 50%	**2** 33.33%	0	0
Papers are distributed in a timely manner, sufficient for members and attendees to adequately read, understand and scrutinise their content: .	**2** 33.33%	**3** 50%	**1** 16.67%	0	0
There is good monitoring of matters arising and agreed actions to support the Committee in its role:.	**2** 33.33%	**3** 50%	**1** 16.67%	0	0
Reports to the Board cover all key issues discussed at Committee. The Board takes due regard of the Committee's views (i.e. recommendations, escalated items, sharing of good practice) and shares feedb	**2** 33.33%	**4** 66.67%	0	0	0

KEY THEMES:

- **Committee process**
- **Effective Charing**
- **Reporting/Assurance to Board**

Comments:

- I think this committee process has improved but there is more work to be done.
- The chair is very effective in the summing up and confirmation of what has been discussed in the meetings
- Opportunities to consider issues raised in the committee at Board are limited due to Board time pressures. There are few discussions on sharing of good practice

Section 4 – Assurance

Overview of ratings – Assurance

Section 4 - Assurance					
Question	Strongly Agree	Agree	Sometimes	Disagree	Strongly disagree
The Committee receives advice and assurance on key issues which clearly sets out the analysis of the situation, key risks and what is required of the Committee to allow the Committee to discharge its	**1** 16.67%	**5** 83.33%	0	0	0
Information received is sufficiently balanced in terms of evidence (assurance) and professional opinion (reassurance):.	**1** 16.67%	**5** 83.33%	0	0	0
The Committee receives timely reports on the work of external regulatory and inspection bodies and other independent sources of assurance: .	0	**5** 83.33%	**1** 16.67%	3	3
The Committee receives regular and sufficient evidence that the organisation is learning and improving:.	0	**4** 66.67%	**2** 33.33%	0	0
The Committee receives the assurance (quantity, quality and timeliness) it needs to fulfil its role effectively:.	0	**6** 100%	0	3	3
The mechanism for providing onwards assurance to the Board is effective:.	**3** 50%	**3** 50%	0	0	0

Comments:

- May be time for a committee reset
- The process is always on going and the members provide the challenge if required

Section 5 – Leadership and Culture

Overview of ratings – Leadership and Culture (Page 1 of 2)

Section 5 - Leadership and Culture					
Question	**Strongly Agree**	**Agree**	**Sometimes/Unsure**	**Disagree**	**Strongly disagree**
In meetings, contributions from members and other attendees are encouraged, open debate is welcomed, and all contributions are listened to and respected: .	**5** 83.33%	**1** 16.67	0	0	0
The Committee environment is one in which members can provide supportive but critical challenge on key/sensitive issues:.	**5** 83.33%	**1** 16.68	0	0	0
The Chair summarises discussions well, captures the main points that have been made and clarifies how the Committee will progress the item under discussion:.	**3** 50%	**2** 33.33%	**1** 16.67%	0	0
Committee members routinely probe the facts, challenge assumptions and identify the advantages and disadvantages of proposals:	**3** 50%	**3** 50%	0	0	0

Powell Bethan
01/05/2025 10:03:13

Overview of ratings – Leadership and Culture (Page 2 of 2)

Section 5 - Leadership and Culture					
Question	**Strongly Agree**	**Agree**	**Sometimes/Unsure**	**Disagree**	**Strongly disagree**
There is an effective relationship between Committee members and Executive colleagues:.	**3** 50%	**3** 50%	0	0	0
Matters considered by the Committee are improved/strengthened as a result of the Committees involvement and/or feedback:.	**2** 33.33%	**3** 50%	**1** 16.67%	0	0
The Committee is conducted in a manner consistent with the values of PTHB:	**4** 66.67%	**2** 33.33%	0	0	0
The Committee is conducted in a manner consistent with the principles of compassionate leadership: .	**5** 83.33%	**1** 16.67	0	0	0

Summary of Comments – Leadership and Culture

- There were no comments to share for this section

Section 6 – General Comments

Comments - What areas are going well?

In what areas do you think the Committee is doing well?
• It is grappling issues in a way that it did not a year ago
• It's on going performance and understanding of the requirements of the committee
• Monitoring performance and finance. There is a clear understanding of what is driving increasing costs and the measures being taken to seek to address them. Scheduled scrutiny of individual functions (e.g Primary Care, Dental Service) works well.
• Obtaining regular assurance on the key performance issues for PtHB. The cttee culture is one of respect and constructive scrutiny
• Clear and focused
• Manages it range of content appropriately and prioritises a busy schedule appropriately

Comments – What could be Improved?

In what areas do you think the Committee could improve and how?
• The culture should be one of continuous improvement
• Occasional refresh on items that may not have been on the agenda for a while
• The papers, particularly the performance report could be more succinct. It is sometimes difficult to identify key issues in the volume of information when much of it shows little change from meeting to meeting.
• The majority of agenda items have a short-term focus in terms of current performance. More time is needed to consider longer-term strategic issues for PtHB.
• Papers across the whole HB need to be refined.
• More clearly define what we mean by 'delivery' as well as 'performance'

Comments – What training/other development activity would support the Committee in its role?

What training/other development activity would support the Committee in its role?
• External training should be offered in chairing meetings. This is not an empirical skill.
• Better insight into the dynamics of the commissioning process. Increased understanding of where the opportunities lie to improve integration between health and social care and the opportunities that creates for reducing DTOC.
• I think everything is covered through board development and briefing sessions, so I don't believe additional support is required specifically for this cttee

Comments – What areas should the Committee focus on in the future (incl. areas to be looked at more or less frequently)?

What areas should the Committee focus on in the future (incl. areas to be looked at more or less frequently)?
• Finance driven improvement
• this would be directed by the annual plan
• Commissioning performance, DTOC.
• The committee should have an increasing oversight of the Better Together programme as options for future service configuration are developed. This may be alongside the PPH committee too, but D&P has a role to play in ensuring the programme itself is performing efficiently and effectively
• More on relevant primary care matters

Any Other Comments

Please feel free to expand on your answers above or make any other comments under this heading:
• A final point would be that papers considered at Committee then often come to the full Board with little or no acknowledgement that they have already been considered in Committee. I think Board time could be used more effectively if routine performance papers were not duplicated.

Overall Summary

Overall Summary

- Scoring / ratings are strong across the survey with no negative scores
- Some specific areas to address:
  - Performance Reporting and quality/timeliness of papers overall
  - Integration of Risk
  - Consider level of focus/training on Commissioning, DTOC and Primary Care
  - Onwards reporting/assurance to the Board and reducing any duplication

Next Steps

Next Steps

Actions	Timescale
1. Share content of the Effectiveness questionnaire with Committee	1 May 2025
2. Receive feedback from the Committee, discuss any actions / improvements	1 May 2025
3. Develop action plan, in partnership with Committee Chair, for Committee oversight based on Committee survey and contributions	Next Committee meeting (26 June 2025)
4. Committee feedback and key actions will be incorporated into summary report with other Committees' feedback and shared with the Board	By end May 2025
5. Committee forward plan for 2025/26 is in development and will form part of the Committee meeting (reviewed at each meeting)	Next Committee meeting (26 June 2025)
6. PTHB Chairs Forum will continue to develop an overarching role in committee focus areas and work plans	Ongoing

Key Questions

- Does the Committee collectively recognise the feedback?
- Are there any further reflections?
- Any areas of specific focus / priority to address?

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 5.8

Delivery and Performance Committee	**Date: 01 May 2025**
Subject:	Delivery and Performance Committee Terms of Reference
Approved and presented by:	Helen Bushell, Director of Corporate Governance and Board Secretary
Prepared by:	Deputy Board Secretary
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:

- **ENDORSE** the proposed amendments to the Terms of Reference;
- **IDENTIFY** any further potential amendments;
- **COMMENT** on the options being considered with regards to financial performance;
- **AGREE** that the Chair of the Committee and Director of Corporate Governance will finalise the revised Terms of Reference for presentation to the Board in May 2025 for approval.

Approve/Take Assurance	**Discuss**	**Note**
Y	Y	

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing		Commitment to good governance is a key element of Transforming in Partnership.
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	Y	

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 (May 2024) for the Workforce and Culture Committee are attached as Appendix A, and the proposed revised draft are attached as Appendix B.

Any suggested changes will need to be recommended to the Board for approval.

The Committee is asked to discuss the draft terms of reference, identify any further suggested amendments and note that the volume of work currently considered by the Delivery and Performance Committee is recognised as significant. Work is underway to ensure clarity in regard to remit. Two options currently under active consideration to more effectively manage the Committee's workload as well as ensure the organisation appropriately responds to its escalation and intervention status are:

Option 1: The establishment of an additional Board Committee to consider Financial Delivery/Performance; and

Option 2: The continued integration of finance and performance within the Delivery and Performance Committee, with some elements of the Committee's current remit identified for transfer to another appropriate Committee of the Board.

The evaluation of these options will evolve over the coming weeks and relevant matters will be integrated into the Committee's Terms of Reference in readiness for the May Board. Any observations from the Committee with regards the options are welcome.

The Chair of the Committee and Director of Corporate Governance will take forward any recommendations and/or final amendments to the Board in May 2025 to take effect into 2025/26.

It is suggested that the Committee considers **the following proposals**:

Section of Terms of Reference	Updates
3 – Delegated Powers and Authority	Assurance in regard to the performance management of digital and information management and technology (IM&T) systems is removed, to be transferred to the Audit, Risk and Assurance Committee.

	Assurance in regard to Health and Safety arrangements for employees, patients, members of the public, volunteers, contractors etc. to be included as a holistic item, transferred from the Workforce and Culture Committee and Patient Experience, Quality and Safety Committee who previously considered Staff Health and Safety and Patient Safety respectively.
5 - Committee meetings	The modern practice of holding meetings virtually has been reflected, including clarification in regard to arrangements for in-person meetings
Tidying up	The document has undergone general tidying up to ensure correct job titles etc. are reflected

NEXT STEPS:
The Chair of the Committee and Director of Corporate Governance will take forward any recommendations to the Board in May 2025 to take effect into 2025/26.
APPENDICES
a. Delivery and Performance Committee Terms of Reference (Approved May 2024) **b.** Delivery and Performance Committee Terms of Reference (Draft March 2025)

Delivery and Performance Committee

Terms of Reference & Operating Arrangements

May 2024

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 **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;

D. 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.

E. 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 Members 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:

- Executive Director of Finance, Capital and Support Services (Joint Officer Lead)
- Executive Director of Commissioning, Performance and Planning (Joint Officer Lead)
- Executive Director of People and Culture
- Executive Director of Primary Care, Community and Mental Health
- Executive 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 Corporate Governance Team 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 six times a year, 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);
- meetings may be held virtually with opportunities extended to the public to observe meetings held virtually on request;
- 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;
- where appropriate items may be included as 'consent' items (items that do not require discussion or debate either because they are routine or have already been unanimously agreed. A Consent Agenda allows the Committee to approve all these items together without discussion which can free up the meeting for more substantial discussion. When using a

Consent Agenda, the Chair will invite members to request a discussion on any item on the Consent Agenda. If a request is made this item will move onto the Main Agenda for discussion); 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 (holding joint meetings where appropriate);
- 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

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

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.

Delivery and Performance Committee

Terms of Reference & Operating Arrangements

Draft April 2025

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.

ADVICE

2.2 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, NHS Wales Joint Commissioning Committee 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 **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;

D. Seek assurance that arrangements for the **Health and Safety** of all employees and of those who may be affected by work-related activities, such as patients, members of the public, volunteers, contractors etc. are sufficient, effective and robust

E. 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 Members 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:

- Executive Director of Finance, Capital and Support Services (Joint Officer Lead)
- Executive Director of Commissioning, Performance and Planning (Joint Officer Lead)
- Executive Director of People and Culture
- Executive Director of Primary Care, Community and Mental Health
- Executive 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 Corporate Governance Team 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 Director of Corporate Governance/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 six times a year, 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);
- meetings may be held virtually with opportunities extended to the public to observe meetings held virtually on request;
- 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;
- where appropriate items may be included as 'consent' items (items that do not require discussion or debate either because they are routine or have already been unanimously agreed. A Consent Agenda allows the Committee to approve all these items together without discussion which can free up the meeting for more substantial discussion. When using a Consent Agenda, the Chair will invite members to request a

discussion on any item on the Consent Agenda. If a request is made this item will move onto the Main Agenda for discussion); 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.

Other meeting arrangements

5.7 Committee meetings will be held via virtual means unless otherwise specified.

Should a meeting be held in person this will be confirmed in advance by the Chair and Director of Corporate Governance/Board Secretary. In-person meeting arrangements will be co-ordinated and communicated in advance by the Corporate Governance Team.

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 (holding joint meetings where appropriate);
- 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 written assurance 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 Director of Corporate Governance/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

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

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 Director of Corporate Governance/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 Director of Corporate Governance/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.

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

Agenda item: 7.1

Delivery and Performance Committee	**Date: 01 May 2025**
Subject:	**Delivery and Performance Committee Annual Report 2024/2025**
Presented & Approved by:	Director of Corporate Governance/Board Secretary
Prepared by:	Corporate Governance Business Officer
Other Committees and meetings considered at:	N/A

PURPOSE:

The purpose of this report is to provide the Delivery and Performance Committee Report for 2024/2025.

RECOMMENDATION(S):

It is recommended that the Delivery and Performance Committee:

- **CONSIDER** the Delivery and Performance Committee Annual Report for 2024/2025 summarising the key areas of business activity undertaken;
- **RECOMMEND** the report to the Board for the 21 May 2025 meeting.

Approve/Take Assurance	Discuss	Note
Y	Y	N

ALIGNMENT WITH THE HEALTH BOARD'S WELLBEING OBJECTIVES:		
1. Focus on Wellbeing	Y	
2. Provide Early Help and Support	Y	
3. Tackle the Big Four	Y	
4. Enable Joined up Care	Y	
5. Develop Workforce Futures	Y	
6. Promote Innovative Environments	Y	
7. Put Digital First	Y	

Contents

1. Introduction

The Delivery and Performance Committee has been established by the Board in order 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.

This report summarises the key areas of business activity undertaken by the Delivery and Performance Committee ('the Committee') over the past year and highlights some of the key issues which the Committee intend to give further consideration to over the next 12 months.

