Delivery and Performance Committee

Thu 02 September 2021, 10:00 - 13:00

via Teams

Agenda

10:00 - 10:00
0 min

1. PRELIMINARY MATTERS

D&P_Agenda_02Sept21_Final.pdf (2 pages)

1.1. Welcome and Apologies

1.2. Declarations of Interest

1.3. Delivery and Performance Committee Action Log

D&P_Item_1.3_Action Log_2021-22 (Sept2021).pdf (2 pages)

10:00 - 10:00
0 min

2. ITEMS FOR APPROVAL / RATIFICATION / DECISON

There are no items for approval, ratification or decision

10:00 - 10:00
0 min

3. ITEMS FOR DISCUSSION

3.1. Performance Overview

3.1.1. Performance Dashboard

D&P_Item_3.1a_PerformanceOverview_August 2021_.pdf (35 pages)

3.1.2. Commissioning Assurance

D&P_Item_3.1b_CAF Escalation SATH Report September 2021.pdf (13 pages)
D&P_Item_3.1bi_Annexe 1 RTT Report - PR Sept 2021.pdf (10 pages)

3.2. Elective Care Performance Update

D&P_Item_3.2_ PerformanceResources_Planned Care Update.pdf (21 pages)

3.3. Neurodevelopmental Services Performance Update

D&P_Item_3.3_ND Performance.pdf (7 pages)
D&P_Item_3.3a_Appendix 1 – Guidance on the Delivery of Neurodevelopment Services in Wales.pdf (10 pages)
D&P_Item_3.3b_Appendix 2 - Together for Children and Young People (2) Programme.pdf (26 pages)

3.4. Financial Performance, Month 04

D&P_Item_3.4_Financial Performance Report Mth 4 PR.pdf (19 pages)

3.5. General Medical Services Out of Hours Performance 2020/2021

D&P_Item_3.5_PTHB OOH EOY Performance report-PR committee.pdf (13 pages)
D&P_Item_3.5i_Appendix 1 – All Wales OOH Standards - national metrics.pdf (5 pages)
D&P_Item_3.5ii_Appendix 2 – All Wales OOH Standards – local metrics.pdf (8 pages)
D&P_Item_3.5iii_Appendix 3 – PTHB OOH Monitoring Group.pdf (4 pages)
D&P_Item_3.5iv_Appendix 4 – 111 Calls Answered and abandonment rate.pdf (1 pages)
D&P_Item_3.5v_Appendix 5 - All Wales 111 OOH Urgent Primary Care Quality 5.pdf (5 pages)
D&P_Item_3.5vi_Appendix 6 – Shropdoc standards compliance month by month.pdf (3 pages)
D&P_Item_3.5vii_Appendix 7 – SBUHB OOH service Powys contacts breakdown.pdf (1 pages)

3.6. Funded Nursing Care and Continuing Healthcare Performance Report

D&P_Item_3.6_ PRC_CHC Annual Report 2020 - 2021.pdf (14 pages)
D&P_Item_3.6i_Appendix_1.pdf (2 pages)
D&P_Item_3.6ii_Appendix_2_All Wales Care Home Framework self assessment – powys teaching health board.pdf (6 pages)
D&P_Item_3.6iii_Appendix_3.pdf (2 pages)
D&P_Item_3.6iv_Appendix_4.pdf (2 pages)
D&P_Item_3.6v_Appendix_5.pdf (1 pages)

3.7. Capital and Estates Performance Update

D&P_Item_3.7 Committee Capital and Estates Update August 2021 (002).pdf (13 pages)

3.8. Information Governance Performance Report

D&P_Item_3.8_IG Key Performance and Compliance Metrics_Aug21.pdf (16 pages)

3.9. Records Management Improvement Plan Update

D&P_Item_3.9_Records Management Improvement Plan_July21.pdf (11 pages)
D&P_Item_3.9a_Appendix 1_Records Management_Final Internal Audit Report.pdf (38 pages)
D&P_Item_3.9b__App2__Records Management Improvement Plan_Nov19.pdf (10 pages)
D&P_Item_3.9c_ Records Managment Framework v1.0.pdf (72 pages)