2. Roles and Responsibilities

The Terms of Reference for the Delivery and Performance Committee were reviewed and agreed by the Board in March 2024. The purpose of the Delivery and Performance Committee is to:

a. 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.
b. Committee will seek assurances:
    - on timely and appropriate access to health care services to achieve the best health outcomes within agreed targets, for directly provided and commissioned services;
    - 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;
    - that services are improving efficiency and productivity and financial plans are being delivered;
    - risks are suitably identified, mitigated and residual risks controlled and corrective actions are taken as required to sustain or improve performance.

The Committee will play a key role in monitoring the achievement of the Board strategic aims, objectives and priorities and will:

a. seek assurance that arrangements for financial management and financial performance are sufficient, effective and robust,
b. seek assurance that arrangements for the performance management and accountability of directly provided and commissioned services are sufficient, effective and robust,
c. assurance that arrangements for compliance with Health and Safety Regulations and Fire Safety Standards are sufficient, effective and robust,
d. assurance that arrangements for information management are sufficient, effective and robust,
e. assurance that arrangements for the performance management of digital and information management and technology (IM&T) systems are sufficient, effective and robust, and
f. assurance that performance management of capital, estates and support services related standards and systems are sufficient, effective and robust,

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.

The Committee will seek assurances on the management of strategic risks delegated to the Committee by the Board, via the Corporate Risk Register.

It is expected that the committee will also annually review its own terms of reference and report any changes to the Board for ratification.

2.1 Membership of the Committee

The membership of the Committee during 2024/25 was:

Name	Role	Attendance
Ronnie Alexander	Independent Member (General) and Chair of the Committee	5/7
Rhobert Lewis	Independent Member (General) and Committee Vice Chair	6/7

Kirsty Williams	Independent Member	5/7
Cathie Poynton	Independent Member (Trade Union)	6/7
Mick Giannasi	Independent Member	4/7
Steve Elliot	Independent Member	6/7
Ian Thomas	Independent Member	1/1

2.2 Others in Attendance

During 2024/25, the following staff attended the Committee:

Name	Role	Attendance
Pete Hopgood	Director of Finance, Information and IT (Joint Executive Lead)	7/7
Nicola Johnson	Director of Performance and Commissioning (from 07.10.2024)	4/4
Stephen Powell	Director of Performance and Commissioning (until 18.10.2024)	2/3
Claire Madsen	Director of Therapies & Health Sciences	5/7
Joy Garfitt	Executive Director of Operations/Director of Community and Mental Health	0/3
Debra Wood Lawson	Executive Director of Workforce and OD	2/7
Claire Roche	Executive Director of Nursing, Quality, Women and Family Health	3/7
Elaine Lorton	Executive Director of Primary, Community Care and Mental Health (from 30.09.2024)	4/4
Kate Wright	Executive Medical Director	3/7
Helen Bushell	Director of Corporate Governance/Board Secretary	6/7

Other Directors and officers attended during the year to present reports which related to their areas of responsibility as required.

The Chief Executive, Hayley Thomas was also invited to attend every meeting, and attends at least annually.

The Chair of the Board, Carl Cooper, attended four meetings. The Chair has a standing invite to attend Board Committees.

The Director of Corporate Governance or their representatives attended every meeting.

2.3 Meeting frequency

During 2024/25 the Committee met seven times and was quorate on all occasions.

The terms of reference for the Committee require meetings to be held no less than bi-monthly and in line with the annual plan of Board and Committee Business.

3. Activity in 2024/25

3.1 Main Areas of Committee Activity 2024/25

ITEMS FOR ASSURANCE	
Finance	
Draft Annual Performance Report section of the Annual Report 2023/24.	May 2024
Financial Performance Report	Every meeting
Approach to Annual Accounts	February 2025
Six Monthly Report on Continuing Health Care Savings	August 2024 & February 2025
Performance	
Integrated Quality and Performance Report	Every meeting
Annual Delivery Plan Q4 2023/2024	May 2024
Q1 Integrated Plan Progress Report	August 2024
Q2 Integrated Plan Progress Report (including diagnostic services)	October 2024
Q3 Annual Delivery Progress Report	February 2025
Emergency Ambulance Services Update	May 2024
Endoscopy Update (including JAG accreditation)	February 2025
Neurodiversity (Children) Performance/Planning Update	August 2024
In-reach Fragility	December 2024
Digital and Information Governance	
Information Governance Annual Performance Report 2023/24	May 2024
Digital First Update	May 2024 & December 2024
IT Infrastructure and Asset Management	May 2024
Information Governance Toolkit Outturn Report and Improvement Plan	June 2024
Primary Care	
Primary Care: General Dental Services	June 2024 & December 2024
Primary Care: Out of Hours Report	June 2024 & February 2025

Primary Care: General Medical Services (GMS) Commissioning Assurance Framework	October 2024
Community Pharmacy Annual Report	December 2024
Estates and Support Services	
Food Safety Compliance and Assurance Report	June 2024
Decarbonisation – Action Plan and Progress	June 2024
Capital Programme Delivery & Pipeline Overview	December 2024
Six monthly Report on Catering Services	February 2025
Capital and Estates Compliance Report	February 2025
Powys Public Service Board Climate Working Group Update	August 2024
ESCALATED ITEMS	
Records Management Improvement Plan	May 2024
Organisational Escalation Status – including Enhanced Monitoring Self-Assessment	Every meeting
ITEMS FOR INFORMATION	
Internal Audit Reports: • Integrated Performance Framework • Cleaning Standards	October 2024
Internal Audit Reports: • Core Financial Systems – Treasury Management • Board & Committee Structure / Effectiveness • Capital Systems • Energy Management	February 2025
CORPORATE GOVERNANCE	
Committee Annual Programme of Business/Committee Frequency	May 2024
Committee Risk Register	Every meeting
Committee Work Programme	Every meeting

Communications and Engagement Report	December 2024
IN-COMMITTEE ITEMS	
Integrated Plan 2023/24 Feedback from Welsh Government	March 2025
Corporate risk register	Every meeting

3.2 Work programme and action log

The Committee Work Plan ensures that the Committee discharges its responsibilities in a planned manner. It assists with agenda planning and is updated during the year to ensure that the Committee considers any additional items which may arise during the year.

In order to monitor progress and any necessary follow up action, the Committee has an Action Log that captures all agreed actions. This provides an essential element of assurance to the Committee and from the Committee to the Board.

The Committee reported to the Board through a Committee Chair's report, providing an overview of items considered by the Committee and highlighting any cross-committee issues / themes or items needing to be brought to the Board's attention. The Committee Chair's report and confirmed minutes are published on the website.

4. Assurance to the Board

The Committee wishes to assure the Board that on the basis of the work completed by the Committee during 2024/25, there are effective measures in place and there are no outstanding issues that the Committee wishes to bring to the attention of the Board over and above the risks and issues already raised in the Committee Chairs report or that are already visible in the corporate risk register.

The Chair of the Committee reports into the Board via a report from Committee Chairs, where any significant issues are brought to the attention of the Board. The reporting template was developed in year and made consistent across all committees.

5. Committee Effectiveness

During the year the Committee has continued to review and revise its ways of working to optimise the need for a robust governance approach.

The Committee continued to review its effectiveness thorough the year, to ensure effective use of time and ensure it fulfilled its role to provide assurance to the Board.

The key adaptations made this year included:

- Implementation of the Committee's revised terms of reference.
- The increase of meetings from four per year to six per year.
- The construct of the Committee meeting agendas remained flexible, and the application of a risk based approach to the selection of agenda items.
- The use of verbal updates and presentations where appropriate to ensure the timeliness of information to the Committee given the fast moving pace of some agenda areas.
- The circulation of relevant material outside meetings where appropriate.

The Committee is in the process of undertaking its annual effectiveness review process. The outcome and recommendations following this review will be reported to the Board in Quarter 1 of 2025/26.

6. Planned Activity in 2025/26

The Committee has developed its annual work programme and is committed to continuing to develop its function and effectiveness as per its terms of reference. The Committee welcomes any feedback from the Board in relation to its annual work programme.

Community Cardiology Service

Final Internal Audit Report 2024/25

Powys Teaching Health Board

Reasonable Assurance

Contents

Review Reference	PTH-2425-24
Fieldwork	December 2024 – February 2025
Executive Sign Off	18th February 2025
Audit Committee	March 2025
Executive Lead	Elaine Lorton, Executive Director of Primary, Community Services & Mental Health
Audit Team	Ian Virgill, Head of Internal Audit Lucy Jugessur, Deputy Head of Internal Audit Stuart Bodman, Principal Internal Auditor

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Executive Summary

Purpose

A review of the structure and delivery of the Community Cardiology Service implemented in North Powys, to inform further roll-out across Powys.

Overview

The Health Board's Community Cardiology Service (the 'Service') provides a direct access, one-stop, cardiology diagnostic and management service with a comprehensive cardiac rehabilitation programme.

The development of the service was taken forward through the Circulatory Renewal Programme following a successful application for non-recurrent funding to the Wales Cardiac Network to pilot the first phase of implementation in North Powys during 2022-23. The service continues to operate in North Powys, with a proposal in place for expansion into Mid Powys, ahead of the planned creation of a pan Powys service.

The Service in the North is provided by a multi-disciplinary team consisting of a broad range of specialist staff. The team includes GP(s) with Special Interest (GPwSI), Specialist Cardiac Nurses and physiotherapist, Specialist Cardiac Physiologist, Cardiac Rehabilitation Specialist, Assistant Practitioner, administrative support (patient services, radiology & specialist nurse teams) and the wider multidisciplinary team.
The Service consists of three elements:

- A Cardiology Diagnostics and Management clinic for suspected heart failure, cardiac chest pain or rhythm disturbance;
- Cardiac Rehabilitation for those with confirmed significant heart disease; and
- Supporting the Local Enhanced Service for GP arrhythmia management.

We have concluded **reasonable** assurance on this area. The key matters requiring management attention include:

- The absence of a formal documented Community Cardiology Service structure setting out its relationship to, and reporting lines within the Health Board;
- The governance arrangements in place during the Service's implementation phase have not evolved to support the management and oversight of the Service now that it is fully operational;
- The absence of formal risk management processes, in accordance with Health Board Risk Management requirements;
- Ensuring that the timescales relating to patient's contact and subsequent assessment are in compliance with the Service's Standard Operating Procedure criteria, and also that appointment notifications to patients are recorded on the patient electronic databases;
- Enhancements to the Cardiac Rehabilitation discharge/onward referral pathway through recording of GP/clinician notification and issue of clinical outcome reports on patient databases; and
- The absence of clear reporting and escalation lines for Service Performance Management to Health Board Committee level.

Full details of the matters arising are provided within the Findings & Agreed Action Plan.

The following opportunities for enhancement have been identified that do not impact the overall opinion and are highlighted for management information:

- The update of the Community Cardiology Standard Operating Procedure should be submitted to the Community Services Manager for review, and then formal approval should be obtained by the CSG Operational Group.

Scope & Assurance Summary

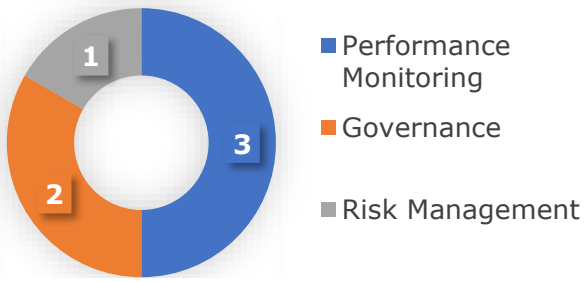
	Objectives	Related Findings	Assurance
1	The Service is appropriately structured and resourced to allow for the effective delivery of its objectives, and there are clearly documented and communicated procedures in place for the operation of the Service.	1,2,3	**Limited**
2	There are documented pathways in place for referral into the Service and these are appropriately communicated and publicised.	-	**Substantial**
3	Patients referred into the Service are appropriately assessed and receive treatment in line with the stated procedures and in accordance with relevant NICE and BACPR guidelines.	4	**Reasonable**
4	Robust processes are in place for discharge from the Service and / or onward referral to further services as required.	5	**Reasonable**
5	Robust systems are in place for the recording of patient data and the details and outcomes of services provided.	-	**Substantial**
6	Systems are in place for monitoring the delivery and quality of the services provided, and performance is regularly reported to appropriate management and groups within the Health Board.	6	**Reasonable**

Management Actions

2 High Priority

4 Medium Priority

Themes



Risk Types

Legal & Regulatory Non-Compliance

Public Perception & Reputational Risk

Quality or Safety Issues

Findings & Agreed Action Plan

Objective 1: The Service is appropriately structured and resourced to allow for the effective delivery of its objectives, and there are clearly documented and communicated procedures in place for the operation of the Service.	**Limited**

Overview / Summary of Observations

The Community Cardiology Service has no formal documented structure that outlines its position within the overall Health Board organisational structure.

The Service is also not currently supported by effective local governance and management arrangements that facilitate its operational decision making and reporting mechanisms. We note that local governance arrangements were in place during the Services' project management and pilot phases, but these have not been continued or developed to support the Service now that it is fully operational.

The Service has Standard Operating Procedures in place that describe the purpose and current operational processes of its three constituent Service areas and also the roles of the key staff within these service areas. We note that at the time of our audit these had been reviewed and updated but required formal approval.

Service management has identified that the current budgeted staffing levels in respect of the Cardiology Diagnostics & Management Clinic and Cardiac Rehabilitation Service are inadequate to ensure efficient and effective delivery of patient management and treatment. This position is evidenced by the times for referrals and assessments we noted as part of our testing under Objective 3. A Business Case to increase and improve staffing is due to be submitted to the Health Board Investments Benefits Group in early 2025.

The operational Service also lacks formal risk management arrangements as required and stipulated by the Health Board's Risk Management Framework. Again, we note that risk management was in place through the Services' project phase.

	Key Findings	Risk & Impact	Agreed Management Action
1	<u>Community Cardiology Service Structure</u> At the time of our audit, there is no formally documented structure for the Community Cardiology Service and its three constituent service areas, (Cardiology Diagnostics & Management Clinic, Cardiac Rehabilitation Service, and Local Enhanced Service for GP Arrythmia Management) and also its relationship to the reporting structure and lines of accountability within the overall Health Board organisational framework. The Community Cardiology Service staffing structure is not formally outlined within its Standard Operating Procedure. We note that the 22.5 hours/week and 15 hours/week currently budgeted to and respectively worked by the Cardiac Rehabilitation Specialists in both North & Mid Powys and South Powys may not be sufficient given current and potential future levels of patient demand and activity.	The Service fails to deliver its stated objectives.	**Agreed Action:** Business Case to be taken to IBG in February 2025, to ensure sustainable and robust service structure and delivery. Standard Operating Procedure (SOP) is currenting being updated to reflected current service and vision for future. When draft completed, SOP to be formally signed off in March 2025.

	Additionally, the Cardiology Diagnostics & Management Clinic is substantively operated by a part time (0.5 WTE) GP with a Specialist Interest in Cardiology, and a Cardiac Physiologist. In the event of staff absences or annual leave, there is no cover and clinics/services do not proceed. As such, there are resultant increased waiting times due to current limited staff resources available, and also insufficient numbers of patient assessment locations (e.g. leisure centres, community centres) in which Cardiac Rehabilitation programme sessions are undertaken. We acknowledge that these issues are known to senior management, and a Business Case has been drafted, and is to be submitted to the Health Board Investments Benefits Group (IBG) in early 2025 to request additional funding to help mitigate the staffing issues within the Service. However, in the event that the Business Case is not successful, it is unclear whether further option appraisals or senior management consideration has been undertaken to source the additional funding required, and also that for any further Service expansion.		**Expected Evidence of Implementation:** Copy of Business case and minutes of IBG meeting. Copy of updated SOP and evidence of sign-off.
	Theme: Governance	**High Priority** Control Design	**Officer: Helen Hathaway, Cardiology Service Lead / Donna Jones, Community Service Manager** **Date: March 2025**
2	<u>Governance and Management Oversight</u> Currently the governance and management oversight arrangements in place for the Community Cardiology Service are outdated and reflect the nature of the Service during its project management and pilot phases, and not that of its fully operational status. The Terms of Reference (ToR) for the 'Community Cardiology Services Implementation Group' that is in place require updating and reconstitution to reflect the fully operational Service objectives and delivery across the Service. This ToR does not accurately reflect current Service objectives, CSG operational management and decision-making arrangements and also Directorate/organisational reporting lines. Furthermore, the 'Community Cardiology Services Implementation Group' has not met since June 2024, and this	The Service fails to deliver its stated objective.	**Agreed Action:** Service Governance Community Cardiology Meeting now re-started, with an updated ToR and Agenda, to meet bi-monthly and chaired by Community Service Manager, first meeting 12th of February 2025. **Expected Evidence of Implementation:** Papers for Service Governance Meeting. Copy of updated TOR.

	current absence of a formal management oversight and decision-making group poses a risk to sound and effective governance within the Community Cardiology Service.	**High Priority**	**Officer: Helen Hathaway / Donna Jones** **Date: Complete**
	Theme: Governance	Control Operation	
3	<u>Risk Management Processes</u> No formal risk management oversight, risk identification and recording, and risk review processes are in place within the Community Cardiology Service, in accordance with the Health's Board Risk Management Framework requirements. We do, however, acknowledge there is regular reporting and escalation of key Service risks to the respective CSG Operations and Quality & Safety meetings, but these are narrative based only and are not scored to reflect their likelihood and impact, and are not supported by risk mitigation actions. Additionally, we could not establish if key risks are being escalated to inform the Community Service Group risk register. We note that an appropriately constituted and scored risk register was in place for the Community Cardiology Service during its project management phases, but this was dated 2022 and was not revised and updated to reflect the transition into a fully operational Service and has not been maintained on an ongoing basis to the present time.	The Service fails to deliver its stated objectives.	**Agreed Action:** Risk Register now in place from January 2025 and being reviewed and escalated as indicated by the scoring system of risk matrix.
			Expected Evidence of Implementation: Copy of Risk Register.
		Medium Priority	**Officer: Helen Hathaway, Cardiology Service Lead / Donna Jones, Community Service Manager**
	Theme: Risk Management	Control Design	**Date: Complete**

Objective 2: There are documented pathways in place for referral into the Service and these are appropriately communicated and publicised.	**Substantial**

Overview / Summary of Observations

The Community Cardiology Service has a current Standard Operating Procedure (SOP) that formally documents patient referral pathways for each of the three Service areas and outlines the stages of patient flow and management prior to and including assessment/treatment and through to discharge or onward referral, and also that of the interconnectivity between the Service areas.

We were informed that Service staff and referring Mid and North Powys GPs/ Health Board clinicians have been provided with copies of the SOP and are aware of its stated referral and patient management criteria via training sessions.

However, the SOP has recently been subject to revision and update and requires formal review and approval by Clinical Service Group management.

Objective 3: Patients referred into the Service are appropriately assessed and receive treatment in line with the stated procedures and in accordance with relevant clinical guidelines.	**Reasonable**

Overview / Summary of Observations

Referral and assessment stages of the patient pathways are outlined in the Community Cardiology Standard Operating Procedure (SOP).

Our review and testing of a sample of patients that were referred into, and assessed by, the Cardiology Diagnostics & Management Clinic and North & Mid Powys Cardiac Rehabilitation Service respectively between April and October 2024, confirmed that they were managed in line with the pathway stages stated within the SOP, and in accordance with relevant NICE and BACPR guidelines which are cited therein.

However, our testing identified that lengthy referral to assessment and then treatment timescales are currently incurred within the North & Mid Powys Cardiac Rehabilitation Service.

Our review of key patient pathway dates for each sampled patient recorded on the Cardiac Rehabilitation Waiting Database List, confirmed that they reconciled to those held on the WPAS (Welsh Patient Administration) and WCCIS (Welsh Community Care Information System) systems.

No testing was undertaken in respect of an assessment and treatment pathway relating to the Local Enhanced Service (LES) for GP Arrythmia Management, as this Service relates to a GP Practice commissioning process relating to the provision and use of cardiac rhythm monitoring devices (Kardia Mobile/Zio) that supports clinical assessment and treatment within the other two services.

We also note that not all parts of the patient pathway as stated in the SOP were reviewed during our testing as they relate to medical/clinical decision making processes.

	Key Findings	Risk & Impact	Agreed Management Action
4	<u>Patient Referral and Assessment Pathway Management</u> • <u>Cardiology Diagnostics & Management Clinic</u> Testing of a sample of patients identified that referrals from GPs/referring clinicians into the Cardiology Diagnostics & Management Clinic are managed quite efficiently, whereby it took an average of 11 working days. 64% of the total sample were received by the Clinic on the same day that the referral was made. The timescale from which the referrals were received by the Clinic to the date a first Clinic appointment is booked was an average of 34 working days, and an average of 58 working days for those patients who could not attend the first appointment offered but then attended a second offered appointment. Whilst the average timescale was above the 6-week target stated in the SOP, we acknowledge that this is due to the issues around the current staffing establishment, as stated previously in this Report. • <u>North & Mid Powys Cardiac Rehabilitation Service</u> Current lengthy timescales were also identified through our sample-based testing and review of the Cardiac Rehabilitation patient referral and assessment pathway, these being; ➢ Average total timescale from Cardiac Diagnostics Clinic/Cardiac Nursing Service onward internal referral to patient receiving assessment into their Cardiac Rehabilitation Sessions - 49 working days ➢ Average total timescale from referral receipt by the Cardiac Rehabilitation Service to commencement of treatment Sessions - 56 working days We acknowledge that these limiting factors are also known to senior management and are covered by the Business Case, as previously stated in this Report. Our testing also identified issues around ensuring compliance with the SOP criteria in respect of Cardiac Rehabilitation patients not being contacted by the Service within 3 working days after receipt of their referral, and an assessment not taking place within 10 working days of the receipt of their clinician's referral.	Potential patient harm due to delays in receiving services and / or non-compliance with relevant clinical guidelines.	**Proposed Agreed Action:** Updated SOP to reflected KPIs and National Guidelines for Cardiac Rehabilitation waiting times. Updated patient pathway, referrals to be triaged electronically via WAP or WCCIS in the near future, and all patient activity to be recorded electronically in WCCIS or WPAS, aiming end of March for new electronic pathway to be completed. **Expected Evidence of Implementation:** Copy of updated SOP. Relevant dates recorded in WPAS and WCCIS.

	Furthermore, dates relating to the issue of appointment invitation letters/calls for patients to attend Cardiac Rehabilitation assessment sessions are not consistently recorded on WPAS and WCCIS.	**Medium Priority**	**Officer: Helen Hathaway, Cardiology Service Lead** **Date: April 2025**
	Theme: Performance Monitoring	Control Operation	

Objective 4: Robust processes are in place for discharge from the Service and / or onward referral to further services as required.	**Reasonable**

Overview / Summary of Observations

Efficient pathway management, supported by clearly outlined processes are in place for patient discharge from the Community Cardiology Service, and / or onward referral to further clinical services if required.

These, however, could be strengthened through recording on WPAS and WCCIS of the dates when a GP/referring clinician is informed of the patients discharge from the Service and provided with a clinical outcome report of the Cardiac Rehabilitation Programme undertaken.

We note that not all parts of the discharge pathway as stated in the SOP can be reviewed and tested as they relate to medical/clinical decision making processes undertaken during this stage of the pathway.

	Key Findings	Risk & Impact	Agreed Management Action
5	<u>Discharge and Onward Referral Pathway Management</u> Based upon the patients we sampled, the timescale between the Cardiology Diagnostics & Management Clinic discharge date to that of the GP/Referrer being notified and issued a Clinic assessment outcome report is 4 working days. In respect of the Cardiac Rehabilitation Service, we did not assess the timescale from assessment date to discharge/onward referral date, as this is a standard 8 weeks of cardiac rehabilitation, fitness monitoring sessions and provision of clinical advice, and we acknowledge that this may also be extended if deemed clinically appropriate to the need of the patient undergoing the sessions. Our key finding relates to there being no entries recorded on WPAS and WCCIS in respect of when a GP/referring clinician is informed of the patients discharge from the Service and the clinical outcome report of the Cardiac Rehabilitation Programme is issued to them. We are therefore unable to provide any assurance around the timeliness of this element of the pathway.	Potential patient harm due to delays in receiving services and / or non-compliance with relevant clinical guidelines.	**Proposed Agreed Action:** Discharge letters now being sent out to GP practices for all patients completing cardiac rehab and/or discharged from the service. Dates will be added to patient WPAS and WCCIS files. **Expected Evidence of Implementation:** Relevant dates recorded in WPAS and WCCIS.
	Theme: Performance Monitoring	**Medium Priority** Control Operation	**Officer: Helen Hathaway, Cardiology Service Lead** **Date: Complete**

Objective 5: Robust systems are in place for the recording of patient data and the details and outcomes of services provided.	**Substantial**

Overview / Summary of Observations

The Community Cardiology Service is supported by several robust clinical and administrative patient management systems that allow for effective integrative recording and reporting of patient referrals, treatment activity, onward referral and discharge.

Cardiac Diagnostics Clinic

Referrals via GPs or any internal referrals are made in writing via letter or GP electronic referral, and the supporting clinical information recorded via two clinical systems, RADIS2 and PACS (Picture Archiving and Communications System).

RADIS2 performs functions such as patient scheduling and clinical reporting involving medical images such as x-rays, CT and MRI scans and ultrasound and works in conjunction with the (PACS) to manage the storage, retrieval, distribution and presentation of images and allows the sharing of these images nationally.

The conjoining of information from these systems then feeds into WPAS (Welsh Patient Administration) which is used to plan clinic appointments, treatment plans and then refer into another function of the Service, or discharge back to the GP for local review and clinical management.

Cardiac Rehabilitation

Data for referral, treatment and discharge/onward referral is sourced from WPAS and the Cardiac Rehabilitation patient caseload/treatment information from the WCCIS (Welsh Community Care Information System).

WCCIS is an integrated system that provides sharing of information between community health and social care, and access to relevant information on the care provided to a range of health and social care professionals, to show where a patient is with their treatment.

The content of these systems is informed by information provided by the GP electronic referral system, and also that of administration staff who support the Service via letters written from/to GPs during referral and discharge stages.

Additionally, within both the North & Mid and South Cardiac Rehabilitation service areas, patient referral, treatment, waiting list and discharge activity is also recorded on an operational day-to-day 'at a glance' basis by the Cardiac Rehabilitation Specialists on an Excel Waiting List Database.

Our testing undertaken in Objectives 3 and 4 of this Report evidences the flow and use of the data from these systems into and through the patient pathways and also confirms that key dates held on WPAS and WCCIS databases fully reconcile.

Objective 6: Systems are in place for monitoring the delivery and quality of the services provided, and performance is regularly reported to appropriate management and groups within the Health Board.	**Reasonable**

Overview / Summary of Observations

The Community Cardiology Service is supported by a Power BI database that integrates the patient data held on the clinical and patient management systems and produces management information relating to Service performance that is regularly reported to the Clinical Service Group Operations and Quality & Safety Groups.

However, we were unable to verify if there is any provision in place for onward reporting of the Service's performance to an appropriate Health Board Group or Committee.

The Service has Key Performance Indicators (KPIs) in place that outline patient activity and Service performance measures to aid monitoring of service delivery.

Key Findings	Risk & Impact	Agreed Management Action
<u>Reporting and Escalation of Service Performance Management</u> Information used for reporting patient activity and Service performance information comes from the IFOR (Information Focused Online Reporting) Power BI database that electronically sources data from WCCIS and WPAS, and information on WPAS is informed from the clinical systems PACS and RADIS. We note that patient referral, caseload and waiting list activity relating to the Community Cardiology Service is being reported to the Clinical Service Group Operations and Quality & Safety meetings on a bi-monthly basis. However, given the current absence of a formalised Service structure and reporting arrangements, it is unclear whether this information is being reported onward/escalated to any Health Board Group/Committee meetings.	Areas of poor performance are not identified or addressed.	**Agreed Action** Demand and capacity data is being closely monitored for each area and specialism for community cardiology. Discussed during bimonthly service governance meeting and escalated as needed. To set up a demand and capacity graph for each service area, to show monthly data and trend of demand, to be completed by end of March 2025. **Expected Evidence of Implementation:** Copy of demand and capacity graphs. Record of escalation.
Theme: Performance Monitoring	**Medium Priority** Control Operation	**Officer: Helen Hathaway, Cardiology Service Lead** **Date: April 2025**

Appendix A

Assurance Opinion

 **Substantial**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
 **Reasonable**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
 **Limited**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
 **Unsatisfactory**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
 **Advisory**	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 Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership]

Disclaimer

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of Powys Teaching Health Board, and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management of Powys Teaching Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Patient Flow and Discharge Management

Final Internal Audit Report 2024/25

Powys Teaching Health Board

Reasonable Assurance

Review Reference	PTH-2425-06
Fieldwork	October 2024 – January 2025
Executive Sign Off	27th February 2025
Audit Committee	March 2025
Executive Lead	Elaine Lorton, Executive Director of Operations, Community and Mental Health.
Distribution	David Farnsworth, Assistant Director Community Services Group. Claudia O'Shea, Senior Manager USC Christina Thomas, Senior Manager USC
Audit Team	Ian Virgill, Head of Internal Audit Liz Vincent, Principal Auditor

Contents

Powell Bethan 01/05/2025 10:03

GIG CYMRU NHS WALES

Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Executive Summary

Purpose

The overall objective of the audit was to review the current controls and systems around patient flow, reducing discharge delays and work of the Complex Care and Unscheduled Care Team.