10:00 - 10:00
0 min

4. ITEMS FOR INFORMATION

There are no items for inclusion in this section

10:00 - 10:00
0 min

5. OTHER MATTERS

5.1. Items to be brought to the attention of Board and Other Committees

5.2. Any Other Urgent Business

1 November 2021 at 10:00 via Teams

5.3. Date of the next meeting:

1 November 2021 at 10:00 via Teams

POWYS TEACHING HEALTH BOARD
DELIVERY AND PERFORMANCE COMMITTEE

2 SEPTEMBER 2021, 10:00 – 13:00
TO BE HELD VIA TEAMS

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

AGENDA			
Item	**Title**	**Attached /Oral**	**Presenter**
1	**PRELIMINARY MATTERS**		
1.1	Welcome and Apologies	Oral	Chair
1.2	Declarations of Interest	Oral	All
1.3	Committee Action Log	Attached	Chair
2	**ITEMS FOR APPROVAL/RATIFICATION/DECISION**		
	There are no items for approval, ratification or decision.		
3	**ITEMS FOR DISCUSSION**		
3.1	Performance Overview a) Performance Dashboard b) Commissioning Assurance	Attached	Director of Planning & Performance
3.2	Elective Care Performance Update	Attached	Director of Primary, Community Care & MH
3.3	Neurodevelopmental Services Performance Update	Attached	Director of Primary, Community Care & MH
3.4	Financial Performance, Month 04	Attached	Director of Finance & IT
3.5	General Medical Services Out of Hours Performance 2020/2021	Attached	Director of Primary Care, Community & MH
3.6	Funded Nursing Care and Continuing Healthcare Performance Report	Attached	Director of Nursing & Midwifery
3.7	Capital and Estates Performance Update	Attached	Director of Planning & Performance
3.8	Information Governance Performance Report	Attached	Board Secretary
3.9	Records Management Improvement Plan Update	Attached	Board Secretary
4	**ITEMS FOR INFORMATION**		
4.1	There are no items for inclusion in this section		
5	**OTHER MATTERS**		
5.1	Items to be Brought to the Attention of the Board and Other Committees	Oral	Chair
5.2	Any Other Urgent Business	Oral	Chair
5.3	Date of the Next Meeting: • 01 November 2021 at 10:00AM, Via Microsoft Teams		

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.

However, in light of the current advice and guidance in relation to Coronavirus (COVID-19), the Board has agreed to run meetings virtually by electronic means as opposed to in a physical location, for the foreseeable future. This will unfortunately mean that members of the public will not be able attend in person. The Board has taken this decision in the best interests of protecting the public, our staff and Board members.

The Board is expediting plans to enable its committee meetings to be made available to the public via live streaming. In the meantime, should you wish to observe a virtual meeting of a committee, please contact the Board Secretary in advance of the meeting in order that your request can be considered on an individual basis (please contact Rani Mallison, Board Secretary, rani.mallison2@wales.nhs.uk).

In addition, the Board will publish a summary of meetings held on the Health Board's website within ten days of the meeting to promote openness and transparency.

Key:

Completed
Not yet due
Due
Overdue

DELIVERY AND PERFORMANCE COMMITTEE ACTION LOG 2021/22 (September 2021)

Bwrdd Iechyd Addysgu Powys
Powys Teaching

Minute	Meeting Date	Action	Responsible	Progress Position	Status
The actions below transferred from the Performance & Resources Committee which was in place up to 28 July 2021					
ARA/21/46 (Action transferred from Audit, Risk & Assurance Committee)	12 July 2021	Machynlleth Post-Project Evaluation and Lessons Learned reported to the Committee	Director of Planning and Performance	Capital and Estates Update Report included on the Committee's agenda – 02/09/21	
P&R/20/12	30 June 2020	Waste Management Procurement Process. Assurance to be provided to IMs that quality, reliability and reduction in environmental impact would be appropriately weighted in procurement process.	Director of Workforce and OD	Waste Management Procurement Process was deferred until appropriate timing on the contract had been established. Procurement had been postponed during the COVID-19 pandemic as an appropriate disposal system would be required. An environmental review was to follow.	
PTHB/21/25 PTHB Annual Performance Report 2020/21 (Action transferred from Board)	10 June 2021	Detailed report on access waiting times to be reported to Performance and Resources Committee	Board Secretary/ Director of Planning & Performance	Performance Update and Planned Care update included on the Committee's agenda – 02/09/21	