Overview

Providing safe, timely and effective discharge for every person who attends hospital is essential, however due to the ageing demographic and an increasing number of older patients being admitted, the complexity of the discharge planning has increased.

The Welsh Governments (WG) 'Hospital Discharge Guidance' issued in September 2024 sets out guidance on Hospital Discharge standards for health, social care, third and independent sector partners in Wales. The principles and processes that support effective discharge are set out in the Discharge to Recover then Assess (D2RA) Pathways Guidance. All patients with a decision to admit to hospital should be assessed and provisionally allocated to one of four pathways.

The national 'Six Goals for Urgent and Emergency Care Programme' sets out the expectations for the Health Boards and their partners for the delivery of the right care, in the right place, first time for physical and mental health. It outlines six goals to help achieve the best possible clinical outcomes, value and experience for patients and staff involved in the delivery of care. The goals include:

Goal 5 – Optimal hospital care and discharge practice from the point of admission.

Goal 6 – Home first approach and reduce the risk of readmission.

We have concluded **Reasonable** assurance on this area. The significant matters requiring management attention include:

- The Community Hospital Discharge policy is outdated and requires revision to align with the Welsh Government's 'Hospital Discharge Guidance' released in September 2024.
- Staff members are required to retake the D2RA training course to guarantee full compliance and to ensure that their records are updated in the ESR system.
- Staff members comprehension of Red2Green (R2G) days did not completely align with the guidance provided by Welsh Government. Additionally, the recording of R2G days within the DigiFLO whiteboards indicated that the wards included in the sample were not effectively updating or utilising the R2G feature.
- We were unable to locate adequate evidence within the current systems to explain the rationale behind the decision regarding the D2RA Pathway.
- A Clinical frailty Score for patients over 65 does not form part of the patient assessment on admission to the Community Hospitals.
- The remaining six key findings are operational in nature and include the utilisation of DigiFLO whiteboards, use of Inpatient Notes within WNCR, and delays in setting an estimated date of discharge.

Full details of matters arising are detailed within the Findings & Agreed Action Plan. The following opportunities for enhancement have been identified that do not impact the overall opinion and are highlighted for management information:

- Pharmacy are not always in attendance at MDT meetings.
- User Access Guidance for the Patient Flow List has been prepared and is currently under review by the Local Authority for approval. Once finalised, it needs to be included as an Appendix to the Integrated Patient Flow SOP.
- A comprehensive reporting structure detailing the hierarchy and communication flow concerning discharge management would be beneficial.
- Identifying the attendees of meetings proved challenging due to the absence of this being documented.
- There were limited instances of delays in the identification of a Powys Plan pathway for patients in the Wye Valley Trust.

Scope & Assurance Summary

	Objectives	Related Findings	Assurance
1	The Health Board has up to date policies and procedures in place for discharge management that reflect the requirements of the Welsh Government's Hospital Discharge Guidance and the D2RA Pathways Guidance.	1,2	**Reasonable**
2	Relevant staff within the Health Board are aware of the policies and procedures in place and have received appropriate training where required.	3	**Reasonable**
3	Processes and resources are in place to support timely discharge of patients from the Health Board's Community Hospitals, including allocation to a specified D2RA pathway discharge stream and identification of an Expected Discharge Date (EDD) at the point of admission.	4,5,6,7,8,9,10,11	**Limited**
4	The Health Board has processes and resources in place to work with local teams in provider Health Boards and Trusts to support the timely discharge and / or repatriation of Powys residents.	10,11	**Reasonable**
5	Data is collated, reviewed and analysed to demonstrate the effectiveness of the discharge management arrangements and support compliance with the key principles of the guidance, and actions are taken to address areas of poor performance and low/non-compliance.		**Substantial**
6	Robust governance arrangements are in place to ensure timely and effective monitoring and oversight of discharge management, including effective co-ordination with local authorities and the third sector.		**Substantial**

Management Actions

2 High Priority

9 Medium Priority

Powell Bethan 01/05/2025 10:03:13

Themes

Risk Types

Legal & Regulatory Non-Compliance

Quality or Safety Issues

Public Perception & Reputational Risk

Findings & Agreed Action Plan

Objective 1: The Health Board has up to date policies and procedures in place for discharge management that reflect the requirements of the Welsh Government's Hospital Discharge Guidance and the D2RA Pathways Guidance.	**Reasonable**

Overview / Summary of Observations

There are three established policies and procedures governing Patient Flow and discharge management: the 'Community Hospital Discharge Policy & Procedures', the 'Management of Reluctant Discharge procedure', and the 'Integrated Patient Flow Standard Operating Procedure' (SOP). The Management of Reluctant Discharge procedure was released in June 2024, aligning with the WG guidance. However, the Integrated Patient Flow SOP, issued in July 2024, has become outdated due to recent changes in certain processes. Additionally, it is important to note that the Community Hospital Discharge Policy is out of date, with its last review occurring in January 2018.

	Key Findings	Risk & Impact	Agreed Management Action
1	**Out of date 'Community Hospital Discharge Policy & Procedures'.** The Health Boards 'Community Hospital Discharge Policy & Procedures' (GNP042) is outdated and does not include the specific requirements and processes that are detailed in the September 2024 WG hospital discharge guidance. The WG document is key to patient flow and sets out the guidance on Hospitals Discharge standards for health, social care, third and independent sector partners in Wales. The update to the Health Board's Hospital Discharge Policy & Procedures will need to incorporate all the necessary elements of the guidance to ensure the delivery of optimal outcomes is fully addressed. For example, D2RA, SAFER, REDtoGREEN and Prevent Deconditioning. Including a 'Planning your Discharge' Letter as an appendix to the Policy would also be advantageous Powell, Bethan 01/05/2025 10:03:13	If detailed policy and procedures are not in place, the principles set out in the WG guidance may not be adhered to.	**Agreed Action:** Develop an updated 'Community Hospital Discharge Policy & Procedures', incorporating all relevant information from the September 2024 WG hospital discharge guidance. Once the Policy has been developed, staff will be made aware of its existence, and it will made accessible to staff via the intranet pages. **Expected Evidence of Implementation:** GNP 042 Community Hospital March 2025 - revision in process of being uploaded to intranet Minutes of Bi Monthly Operations - Minutes of approval for the above in CSG ops
	Theme: Policies & Procedures	**High Priority** Control Design	**Officer:** Claudia O'Shea **Target Implementation Date:** 1/4/25

2	**Update the Integrated Patient Flow SOP.** The Integrated Patient Flow SOP (GNP 088) documents the overarching approach adopted by the Health Board and Powys County Council (PCC) to ensure appropriate flow of Powys residents, both in the Community Hospitals and bordering District General Hospitals. The procedure references the WG Six Goals for Urgent and Emergency Care (with a hyperlink to the relevant document on page 8) and also mentions the D2RA model and Hospital Discharge Guidance. However, the hyperlink for the D2RA pathway incorrectly directs to the Six Goals Policy, whereas it would be more appropriate to link the 'Delivering optimal outcomes and experience for people in hospital'. The link to the Hospital Discharge Policy also needs to be updated once the Policy has been developed. This SOP is primarily operational in nature, emphasising governance, reporting on Pathways of Care Delays and Census, as well as system escalations. Recent modifications to several of these processes have occurred and the policy requires an update to align with the new Patient Flow List which was introduced on 21st October 2024. Additionally, it should include the new Ready to Go units and the governance related to user access for SharePoint.	Incorrect details in the SOP could compromise compliance with the principles established in the WG guidance.	**Agreed Action:** Revise the Standard Operating Procedure to incorporate the recent modifications to several processes and verify that all links are functioning properly. **Expected Evidence of Implementation:** Revision and publication of SOP
		Medium Priority	**Officer:** Senior Nurse Patient Flow **Target Implementation Date:** 1/4/25
	Theme: Policies & Procedures	Control Operation	

Objective 2: Relevant staff within the Health Board are aware of the policies and procedures in place and have received appropriate training where required.	Reasonable

Overview / Summary of Observations

Meetings were conducted with the Discharge Coordinator and the Nurses in Charge of both Y Bannau Ward and Epynt Ward. During these discussions, they demonstrated their familiarity with the location of the Discharge Policies and provided explanations regarding the D2RA concept.

D2RA videos are available on the intranet, and staff have undergone training provided by the national team. To promote awareness of this training, posters have been placed in the wards, and a dedicated SharePoint page for D2RA and Optimal Hospital Flow has been established. This page features the latest Welsh Government Hospital Discharge Guidance and the Management of Reluctant Discharge/Transfer of Care document. It also guides staff to the D2RA training modules that were incorporated into the ESR system in June 2023.

	Key Findings	Risk & Impact	Agreed Management Action
3	**Compliance with D2RA module within ESR** A request for a list of staff who have completed the D2RA course revealed that only one individual had done so. The USC Senior Manager clarified that some staff completed the training before the D2RA module was launched on ESR. Consequently, a request has been sent to all staff to retake the course to ensure their records are updated in ESR. There is no specific deadline for retaking this module, but discharge remains a regular agenda item in their internal meetings. Furthermore, bi-monthly meetings are held with Ward Staff. Although this training is not formally structured, it includes updates on policies and encourages discussions about the impact of these changes on patient care.	Insufficiently updated records could lead to incomplete training documentation, which may have implications for compliance.	**Agreed Action:** Establish a specific timeframe for staff to retake the course, ensuring accountability and timely compliance. Monitor training progress and follow up with staff who have not yet completed the module. Consider using the existing bi-monthly meetings to emphasise the importance of the training, address questions, and provide support for those retaking the course.
			Expected Evidence of Implementation: ESR Monitoring in place with minuted bi monthly meetings with training as a standard agenda. To discuss and agree timeframes with HoN & Clinical Service Managers
		Medium Priority	**Officer:** Clinical Service Managers
	Theme: Training & Development	Control Design	**Target Implementation Date:** Quarter 3 2025

Powell Bethan 01/05/2025 10:03:13

Objective 3: Processes and resources are in place to support timely discharge of patients from the Health Board's Community Hospitals, including allocation to a specified D2RA pathway discharge stream and identification of an Expected Discharge Date (EDD) at the point of admission.	Limited

Overview / Summary of Observations

The WG Hospital Discharge guidance offers detailed insights into the tasks, standards, and expectations applicable to different teams and departments. In our audit review, we assessed the processes in place at the ward level at Y Bannau and Epynt Ward at Brecon War Memorial Hospital to evaluate whether the Health Board had established appropriate practices for the effective implementation of the D2RA Pathways.

We were informed that early morning and afternoon huddles are not conducted on the wards, however, a handover occurs prior to the commencement of each shift. The handover notes do not contain any reference to the D2RA pathway for the patient, nor do the action notes specify whether the patient is classified as a red or green day.

Multi-disciplinary Team (MDT) meetings are conducted weekly in each of the wards included in the sample testing. For the 12 patients reviewed, the attendees at these meetings were considered appropriate. However, there was no evidence of Pharmacy attendance at any of the MDTs, which could potentially lead to delays in the administration of take-home medications.

WG guidance states that in order to minimise any delays to recovery and discharge the Red2Green (R2G) process must be adopted at all times. Although we can evidence the recording of R2G on the manual whiteboards and the DigiFLO whiteboards, staffs' comprehension of R2G days did not completely align with the guidance provided by Welsh Government.

The decision around how the D2RA Pathway was decided, and how the rationale is conveyed from ward to a discharge co-ordination hub is unclear. Also evidencing how the family/ careers have been informed of this decision is also uncertain.

The organisation employs three methods for documenting electronic data related to Patient Flow; The Welsh Nursing Care Record (WNCR), the DigiFLO whiteboards and the Patient Flow Microsoft List database, which is managed by the Local Authority and is accessible to various staff members at USC Powys.

Before conducting our ward visits, we extracted the essential principles from the Welsh Government guidance and evaluated them against the patients in our sample. A number of issues were identified, which have been highlighted under key findings 7,8, 10 and 11.

Further testing was conducted on patients with complex discharge needs to determine whether their discharge was manged efficiently and promptly. Identifying the locations of blockages within the process was difficult due to the notes in Patient Flow. There was frequently a lack of clarity regarding when the assessments were sent to the Complex Care Team, if the documentation was returned for further information and when panel approval was obtained.

	Key Findings	Risk & Impact	Agreed Management Action
4	**Red2Green Process** The R2G standard has been integrated into the DigiFLO application and by default, all patients are categorised as red, requiring staff to manually update their status to green each day. Staff members comprehension of R2G days did not completely align with the guidance provided by Welsh Government.	Government guidance not adhered to in relation to managing patient discharge and hospital flow.	**Agreed Action:** Provide clear, step-by-step guidance for staff to fully understand the "Red2 Green Process" and how to correctly apply it using both the manual and electronic whiteboards. Conduct refresher training sessions for staff to ensure they fully understand the process. Incorporate the D2RA pathway and R2G standard to the handover documentation.

	All patients listed on the DigiFLO Whiteboards for Y Bannau Ward and Epynt Ward were indicated as having a red day. This suggests that staff may not be adequately updating or using the R2G feature on the DigiFLO application. Furthermore, the manual boards are showing discrepancies, with some patients recorded as having a Green Day, leading to inconsistent reporting. It was also noted that the handover notes prepared before each shift currently lack references to the D2RA pathway and do not specify whether the patient is categorised as a red or green day. Integrating this information into the handover notes, can ensure that all staff members are well-informed and can effectively contribute to maintaining the appropriate pathway, promoting an increase in green days.		**Expected Evidence of Implementation:** Concordance with boards and compliance of D2RA R2G demonstrated with reporting nationally
		High Priority	**Officer:** Clinical Change Manager (Unscheduled Care) **Target Implementation Date:** Quarter 3 2025
	Theme: Quality, Safety & Patient Experience	Control Design	
5	**How the D2RA Pathway is decided and communicated** The Hospital Discharge guidance from WG emphasises there must be simple, robust and responsive local processes to enable the definitive pathway decision and rationale to be accurately conveyed from the ward to a discharge co-ordination hub, to ensure that safe and appropriate onward care and assessment can be arranged via the appropriate D2RA Pathway. Furthermore, once the decision of the definitive discharge pathway has been agreed, the patient and their family or unpaid carer and existing care providers must be informed and be provided with details of the decision. We could not find sufficient evidence within the existing systems to clarify how the decision regarding the D2RA Pathway was made. Additionally, the communication of this rationale from the ward to the discharge coordination hub remains unclear. It is also uncertain how families and caregivers have been informed about this decision.	Government guidance not adhered to in relation to managing patient discharge and hospital flow.	**Agreed Action:** Establish a standardised procedure for recording the decision-making process related to the D2RA Pathway, ensuring that the rationale and supporting evidence are clearly outlined. Additionally, document how families and caregivers have been informed about these decisions within the appropriate systems.
			Expected Evidence of Implementation: D2RA pathways recorded on Digiflow with HB wide compliance which feeds into national reporting Documentation on WNCR to reflect family discussions
		Medium Priority	**Officer:** Clinical Change Manager (Unscheduled Care) **Target Implementation Date:** Quarter 3 2025
	Theme: Information, Data Quality & Data Accuracy	Control Design	

6	**Utilisation of DigiFLO whiteboards** The DigiFLO whiteboard app can be installed on phones, tablets, laptops, and large screens, with nine wards currently equipped. It replicates manual whiteboard processes but faces information governance challenges, particularly maintaining an audit trail to track changes. Currently, large screens are accessible to all staff, but generic accounts only allow display access. Modifications require logging in with individual identification on a computer. Future plans include tap-to-login or PIN systems to enable broader access, including bank and agency staff. The current utilisation of the DigiFLO whiteboards is mixed with some departments still relying on manual whiteboards, as observed during the audit of the two wards.	Government guidance not adhered to in relation to managing patient discharge and hospital flow.	**Agreed Action:** Conduct targeted training and engagement sessions for departments still relying on manual whiteboards to demonstrate the benefits of the electronic whiteboard and address barriers to adoption. Expedite the implementation of a secure tap-to-login or PIN-based system to ensure accurate tracking of user actions while improving accessibility for all staff, including temporary personnel. **Expected Evidence of Implementation:** Utilization flow boards for all wards with user access, log ins, ability to audit data and bank and agency staff to access removing barriers to access. Ability to confirm access to all with IG barriers resolved for usability and visibility.
		Medium Priority	**Officer:** Clinical Change Manager (Unscheduled Care) **Target Implementation Date:** Quarter 3 2025
	Theme: Information, Data Quality & Data Accuracy	Control Operation	
7	**Clinical Frailty Score** The suggested standards outlined in the WG operational guidance for delivering optimal outcomes and experience for people in hospital states that patients aged 65 and over must have a clinical frailty score (CFS) on arrival into urgent care and those that are frail must have rapid access to comprehensive geriatric assessment (CGA) and rehabilitation. Currently this is not a requirement within WNCR, and it does not form part of the patient assessment on admission to the Community Hospital. Although the DigiFLO app includes a section for recording this information, it is currently underutilised. We have been notified that a new national deconditioning score is being developed, which will monitor deconditioning over time based on the length of stay. The DigiFLO whiteboards will be updated accordingly once this new score is implemented.	Government guidance not adhered to in relation to managing patient discharge and hospital flow.	**Agreed Action:** Utilise the DigiFLO system to document the clinical frailty scores of patients aged 65 and above. It may be beneficial to incorporate this procedure into the admission pack. **Expected Evidence of Implementation:** Clinical frailty scores as part of the output and recording function for DigiFlow.
		Medium Priority	**Officer:** Clinical Change Manager (Unscheduled Care) **Target Implementation Date:** Quarter 4 2026
	Theme: Information, Data Quality & Data Accuracy	Control Design	

8	**Use of Inpatient Notes within WNCR**
	
	Within WNCR, there is a dedicated section for Inpatient Notes that allows users to select a 'note type' when updating entries, depending on the contributor or content being added. Available options include MDT Review, and Discharge discussions. The admission details and the estimated Date of Discharge (EDD) is also recorded in the system.
	
	As part of the sample testing, we examined the Nursing Notes and although it provided insights into patient mobility, nutrition, and assistance needs, the information could better align with the Hospital Discharge guidance. The notes should include indicators of whether a patient is experiencing a red or green day and the rationale behind this, thereby demonstrating that the R2G framework has been considered and discussed. Currently, the information provided is limited.
	
	Furthermore, the discharge discussion notes section within the Inpatient notes is infrequently utilised, with only three instances identified out of twelve.
	
	As highlighted in key findings 5 and 11, fully utilising WNCR to record all key information would enhance documentation practices and establish a more comprehensive audit trail.
		Government guidance not adhered to in relation to managing patient discharge and hospital flow.	**Agreed Action:**
			
			Establish a step-by-step guidance on what should be recorded within the Inpatient Notes under each specific 'note type' so that the information recorded is better aligned with the Hospital Discharge Guidance. The guidance should cover the following:
			
			• Highlight the key elements of the guidance that must be reflected in the Nursing Notes (e.g., indicators of R2G days, rationale for observations).
			• MDT Review Notes to include how the decision regarding the D2RA Pathway was made and communicated to patient and family. (Key Finding 5)
			• Enhance Discharge Discussion Notes by including key information, such as:
			  ○ What was discussed with the patient or their family, including discussions around EDD. (Key finding 10)
			  ○ Date the 'Planning your Discharge' Letter was issued and to whom it was issued. (Key Finding 11)
			
			After the guidance has been established, inform staff about its availability.
			
			Expected Evidence of Implementation:
			
			Update of WNCR user notes for guidance on the above completion (CNO Informatics) will need discussion with national team who control WNCR inputs.
			
			Implementation and monitoring of completion with Community Service Managers of PTHB Community Hospitals if above agreed.

	Theme: Information, Data Quality & Data Accuracy	**Medium Priority** Control Operation	**Officer:** Emma McGowan, Chief Nursing Information Officer **Target Implementation Date:** Quarter 3 Scoping & implementing into WNCR / Quarter 4 to implement into practice
9	**Patients with complex needs** Patients categorised under Pathway 3 present complex needs. Those who are either CO or Discharge Ready and require Nursing Care must undergo a DST assessment or a PAN assessment by the appropriate ward. The findings should be sent to the Complex Care Team for review and submitted to the panel as needed.	Government guidance not adhered to in relation to managing patient discharge and hospital flow.	**Agreed Action:** Improve documentation practices by implementing a standardised template or clear guidelines for recording and tracking key dates, such as when assessments are forwarded to the Complex Care Team and when panel approvals are granted. This will enhance transparency and traceability and help to identify themes and trends.

	We reviewed 24 patients on Pathway 3 and identified that four had a length of stay exceeding 100 days. Two of the four assessment documents for these patients took longer than 30 days to be completed and forwarded to the Complex Care Teams, with one extending up to 60 days. Additionally, we examined the time from the decision to assess the patient (when patient is CO) to the testing date (18/12/24). All four assessments exceeded 90 days, and two patients have been discharge ready since October 2024. Determining the locations of blockages within the process proved challenging based on the notes in Patient Flow. It was often unclear when the assessments were forwarded to the Complex Care Team or when they received panel approval. Accurately documenting these dates will enable management to determine whether delays originate from the wards or the Complex Care Teams. The Health Board, however, has recognised existing quality issues with the documentation sent to the Complex Care Team, and training needs have been identified to address these concerns.		Explore alternative systems like DigiFLO or WNCR for recording and tracking key dates, as access to Patient Flow is limited to specific staff members. Conduct targeted training sessions for Ward staff to address quality issues in the documentation submitted to the Complex Care Team.
			Expected Evidence of Implementation:
		Medium Priority	**Officer:** Clinical Change Manager (Unscheduled Care) – DigiFlow Quarter 3 2025
	Theme: Training & Development	Control Operation	**Rhian Price Evans –** CHC Training Quarter 2 2025 **Target Implementation Date:** As above

Objective 4: The Health Board has processes and resources in place to work with local teams in provider Health Boards and Trusts to support the timely discharge and / or repatriation of Powys residents.	Reasonable

Overview / Summary of Observations

Wye Valley Trust (WVT) use three methods for documenting electronic data relating to Patient Flow. These methods include the Wye Valley system, the daily live list, which is an Excel document, and the Patient Flow list. A daily live report is generated from the Wye Valley system, capturing all patients registered with a GP in Powys. This information is then exported into the Excel document.

An email is distributed to recipients from Powys Teaching Health Board and Wye Valley, including senior managers, nursing staff, and members of their Care Transfer Coordinators (CTC) team. This communication outlines patients awaiting assessment from a local authority standpoint, highlights individuals who may qualify for the 'Ready to Go' unit, and specifies which patients are palliative and set for discharge today and tomorrow. The email also includes the 'daily live list' for information. This procedure offers a thorough overview of forthcoming discharges and incoming patients. This process is repeated again in the afternoon to ensure that all individuals are informed of any updates.

The Estimated Discharge Date (EDD) is determined during the Multidisciplinary Team (MDT) meetings, which occur daily, and in certain wards, twice a day. While the objective is to establish this date within 24 hours of a patient's admission, the decision is often influenced by the patient's complexity and can sometimes delay the outcome or they provide a preliminary estimate, which may evolve as the patient's journey progresses.

The D2RA care pathways are not implemented in WVT; however, a comparable pathway system is in place for each patient. For instance, Pathway 0 is designated for those returning home, while Pathway 1 caters to reablement or those with slightly elevated needs. Pathway 2 involves admission to a community hospital, and Pathway 3 addresses more complex cases.

The CTC attend daily meetings with social workers and a coordinator from the local authority, which is kept small for efficiency. During the meeting, each participant provides updates. The LA coordinator meets with brokerage beforehand to gather information on assessments and discharge dates. If a discharge date is set, the CTC will inform the ward and arrange the transfer home or to a nursing home by 4:00 PM. Additionally, the CTCs will coordinate transport and provide contact numbers for handovers, whether nurse-to-nurse or doctor-to-doctor. Any changes to the patient journey is documented on all three systems. Alongside the daily meetings, a Delay in Transfer of Care (DTOC) meeting is held every Tuesday. This meeting brings together all CTCs and local authorities, providing a platform for Senior Managers to participate and present challenges.

A sample of the 'daily live lists' was received and evaluated. However, we were unable to compare this data with the Patient Flow List, as the Patient Flow List is a live system, making retrospective analysis impossible.

	Key Findings (Relating to Objectives 3 and 4)	Risk & Impact	Agreed Management Action
10	**Estimated Date of Discharge (EDD)** **Powys Community Hospitals** As part of the sample testing, we compared the EDD recorded on the manual whiteboard to those documented in the WNCR. We identified three instances within Epynt Ward where the dates did not align. Additionally, we examined the interval between the admission date and the date when the original EDD was established. Across both wards, we discovered six cases where the EDD was set more than seven days post-admission, with the longest delay being 51 days.	Government guidance not adhered to in relation to managing patient discharge and hospital flow.	**Agreed Action:** Clear guidance on the management and recording of EDD needs to be established. Each patient should have an agreed-upon EDD confirmed during their initial Multidisciplinary Team (MDT) meeting or within 24 hours of admission, which must be documented and communicated to the patient and their family or caregivers. Any discussions or modifications regarding the EDD should occur and be recorded prior to the expiration of the original EDD.

It is common for the EDD to be adjusted based on changes in patient needs and their progress in rehabilitation. Out of 12 patients, five had their EDDs modified from the original dates. Notably, for two of the five, the amendments recorded in WNCR occurred after the original EDD had lapsed, with one instance being 38 days later. It is essential that the EDD is discussed with both the patient and their family; however, we were unable to locate any documentation of such discussions in the In-Patient notes under the MDT Review, or discharge discussion records. (key finding 8). **WVT** We tested a sample of 38 patients, 12 had an estimated discharge date (EDD) set within 24 hours of admission. The remaining 26 patients did not have an EDD within that timeframe, with 8 patients still lacking an EDD after 4 days, and one patient waiting up to 7 days. While 68% of patients did not receive an EDD within 24 hours of admission, we recognise that there may be valid reasons or factors contributing to this situation. For instance, • There are currently two CTCs operational. If one is absent from the office, the inclusion of the EDD in the daily live list may be affected by the volume of new admissions and overall workload. Although the EDD has been identified in the WVT system, the CTCs have not yet had the opportunity to update the list accordingly. • There may be instances when WVT are at full capacity upon the admission of a Powys patient, resulting in them being allocated a bed within the boarding bays. Consequently, the CTCs will not be informed of this patient until they visit the wards, as the patient is not officially assigned a 'bed'. • Delays in receiving MRI results, especially for stroke patients, can hinder timely decision-making regarding the expected EDD. The CTC team is aware of these delays in the process and is actively working to enhance the situation.		**Expected Evidence of Implementation:** EDD guidance recording to be reflected in Digiflow SOP & recorded as a reporting output measure. WVT evidence, all WVT pts have an EDD with an improved system to identify PTHB pts regardless of bed allocation.
Theme: Information, Data Quality & Data Accuracy	**Medium Priority** Control Design	**Officer: Officer:** Clinical Change Manager (Unscheduled Care) – DigiFlow / Chistina Thomas WVT **Target Implementation Date:** Clinical Change Manager (Unscheduled Care) – DigiFlow – Quarter 2 2025 / Chistina Thomas WVT – Quarter 3 2025

11	**'Planning your Discharge' Letter** Individuals and their families or unpaid carers must be fully informed of the next steps at all stages of the inpatient stay and involved in the discharge planning process. The Welsh Government Hospital Discharge guidance includes a template for a 'Planning your Discharge' letter, which should be provided to patients. This letter emphasises that discharge planning should already be in progress and outlines the importance of facilitating a quick and safe discharge to enhance the patient's recovery. **Powys Community Hospitals** Our sample testing identified only one instance out of twelve where the system recorded that this letter had been issued. The WG guidance does not specify the appropriate timing for issuing the letter. It is therefore important for the Health Board to decide whether the letter should be provided after the patient's initial MDT review or included as part of the admission pack. Additionally, it would be beneficial to document the issue of the discharge letter in the Discharge Discussions section of the WNCR. (Key Finding 9) **WVT** During discussions with the CTC, it was observed that they do not provide a 'Planning your Discharge' letter to patients and caregivers. The CTC acknowledged that the letter was discontinued due to the outdated policy. However, they expressed their willingness to resume issuing and documenting the letter once the new policy, which incorporates the standard letter, is implemented.	Government guidance not adhered to in relation to managing patient discharge and hospital flow.	**Agreed Action:** Ensure that a 'Planning your Discharge' Letter is issued to each patient. Establish clear guidance on when the letter should be issued. Ensure that the issue of the letter is documented within WNCR system, as highlighted in key finding 9. **Expected Evidence of Implementation:** March 2025 for letter and issuing as part of PTHB Discharge Policy.
		Medium Priority	**Officer:** Senior Manager Unscheduled Care & Community Service Managers
	Theme: Information, Data Quality & Data Accuracy	Control Operation	**Target Implementation Date:** Quarter 2 2025

Objective 5: Data is collated, reviewed and analysed to demonstrate the effectiveness of the discharge management arrangements and support compliance with the key principles of the guidance, and actions are taken to address areas of poor performance and low/non-compliance.	Substantial

Overview / Summary of Observations

The Integrated Patient Flow SOP is in place to guide this process. The primary data source is obtained from the Patient Flow list, which contains real-time patient information and tracks critical milestones for all admissions throughout their inpatient journey. It also tracks the Pathway of Care Delay (POCD) codes associated with each patient who has been classified as Clinically Optimised, and has exceeded 48 hours without being discharged.