PTHB/21/10 Financial Performance (Action transferred from Board)	26 May 2021	Report on Continuing Healthcare and associated risks to be presented to Performance and Resources Committee	Board Secretary/ Director of Nursing & Midwifery	Integrated CHC Report included on the Committee's agenda – 02/09/21	
PTHB/21/10 Performance Reporting (Action transferred from Board)	26 May 2021	Issue regarding the non-availability of performance data regarding cancer from Welsh providers to be monitored by Performance and Resources Committee	Director of Planning & Performance	Performance Update included on the Committee's agenda – 02/09/21	
P&R 21/21	26 May 2021	WAST report on Red and Amber Calls to be brought to Committee	Director of Primary, Community Care and MH	Report scheduled for presentation to Committee November 2021	

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.1a

Delivery and Performance Committee	**Date of Meeting: 02/09/2021**
Subject:	**Performance Overview against National Outcome Framework – August, 2021/22**
Approved and Presented by:	Director of Planning and Performance
Prepared by:	Performance Manager
Other Committees and meetings considered at:	To be discussed at the Delivery and Performance Group on 26 August 2021.

PURPOSE:
This report provides a brief update on the changes to the latest performance position for Powys Teaching Health Board at Month 3, including a high-level overview of COVID, Test, Trace and Protect and mass vaccination performance.
RECOMMENDATION(S):
The Delivery and Performance Committee is asked to DISCUSS and NOTE the content of this report.

Approval/Ratification/Decision	**Discussion**	**Information**
✖	✓	✓

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

EXECUTIVE SUMMARY:

This report provides the Committee with a performance update against the 2020/21 NHS Delivery Framework and limited local measures.

This continues to be an interim process as a result of the COVID pandemic in the absence of the regular Integrated Performance Report.

This report contains a high-level summary of COVID e.g. infection rates, mortality and vaccination progress.

A brief update on Powys Teaching Health Board's (PTHB) performance, set against the four aims and their measures including a dashboard showing the levels of compliance against the National Framework and Powys Teaching Health Board local measures.

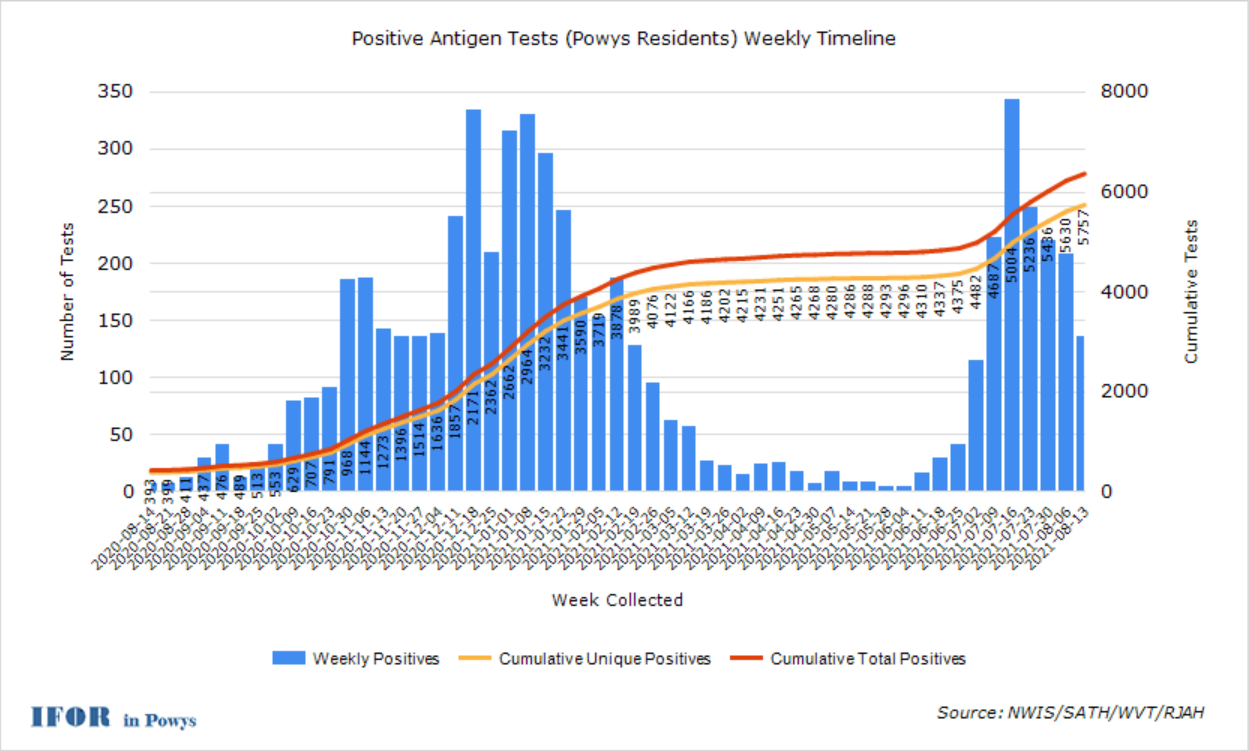
Using this data, we highlight performance achievements and challenges at a high level, as well as brief comparison to the All Wales performance benchmark where available.