The allocation of POCD codes to patients occurs on Census day during a meeting with the USC Senior Management team and the Local Authority Hospital Patient Transfer Manager. A Joint Validation meeting follows to confirm codes linked to delays, with validation finalised and approved within three days.

After the census submission, the national team will provide a spreadsheet to the Health Board and a dashboard that illustrates the organisation's performance in relation to the national targets. Themes and trends from the census reports, previously reviewed by the now-dissolved Strategic Oversight Group (SOG), are monitored by the POCD Action Plan working group, which meets quarterly. The Management Team uses the dashboard to track delay progress. The Senior Management Group has noted a reporting gap since the SOG's disbandment.

For 2024/25 the Care Action Committee has agreed the following ministerial targets of:

- 15% reduction in total Delays
- 20% reduction in total days delayed
- 20% reduction in delays due to an assessment reason code

In October, the Health Board reported a 21% decrease compared to their baseline for the 15% target reduction in total delays. Additionally, there was a 19% reduction against the 20% target for total days delayed, and a significant 43% reduction in delays attributed to an assessment reason code, surpassing the 20% reduction goal.

Every quarter, the Health Board is required to submit a POCD action plan. This plan outlines their top 1-5 key actions, details their initiatives related to the POCD reason codes, and assesses their progress towards meeting ministerial targets. The WG reviews the plan and offers feedback on the Health Board's latest submission. In August 2024, the WG acknowledged several positive aspects of the July POCD action plan but recommended that the Health Board include in their October submission the progress made during the second quarter to tackle capacity issues resulting from funding decisions. Additionally, they requested more detailed information regarding engagement with the regional Mental Health and Learning Disabilities lead.

A review of the October POCD Action Plan submissions indicates that the Health Board has supplied WG with further information on capacity issues. However, they could not advance engagement with the regional Mental Health and Learning Disabilities leads due to the Strategic Oversight Group being stepped down.

Objective 6: Robust governance arrangements are in place to ensure timely and effective monitoring and oversight of discharge management, including effective co-ordination with local authorities and the third sector.	Substantial

Overview / Summary of Observations

To ensure that there is effective monitoring and oversight of discharge management within the Health Board, Unscheduled Care has established several meetings. These involve executive-led groups, representatives from Powys County Council, and third sector organisations, all collaborating alongside health professionals.

Patient Flow meetings primarily focus on reviewing district general hospitals, community hospitals extended length of stay, whereas the Daily Flow meetings are held to discuss safe care practices, which are escalated to organisational management and reported to the Delivery Coordination Group as needed. Alongside the daily meetings, the team has established the Delivery Co-location Group, tasked with monitoring the advancements of the temporary colocation modifications. Furthermore, they engage in the National Call to communicate the operational pressure levels of the Health Boards to the National Team.

In addition to these meetings, there is the bi-weekly Care Action Committee (CAC), formed in November to tackle the 50-day Integrated Care Winter Challenge initiated by the Welsh Government. This committee has taken the place of the SOG. After reviewing the information presented at the CAC, we are assured that the data previously discussed at the SOG is now being addressed within the CAC.

The POCD Action Plan working group convenes on a quarterly basis, prior to the submission of the updated action plan to Welsh Government. There is a Bimonthly Community Service Group Operational Meeting, which receives updates from each service. It was noted that the Terms of Reference for this meeting was incomplete and remained in draft form. Between April and July 2024, the Lead of Unscheduled Care participated in only one out of three scheduled meetings. Additionally, the meeting in October did not occur, and no subsequent meetings were communicated during the audit.

Before the disbandment of the USC SOG, a monthly highlight report was prepared for the Joint Executive Committee. This report included any unresolved operational issues that could impact service delivery. However, we could not determine whether this practice has continued or if the committee still convenes, as we were unable to obtain evidence of any recent meetings.

It has been noted that while several meetings are recorded in the Integrated Patient Flow Standard Operating Procedure, a comprehensive reporting structure detailing the hierarchy and communication flow concerning discharge management would be beneficial. Additionally, identifying the attendees of these meetings proved challenging due to the absence of this being documented.

Appendix A

Assurance Opinion

Substantial

Few matters require attention and are compliance or advisory in nature.

Low impact on residual risk exposure.

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Limited

More significant matters require management attention.

Moderate impact on residual risk exposure until resolved.

Unsatisfactory

Action is required to address the whole control framework in this area.

High impact on residual risk exposure until resolved.

Advisory

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.

Disclaimer

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Powys Teaching Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management of the Powys Teaching Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Prioritisation of Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership]

Pharmacy Stores

Final Internal Audit Report 2024/25

Powys Teaching Health Board

Reasonable Assurance

Contents

Review Reference	PTHB-2425-04
Fieldwork	February – March 2025
Executive Sign Off	9th April 2025
Audit Committee	May 2025
Executive Lead	Kate Wright, Executive Medical Director
Audit Team	Ian Virgil, Head of Internal Audit
	Geoffrey Woolley, Principal Internal Auditor

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Executive Summary

Purpose

The overall scope of the audit was to review the policies and procedures in place regarding the Pharmacy Stores.

Overview

Appropriate storage and management arrangements are necessary to ensure that the quality of medicines/vaccines is maintained and so prevent potential harm to patients.

The current arrangements and procedures for the ordering, receipt, storage and distribution of medicines/vaccines were established during the Covid-19 Pandemic in response to the emergency situation.

The Main Pharmacy Store, which was the focus of our review, is situated in Hafren ward on the Bronllys site. This then delivers vaccines into wards, departments and vaccination centres across the Health Board.

We have concluded **Reasonable** assurance on this area. The matters requiring management attention include:

- A lack of supporting documentation for the ordering, receipt and distribution of vaccine stock;
- Inadequate and / or incomplete recording of information within the stock management spreadsheets; and
- Inadequate stock reconciliation procedures, including a lack of book to physical stock reconciliations.

Full details of matters arising are detailed within the Findings & Agreed Action Plan. The following opportunities for enhancement have been identified that do not impact the overall opinion and are highlighted for management information:

- While each vaccine spreadsheet is broadly similar in structure, they have been set up separately and are not identical templates.
- A separate spreadsheet should be set up for each annual vaccination programme.

Scope & Assurance Summary

Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	Appropriate and up to date written policies/procedures are in place which have been communicated to all staff required to follow them.	-	**Substantial**
2	The written policies/procedures are being followed correctly and ensure that medicines/vaccines are being ordered, received, stored and distributed appropriately.	1, 2, 3	**Limited**
3	Medicines/vaccines are being managed correctly and safely in accordance with recognised pharmacy standards, Health & Safety requirements and other relevant regulations.	-	**Substantial**

Management Actions

3	0
High Priority	Medium Priority

Themes

Risk Types

Public Perception & Reputational Risk

Choose an item.

Powell Bethan
01/05/2025 10:03:13

Findings & Agreed Action Plan

Objective 1: Appropriate and up to date written policies/procedures are in place which have been communicated to all staff required to follow them.	**Substantial**

Overview / Summary of Observations

Appropriate and up to date policies and procedures are in place for Pharmacy Stores which are available on the Health Board's intranet and public website.

A log is maintained which records when the written policies/procedures were last read in full by staff required to follow them.

'Good Distribution Practice' training is also provided to staff for which an accompanying test must be passed. Both had been completed by the Pharmacy Stores staff within the preceding year.

Objective 2: The written policies/procedures are being followed correctly and ensure that medicines/vaccines are being ordered, received, stored and distributed appropriately.	**Limited**

Overview / Summary of Observations

Pharmacy Stores manages the vaccine stock for each of the three core vaccination programmes i.e. Covid-19, Flu and RSV (Respiratory Syncytial Virus).

Vaccine stock is managed using a series of spreadsheets, with a separate spreadsheet set up for each vaccination programme. Each spreadsheet comprises a series of detailed worksheets which record a comprehensive range of relevant information for orders, receipts, storage and distributions.

Ordered

The types of vaccines ordered reflect central guidance, they are ordered from known suppliers, and the quantities ordered reflect known requirements. Vaccine orders are completed by the Senior Pharmacy Technician, Vaccinations/Therapies & Pharmacy Stores which is a key aspect of the role.

Received

When vaccines are delivered to Pharmacy Stores, the items received are checked for consistency with the order and any quantity or quality issues would be immediately followed up with the supplier.

Full receipt details, including batch reference and expiry date, are recorded against the order on the vaccination order worksheet. In addition, Pharmacy Stores is required to record vaccine receipts online on the Welsh Immunisation System (WIS).

However, copies of orders and delivery notes are not being consistently retained so we were not able to fully validate these processes for all the orders sampled.

Stored

Pharmacy Stores is made up of three rooms. The main room is a preparation area where receipts are checked and distributions are prepared and the other two rooms hold nine large fridges. Access is restricted by a locked door.

The fridges are medical grade with digital temperature displays which are designed to store vaccines within the required +2°C to +8°C range, plus cool packs used to maintain vaccine temperature during distribution. They have glass doors so their content can be viewed without having to open the door.

The high and low temperatures for each fridge are checked and recorded daily on the online Welsh Immunisation System (WIS). If any are outside the required range, then comments should also be added. We checked a sample of temperatures recorded on WIS and confirmed that they were within the required range.

We visited Pharmacy Stores and confirmed that the fridges were operating correctly within the required temperature range and had unique identifier reference numbers attached. Furthermore, each had a label attached confirming it had been calibrated in May 2024 and this was scheduled to be repeated in May 2025.

However, at peak times of the year, some vaccine is initially held at a neighbouring Health Board's hospital prior to being drawn down to Pharmacy Stores. We were informed that this is due to a lack of current available fridge space and therefore, Pharmacy Stores has proposed upgrading to a large capacity walk in cold storage unit. A paper regarding this was produced for wider consideration, and the issue has been added to the department's risk register.

The Health Board has appropriate procedures regarding the use of quarantine stock where special conditions need to be put in place e.g. reduced expiry date where the required temperature range has been exceeded for a limited period. Furthermore, there has been no vaccine wastage which required recording online on WIS.

Distributed

Vaccines are distributed using specialised vaccine carriers which the Health Board has in a variety of sizes.

Vaccination distributions reflect known appointments scheduled at the vaccination centres (Bronllys and Newtown), to whose records Pharmacy Stores has access, or requests from District Nurses, Maternity Services or School Nurses.

Most distributions occur via an NHS Shared Services driver who collects and distributes vaccines, plus District Nurses occasionally collect vaccines personally.

A vaccination delivery template has been developed which records a comprehensive set of information. It accompanies each vaccination distribution and, following sign off by the recipient, the completed version should be returned to Pharmacy Stores for retention. However, these were not present for the majority of deliveries we sampled.

Vaccine distributions are packed in insulated cool boxes along with cool packs which should maintain the required temperature for up to eight hours. Furthermore, most are transferred in temperature controlled vans.

The vaccination centres have medical grade fridges identical to those in Pharmacy Stores and so can hold surplus stock for the next vaccination session.

Distributions to District Nurses and wards comprise individual vials which have been taken from a full box so that excess stock is not distributed.

Again, we were not able to fully validate the delivery processes for all our sample as copies of requests and delivery notes are not consistently retained.

	Key Findings	Risk & Impact	Agreed Management Action
1	**Lack of supporting documentation.** We tested a sample of 8 vaccine orders and 25 distributions and noted the following: • 8/8 supporting orders were not available; • 7/8 supporting delivery notes for orders were not available; • 14/25 supporting requests for distribution were not available; and • 13/25 supporting delivery notes for distribution were not available.	Inadequate support for Pharmacy Stores stock movements.	**Agreed Action:** Supporting documentation will be retained and appropriately filed for all Pharmacy Stores stock orders and movements so that the accuracy of the details recorded can be fully justified.
			Expected Evidence of Implementation: Supporting documentation is readily available for all Pharmacy Stores stock movements.
		High Priority	**Officer:** Senior Pharmacy Technician, Vaccinations/Therapies & Pharmacy Stores.
	Theme: Information, Data Quality & Data Accuracy	Control Operation	**Target Implementation Date:** Complete, already implemented.
2	**Inadequate recording of information.** While the worksheets have a comprehensive set of columns to record relevant information, a small proportion of the cells were empty or had not been completed. We also noted the following issues: • 1/8 receipts showed differences between the supporting delivery note and the vaccine receipts worksheet; • 3/8 receipts were not correctly shown on the stock check worksheet; • Where WIS records were available, as they are only available for three months, while for 2/8 receipts the stock check worksheet was consistent with WIS, only one of these was also consistent with the receipt tested; • Only 9/12 stock check worksheet balances were consistent with WIS; • The stock check worksheet only includes figures, formulae are not used to carry forward and calculate balances.	Inadequate control of Pharmacy Stores stock.	**Agreed Action:** The Pharmacy Stores stock records will be reviewed and amended so that they accurately record all stock movements and balances held and are consistent with movement supporting documentation and the online Welsh Immunisation System (WIS).

	Furthermore, the figures shown occasionally do not cast correctly; • 11/12 supporting delivery notes had differences compared to the distribution worksheet, one supporting delivery note's file name was incorrect and one supporting delivery note was incorrectly filed; • 7/25 transaction movements were not correctly shown in the stock check worksheet and of the 18 transaction movements that were correctly shown, 3 did not clearly show the breakdown; and • For 13/25 transaction movements which indicated that they included pack down separated vials, information was not correctly shown in the pack down worksheets.		**Expected Evidence of Implementation:** The Pharmacy Stores stock records accurately record all stock movements and balances held and are consistent with movement supporting documentation and the online Welsh Immunisation System (WIS).
		High Priority	**Officer:** Senior Pharmacy Technician, Vaccinations/Therapies & Pharmacy Stores. **Target Implementation Date:** Complete, already implemented.
	Theme: Information, Data Quality & Data Accuracy	Control Design	
3	**Inadequate stock reconciliation procedures.** While daily and weekly stock checks are performed, they do not include book to physical stock check reconciliations to confirm the accuracy or otherwise of the records. The stock check worksheet closing balance does not show the split between pack down separated vials and non pack down full box balances. The stock check worksheet does not include the earliest expiry date against the closing balance to ensure that any expiry date issues are promptly highlighted.	Incorrectly recorded Pharmacy Stores stock balances.	**Agreed Action:** Daily and weekly book to physical stock check reconciliations will be performed, with the book and physical stock balances clearly stated along with a reconciliation of the difference between them and the name of the person who completed the stock check. The stock check worksheet closing balances will show the split between pack down separated vials and non pack down full box balances. The stock check worksheet will include the earliest expiry date against the closing balance.
			Expected Evidence of Implementation: Records of completed monthly stock check reconciliations.
	Powell Bethan 01/05/2025 10:03:13	**High Priority**	**Officer:** Senior Pharmacy Technician, Vaccinations/Therapies & Pharmacy Stores. **Target Implementation Date:** Complete, already implemented.
	Theme: Information, Data Quality & Data Accuracy	Control Design	

Objective 3: Medicines/vaccines are being managed correctly and safely in accordance with recognised pharmacy standards, Health & Safety requirements and other relevant regulations.	**Substantial**

Overview / Summary of Observations

The Senior Pharmacy Technician, Vaccinations/Therapies & Pharmacy Stores is the Health Board's designated person responsible for identifying standards and regulations to be complied with in relation to Pharmacy Stores. They have a high level of pharmacy knowledge and experience and are supported by a Pharmacy Technician who also has an appropriate level of pharmacy knowledge and experience.

In relation to Pharmacy Stores, the most significant risks that medicines/vaccines are not being managed in accordance with recognised pharmacy standards, Health & Safety requirements and other relevant regulations are:

- Deterioration of vaccines due to inadequate temperature control:

  The fridges are temperature controlled medical grade with daily temperature checks which were calibrated in May 2024 and are due to be repeated in May 2025.

- Manufacturer product recall:

  The batch references for vaccine stock are on the packaging and recorded in the vaccine programme spreadsheets and on the Welsh Immunisation System (WIS). Therefore, the implications of any recall can be immediately identified and appropriate action taken.

- Quarantine stock:

  Pharmacy Stores staff have confirmed that any such stock would be recorded, and a label attached and advice, confirmed in writing, would be obtained from the manufacturer regarding what action should be taken. However, it was also stated that this is generally not a problem in Pharmacy Stores but is more likely to occur at vaccination locations where the vaccine storage is being repeatedly opened and closed.

Furthermore, no vaccine wastage has been recorded by Pharmacy Stores on the Welsh Immunisation System (WIS) in the preceding three months for which records were available, and we have been assured that this is correct.

We have been informed that the Health Board does not hold an MHRA (Medicines and Healthcare products Regulatory Agency) licence as this is only required by manufacturers / distributers and so is not applicable as the Health Board is merely a user which obtains the vaccines for its own use.

Appendix A

Assurance Opinion

Substantial

Few matters require attention and are compliance or advisory in nature.

Low impact on residual risk exposure.

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Limited

More significant matters require management attention.

Moderate impact on residual risk exposure until resolved.

Unsatisfactory

Action is required to address the whole control framework in this area.

High impact on residual risk exposure until resolved.

Advisory

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.

Disclaimer

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of Powys Teaching Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management of Powys Teaching Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Prioritisation of Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership]

GMS Unified Contract Assurance Framework

Final Internal Audit Report 2024/25

Powys Teaching Health Board

Substantial Assurance

Contents

Review Reference	PTH-2425-16
Fieldwork	January – March 2025
Executive Sign Off	10th April 2025
Audit Committee	May 2025
Executive Lead	Elaine Lorton, Executive Director of Primary Care and Mental Health
Audit Team	Ian Virgill, Head of Internal Audit Lucy Jugessur, Deputy Head of Internal Audit Stuart Bodman, Principal Internal Auditor

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Executive Summary

Purpose

To review the processes for managing the GMS Unified Contract Assurance Framework, and the monitoring and reporting arrangements in place in respect of its implementation.

Overview

A new Unified Contract for GMS Service was negotiated over 18 months as part of a tripartite approach with Welsh Government, NHS Wales and the General Practitioners Committee (Wales) (GPCW).

The NHS (General Medical Services Contracts) (Wales) Regulations 2023 (2023 Regulations) underpinning the Unified Contract came into effect on 1 October 2023.

The Unified Contract for GMS will simplify what services all GP practices in Wales must provide and how they evidence assurance of delivery.

The key aims of the Unified Contract are:

- to make it easier for patients and healthcare professionals to understand responsibilities for the provision of services;
- to reduce administrative bureaucracy, freeing up time and resource for service delivery; and
- to enable use of data and technology to help plan resources and delivery of services.

The GMS Unified Contract Assurance Framework (the "Framework") is in use across NHS Wales and by general medical services (GMS) contractors to provide assurance of delivery of the GMS Unified Contract. The Framework has been developed taking account of the context of the new Health and Care Quality Standards for Wales (2023).

The Framework is a governance process for the evaluation of assurance on services delivered through the Unified Contract, in the context of the Duty of Quality legislation, and has three components:

- A nationally agreed data set for quality, safety, governance and contract management. This comprises of a national set of indicators, a practice assurance return, CGPSAT and IG toolkit.
- A nationally agreed process for assessing contractors' compliance against contractual requirements; and
- A nationally agreed escalation ladder for managing concerns, including an appeals procedure.

We have concluded **Substantial** assurance on this area. This reflects the significant work undertaken within the Health Board to ensure that the requirements of the Framework were complied with in delivering the 2023/24 cycle.

The matters requiring management attention include:

- Absence of a Standard Operating Procedure (SOP) documenting the process for the determination and finalisation of Practice Visit Assessment Report Assurance Ratings.
- Lack of an overall assurance rating for the Practice Visit Assessment reports completed as part of the 2023/24 cycle.

Full details of matters arising are detailed within the Findings & Agreed Action Plan.

Scope & Assurance Summary

Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	Up to date procedure documents are in place setting out the Health Board's processes in relation to the Framework.	1	**Reasonable**
2	An assessment of practice assurance is undertaken for each of the GMS contractors against the National Indicators stated within the Unified GMS Contract and these are formally recorded, reported and outcomes reviewed by the Health Board.	-	**Substantial**
3	Visits are carried out to those practices prioritised for further assessment, with timely verbal and written feedback provided, action plans agreed and monitored, and follow-up reviews planned.	-	**Substantial**
4	The stages of the Framework's Escalation Ladder are appropriately utilised for those practices where a breach or remedial notice may ultimately be issued by the Health Board.	2	**Reasonable**
5	The Health Board receives regular reporting and assurance in respect of the new GMS unified contract performance and patient access to primary care GMS services.	-	**Substantial**

Management Actions

0	2
High Priority	Medium Priority

Themes

Risk Types

Legal & Regulatory Non-Compliance

Choose an item.

Findings & Agreed Action Plan

Objective 1: Up to date procedure documents are in place setting out the Health Board's processes in relation to the Framework.	Reasonable

Overview / Summary of Observations

The Health Board Primary Care Team that oversees the management, oversight and GMS Contractor compliance with the Framework has chosen not to create Standard Operating Procedures in respect of these processes.

Instead, they work solely to the Framework Guidance documentation that supports the implementation of the Framework, and given its content, logical structure and ease of use, we agree that there is no need for a separate Health Board SOP as this would largely be a facsimile of the Guidance itself.

Training has been provided by Welsh Government to ensure that Health Board Primary Care staff can undertake GMS Practice Visit Assessments in accordance with the Framework Guidance Appendix A requirements, and this was evidenced through our testing relating to Objectives 2, 3 and 4 of this Report.

Additionally, our testing also confirmed that GMS Unified Contract Practice Managers are conversant with the requirements of, and also their responsibilities relating to, the performance assessment process undertaken by the Health Board and as detailed within Appendix A of the Framework Guidance.

	Key Findings	Risk & Impact	Agreed Management Action
1	**Standard Operating Procedure: Practice Visit Report Assurance Ratings** Testing undertaken in Objective 4 identified that there is no SOP in place to clarify and formalise the process for the assessment and awarding of Practice Visit Report Assurance Ratings that underpin the potential invocation of the Framework Escalation Ladder, in absence of this approach being provided within the Framework Guidance. The Contract and Visit Governance Report includes twelve Assurance Ratings - one for each assessed Health & Care Quality Standard, and where there is an even or 'close call' split of ratings across the twelve Standards, as we identified in several of the five Reports, there is no current process to determine the final overall Assurance Rating. The Framework Guidance states no criteria relating to the assessment of the Assurance Ratings for the twelve Standards to come to a definitive or overall Report Assurance Rating, nor does it provide advice relating to the 'weighting' to be attributed to the Standards regarding their priority towards the determination of a final Report Assurance Rating.	Non-compliance with the requirements of the Unified GMS contract resulting in potential patient harm, reputational damage and financial penalties.	**Agreed Action:** National guidance is due to be produced that will document and formalise the process for the assessment and awarding of Practice Contract and Visit Governance Report Assurance Ratings. Following production of the National Guidance, management will ensure that it is followed for future Practice Visits. **Expected Evidence of Implementation:** Confirmation that the national guidance has been received and is being followed.
	Theme: Policies & Procedures	**Medium Priority** Control Design	**Officer:** Jayne Lawrence, Assistant Director of Primary Care Services **Target Implementation Date:** Quarter 3 2025/26

Objective 2: An assessment of practice assurance is undertaken for each of the GMS contractors against the National Indicators stated within the Unified GMS Contract and these are formally recorded, reported and outcomes reviewed by the Health Board.	Substantial

Overview / Summary of Observations

Our testing identified that the annual assessment cycle for 2023/24 relating to the sixteen GMS Contractor Practices within Powys was appropriately supported by and based upon on data collated from the Primary Care Information Portal (PCIP), and other relevant and appropriate data/information sources in accordance with the Framework requirements.

The GMS Practice assessment process is undertaken by a Health Board Primary Care Assessment Panel that comprises of the GMS Primary Care Team, Assistant Director of Primary Care, Assistant Medical Director, Senior Pharmacist - Medicines Management and the Public Health Head of Service.

Each GMS Practice assessment is formally recorded in a desktop assessment report which states the data sources used in the assessment, and the assessment outcome and supporting justification against each of the Framework Indicator Domains and Enablers and is also recorded in an Action Plan that is shared with the respective GMS Practice.

The outcomes of each desktop assessment report then determines and states the justification as to which Practices are identified for Practice Visit Assessments, and those Practices that are to undergo assessment are reported to the Executive Director of Primary, Community Care and Mental Health via the Directorate Management Team meeting.

As such, five GMS Practices were identified in the 2023/24 assessment cycle as requiring a Practice Visit Assessment and the outcomes of these is discussed in Objective 3 of this Report.

Objective 3: Visits are carried out to those practices prioritised for further assessment, with timely verbal and written feedback provided, action plans agreed and monitored, and follow-up reviews planned.	Substantial

Overview / Summary of Observations

GMS Contractor Practice visits are formally structured and timetabled and ensure satisfactory prior notice of assessment, agenda of assessment coverage to be undertaken, and the provision of formal written feedback and further actions to be undertaken.

The Primary Care Team maintains a Contract Governance and Assurance Visits Log that timetables GMS Practice Assessment Visits and the issue of the reports and action plans to GMS Contractor Practice Management Teams, and also that of the timescales as prescribed in the Framework Guidance.

All five GMS Practices identified in the 2023/24 assessment cycle as requiring a Practice Visit Assessment were supported by and formally documented within the following:

- A Unified Contract Assurance Framework Outcome and Practice Notification of Visit Letter;
- A Unified Contract Assurance Framework Visit Agenda that summarises the process to be undertaken, the National Indicator Domains to be assessed and the formal reporting outcomes of the assessment undertaken;
- A Contract and Visit Governance Report and covering Health Board Primary Care Department Letter, and Practice Contract and Governance Framework Response Plan (PCGFRP) template to be completed by the GMS Practice Team.

We also note that in accordance with the Framework Guidance, all five GMS Practices were sent their Contract and Governance Visit Assessment Reports within 20 working days of the visit, and each respective submission deadline and date of sending to each Practice were recorded in the Contract Governance and Assurance Visits Log.

All five GMS Contractor Practice visits were fully and formally documented within Contract and Visit Governance Assessment Reports and supported by evidence-based justification to support their assurance levels and supported by Practice Contract and Governance Framework Response Plans (PCGFRPs) that will be subject to compliance monitoring and progress reporting within the Health Board. Additionally, none of the Contract and Governance Visit Assessment Reports stated a 'No Assurance' assessment rating.

We also note that all PCGFRPs were returned to the Health Board in a prompt manner and their assessment findings and improvement action recommendations were uncontested in content by the GMS Practices. The Contract Management Group reviewed the returned PCGFRPs and monitoring of progress towards implementation of the actions will take place as part of the review of the practices 2025/26 Annual Returns.

Objective 4: The stages of the Framework's Escalation Ladder are appropriately utilised for those practices where a breach or remedial notice may ultimately be issued by the Health Board.	Reasonable

Overview / Summary of Observations

None of the five GMS Practice Contract and Governance Visit Assessment Reports required the invocation of the Framework Escalation Ladder, in accordance with the stated requirements of the Guidance We also note that there wasn't any contentious engagement and / or dialogue with the GMS Contractors at any stage of the Practice Assessment Visits, and all respective Governance Framework Response Plans (PCGFRPs) relating to these Reports were accepted by the respective GMS Contractor Practice Management Teams.

Whilst not applicable during the 2023/24 annual assessment cycle, processes are in place to efficiently and effectively manage any future invocation of the Framework Escalation Ladder and the subsequent monitoring undertaken by the Primary Care Team and Health Board senior management in this respect.

	Key Findings	Risk & Impact	Agreed Management Action
2	**Overall assurance rating for the Practice Visit Assessment reports** Our review of each of the five GMS Contract and Visit Governance Reports identified that, based upon the individual Standard Assurance Ratings stated within, all five Reports could have potentially contributed towards the justification of triggering the Framework Escalation Ladder on the basis of an 'averaged' Limited Assurance rating. The Framework guidance states that the Escalation Ladder should be used 'If a contractor receives a Governance Visit Report with Limited or no assurance AND the PCGFRP is either not accepted or monitoring shows non-compliance. However, as noted within Finding 1, there is currently no process for determining the overall assurance rating, and no overall rating was provided for any of the five GMS Contract and Visit Governance Reports produced during the current cycle. The introduction of an overall Assurance Rating and a brief summary to justify this Rating within the Contract and Visit Governance Report would also be of use to GMS Contractor Practice Management Teams as an overall position statement relating to the assessment undertaken.	Non-compliance with the requirements of the Unified GMS contract resulting in potential patient harm, reputational damage and financial penalties	**Agreed Action:** Following receipt of the national guidance referenced in Finding 1, the Primary Care Team will ensure that an overall assurance rating is determined and recorded for all future GMS Contract and Visit Governance Reports. **Expected Evidence of Implementation:** Overall ratings recorded on future reports.
	Theme: Policies & Procedures	Control Design	**Officer:** Jayne Lawrence, Assistant Director of Primary Care Services **Target Implementation Date:** Quarter 3 2025/26

Objective 5: The Health Board receives regular reporting and assurance in respect of the new GMS unified contract performance and patient access to primary care GMS services.	Substantial

Overview / Summary of Observations

GMS Unified Contract performance activity is appropriately subject to monitoring and reporting at a GMS Contract Management Group meeting which meets monthly and has a current Terms of Reference that outlines its role, responsibilities and reporting arrangements Reporting is also made to the Directorate Management Team meetings on a monthly basis, one-to-one meetings between the Assistant Director of Primary Care and the Executive Director of Primary, Community Care and Mental Health, and the Delivery and Performance Committee via the Executive Director of Primary, Community Care and Mental Health.

We also note that GMS Unified Contract activity is also provided via monthly Health Board Primary Care Briefing Reports to Welsh Government.

Additionally, a briefing session to Board members relating to the GMS Unified Contract was undertaken in February 2025 that included a presentation of the Unified Contract Assurance reporting process, and also a situation activity progress report summary as at that date.

We also note that reporting of patient accessibility to GMS services is regularly provided via the Delivery and Performance Committee, and in the event that issues relating to patient access are identified through the annual assessment cycle these will also follow the same reporting lines.

However, in the event that the Framework Escalation Ladder criteria are invoked in future annual assessment cycles, this would be subject to discussion at a GMS Contract Management Group meeting and escalated further within the Health Board via the Assistant Director of Primary Care if deemed appropriate.

Appendix A

Assurance Opinion

 **Substantial**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
 **Reasonable**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
 **Limited**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
 **Unsatisfactory**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
 **Advisory**	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 Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

Disclaimer

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Powys Teaching Health Board, and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management of the Powys Teaching Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership]

Agenda Item
5.2.3

Joint Commissioning Committee

Planning, Performance & Finance Sub-Committee Highlight Report

Dyddiad y Cyfarfod / Date of Meeting	18/03/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Helen Tyler, Head of Corporate Governance
Cyflwynydd yr Adroddiad / Report Presenter	Paul Worthington, Lay Member
Noddwr yr Adroddiad / Report Sponsor	Jacqui Maunder-Evans, Committee Secretary

Pwrpas yr Adroddiad / Report Purpose	For Noting Choose an item.

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
	Click or tap to enter a date.	Choose an item.

1. SITUATION/BACKGROUND

This report had been prepared to provide Members of the Joint Commissioning Committee (JCC) with a summary of the key issues considered by the Planning, Performance and Finance sub-committee at its meeting on 11 February 2025.

Key highlights from the meeting are reported in Section 3.

2. PURPOSE

The Purpose and Role of the JCC and the sub-committees are set out in Paragraphs 2.18 and 2.20 of the JCC Standing Orders.

3. HIGHLIGHT REPORT

(Links to reports highlighted February 2025 – NHS Wales JCC PPF)

RAG Rating	Highlights
Alert / Escalate	• The Chair and Members discussed the Terms of Reference and the adequacy of requiring only two lay members for quorum. Members agreed to review after six months to assess the effectiveness of the sub-committee.
Advise	• The Chair welcomed members and attendees to the first JCC Planning, Performance and Finance (PPF) sub-committee meeting. The Terms of Reference and Forward Work Plan were presented. Members noted the inclusion of a HB CEO as a member rather than an attendee. Concerns were highlighted in relation to the quoracy arrangements as highlighted above. Further work on the forward work plan will be undertaken to ensure alignment with the JCC meetings and the annual plan of business and useful suggestions and feedback was provided.
Assure	• Members were informed about the approach to risk and noted that by April 2025, risks related to planning, performance and finance would be reported to this sub-committee for review and assurance. • A presentation was shared which provided members with an update on developing the Integrated Medium-Term Plan (IMTP). Members received an overview of the financial modelling scenarios as requested by the JCC at its January 2025 meeting. An assessment against the three scenarios was provided. While the JCC was in transition, an annual plan was being considered in place of a three-year rolling IMTP. The interim Chief Commissioner also provided members with an update on the submission of an Accountable Officer letter. • The Month 9 Financial Performance Report and Financial Plan Update was received noting: ○ £4.8 million overspend against the Integrated Commissioning Plan (ICP) financial plan to date with a forecast year-end overspend of £5.7 million; ○ The risk of not receiving anticipated income for activity in NHS England was highlighted but Welsh Government (WG) had confirmed funding of £8.8 million to offset the costs related to this,

	alleviating this financial risk for the current year. This funding does not alter the forecast year-end overspend position of £5.7 million. • The JCC Performance Report for Month 8 was received. The combined legacy approach to performance reporting (WHSSC/EASC formats) remains transitional and a new JCC Performance Management Framework and performance report is under development for 2025/2026.
Inform	• Members noted updates on Implementation of Legacy Plans for Quarter 3. It was noted that this report would also be shared with WG for assurance on delivery. • Members noted the WG Strategic Development and Planning Guidance for 2025/2028. The national requirements and areas of JCC responsibility were highlighted as well as the importance of aligning with the planning framework.
Appendices	None

4. ASSESSMENT

Objectives / Strategy	
Dolen i Amcan (au) Strategol CBC Link to JCC Strategic Objectives(s)	Maximise Value
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Leadership
	If more than one applies please list below:

Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Effective
	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	Yes - Refine
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: N/A
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☒	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	If no, please include rationale below: N/A
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	

Enw da / Reputational	There is no direct impact on the reputation of the Joint Committee as a result of the activity outlined in this report.
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.
	Choose an item.

5. RECOMMENDATIONS

The Joint Committee is asked to:

- **Note** the highlights outlined in Section 3 of this report.

Powys Teaching Health Board Glossary (April 25)

Acronym	
ADoECP	Associate Director of Estates, Capital & Property
CEO	Chief Executive Officer
DCG	Director of Corporate Governance
DIT	Director of Improvement & Transformation
EMD	Executive Medical Director
ED PH	Executive Director of Public Health
ED P&C	Executive Director of People and Culture
ED PP&C	Executive Director of Planning, Performance and Commissioning
ED FCSS	Executive Director of Finance, Capital & Support Services
ED AHPHSD	Executive Director of Allied Health Professions, Health Sciences and Digital
ED NQW&FH	Executive Director of Nursing, Quality, Women and Family Health
EDPCCMH	Executive Director of Primary Care, Community & Mental Health
ABUHB	Aneurin Bevan University Health Board
AFC	Agenda for Change
AGW	The Auditor General for Wales
AHPs	Allied Health Professionals
ALN	Additional Learning Needs
AO	Accountable Officer
ARAC	Audit, Risk and Assurance Committee
ASM	Accelerated Sustainable Model
AR	Audit Recommendations
BAF	Board Assurance Framework
BCUHB	Betsi Cadwaladr University Health Board
BMA	British Medical Association
CAAP	Clinical Associate in Applied Psychology
CAMHS	Child and Adolescent Mental Health Services
CCN	Childrens Community Nursing
CEMT	Chief Executive Management Team
CHC	Continuing Health Care
CIW	Care Inspectorate for Wales
CLIP	Collaborative Learning in Practice
CNO	Chief Nursing Officer
CPD	Continued Professional Development

CPR	Child Practice Review
CRR	Corporate Risk Register
CSP	Clinical Service Plan
CTMUHB	Cwm Taff Morgannwg University Health Board
CV	Curriculum Vitae
CVUHB	Cardiff and Vale University Health Board
CWMPAS	Mid and West Wales Regional Safeguarding Adults Board
CYSUR	Mid and West Wales Regional Safeguarding Children Board
CTC	Care Transfer Co-ordinator
CCOMG	Complex Care Operational Management Group
DATIX	Incident Management System
D&P	Delivery and Performance Committee
DCG	Delivery Co-ordination Group
DGH	District General Hospital
DHCW	Digital Health and Care Wales
DNA	Did not Attend
DNACPR	Do Not Attempt Cardio-Pulmonary Resuscitation
DPA	Data Protection Act
DToC	Delayed Transfer of Care
D2RA	Discharge to Recover and Assess
DST	Decision Support Tool
EASC	Emergency Ambulance Services Committee
EOG	Executive Oversight Group
EOY	End of Year
EMRTS	Emergency Medical Retrieval & Transfer Service
EPMA	Electronic Prescribing and Medicines Administration
ESR	Electronic Staff Record
EMI	Elderly Mentally Infirm
FBC	Full Business Case
FOI	Freedom of Information
FFT	Friends and Family Test
FTE	Full Time Equivalent
GDS	General Dental Services
GIRFT	Getting It Right First Time
GMC	General Medical Council
GMS	General Medical Services
GP	General Practitioner
GNCC	General Nursing Complex Care Team
H&S	Health and Safety
HCA	Health Care Assistant

HCS	Health and Care Standards
HCSW	Health Care Support Worker
HDUHB	Hywel Dda University Health Board
HEIW	Health Education and Improvement Wales
HIW	Healthcare Inspectorate Wales
HP	Health Protection
HPF	Healthcare Professionals Forum
ICF	Integrated Care Funding
IEN	Internationally Educated Nurse
IG	Information Governance
IM	Independent Members
IMTP	Integrated Medium Term Plan
IP&C	Infection Prevention and Control
IQPF	Integrated Quality Performance Framework
IQPG	Integrated Quality & Performance Group
IQPR	Integrated Quality Performance Report
IT	Information Technology
JAG	Joint Advisory Group (on Gastrointestinal Endoscopy)
JCC	Joint Commissioning Committee
JD	Job Description
JET	Joint Executive Team
JIPCA	Joint Inspection of Child Protection Arrangements
JLT	Joint Leadership Team (PTHB and PCC)
JR	Judicial Review
KPI	Key Performance Indicator
LoF	League of Friends
LA	Local Authority
LHB	Learning Health Board
LMC	Local Medical Committee
LPF	Local Partnership Forum
LRF	Local Resilience Forum
LTA	Long Term Agreement
MD	Ministerial Direction
MDTs	Multi-Disciplinary Teams
MEG	Medical E-Governance System
MEG	Main Expenditure Group
MH	Mental Health
MHD	Mental Health & Learning Disability
MIU	Minor Injury Unit
MOU	Memorandum of Understanding

MOA	Memorandum of Agreement
MSK	Musculoskeletal
MV	Mass Vaccination
NHSE	National Health Service England
NHS	National Health Service
NHSWE	NHS Wales Executive
NICE	National Institute of Health and Clinical Excellence
NRI	Nationally Reportable Incidents
NWSSP	NHS Wales Shared Services Partnership
NNA	Nursing Needs Assessment
OBC	Outline Business Case
OCP	Organisational Change Process
OOC	Out of County
OOH	Out of Hours
OSCE	Objective Structured Clinical Examination
OT	Occupational Therapy
PA	Physician Associate
PADR	Personal Appraisal Development Review
PAVO	Powys Association of Voluntary Organisations
PCC	Powys County Council
PEQS	Patient Experience, Quality and Safety Committee
PHE	Public Health England
PHW	Public Health Wales
PPPH	Planning, Partnerships and Population Health Committee
PSB	Public Service Board
PSOW	Public Services Ombudsman for Wales
PTHB	Powys Teaching Health Board
PTR	Putting Things Right
QA	Quality Assurance
RaTS	Remuneration and Terms of Service Committee
RCN	Royal College of Nursing
RIIC	Research, Innovation & Improvement Coordination
RIF	Regional Investment Fund
RISP	Radiology Information System Procurement
RJAH	Robert Jones and Agnes Hunt
RN	Registered Nurse
RPB	Regional Partnership Board
RTT	Referral to Treatment
RTS	Routemap To Sustainability

Q1 Q2 Q3 Q4	Quarter 1 (April, May, June), Quarter 2 (July, August, September), Quarter 3 (October, November, December), Quarter 4 (January, February, March)
QSEG	Quality, Safety and Experience Group
SAR	Subject Access Request
SAS	Specialty and Specialist
SBAR	Situation, Background, Assessment, Recommendation
SBUHB	Swansea Bay University Health Board
SDEC	Same Day Emergency Care
SLA	Service Level Agreement
SOC	Strategy Outline Case
SOP	Standard Operating Procedure
SaTH	Shrewsbury and Telford Hospital NHS Trust
SPB	Strategic Programme Board
SRO	Senior Responsible Owner
TI	Targeted Intervention
ToR	Terms of Reference
TRAC	Online Recruitment Management System
T&V	Transformation & Value
VERS	Voluntary Early Release Scheme
WAST	Welsh Ambulance Services NHS Trust
W&C	Workforce and Culture Committee
WCCIS	Welsh Community Care Information System
WG	Welsh Government
WHC	Welsh Health Circular
WHSSC	Welsh Health Specialised Service Committee
WNB	Was Not Brought
WOD	Workforce and Organisational Development
WPAS	Welsh Patient Administration System
WPOCT	Welsh Point of Care Test System
WTE	Whole Time Equivalent
WVT	Wye Valley Trust
YTD	Year to Date