DETAILED BACKGROUND AND ASSESSMENT:

COVID-19 Update

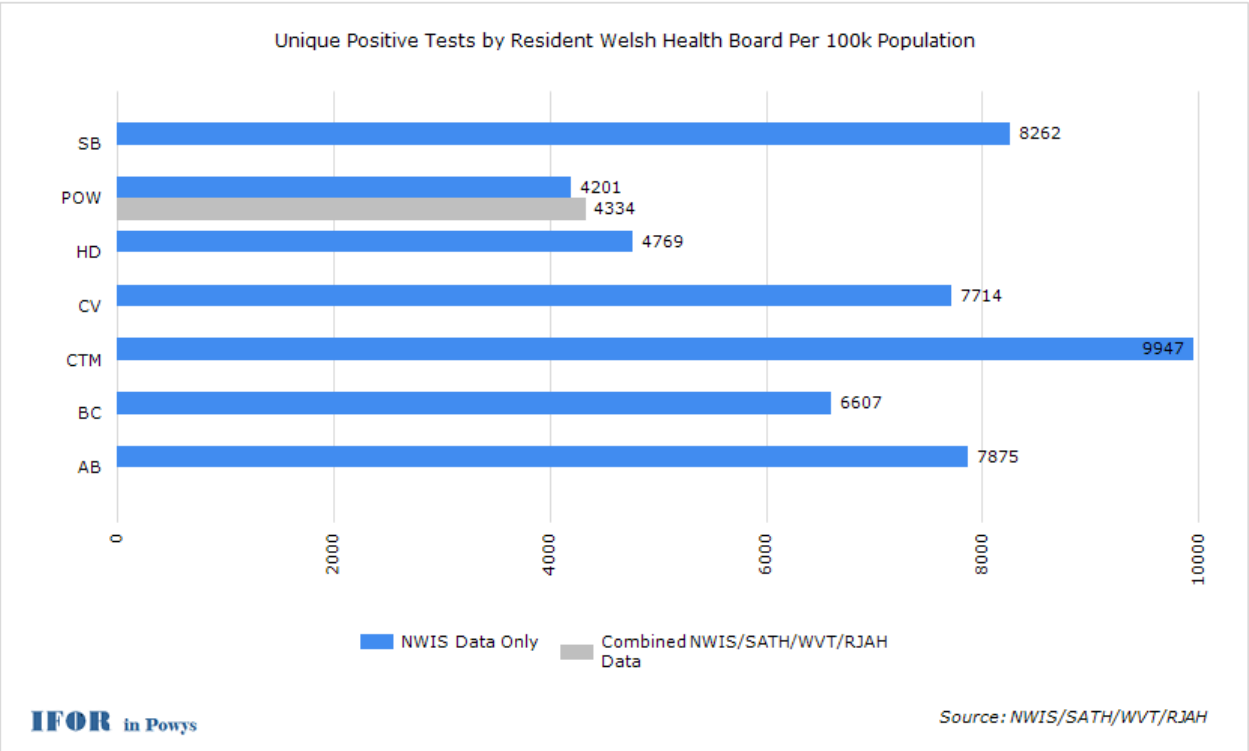
Powys Resident Positive Cases

The latest Powys position on COVID infection rates shows that the number of reported positive cases over a 7-day period has increased in line with the third wave of COVID-19 infections. As a snapshot, the rate for the county was **146.5 per 100k** during the 7-day period 31/07/21 to 06/08/21. Cumulatively **5,757** unique patients have tested positive since the start of the pandemic in March 2019 (data as of 12/08/2021).



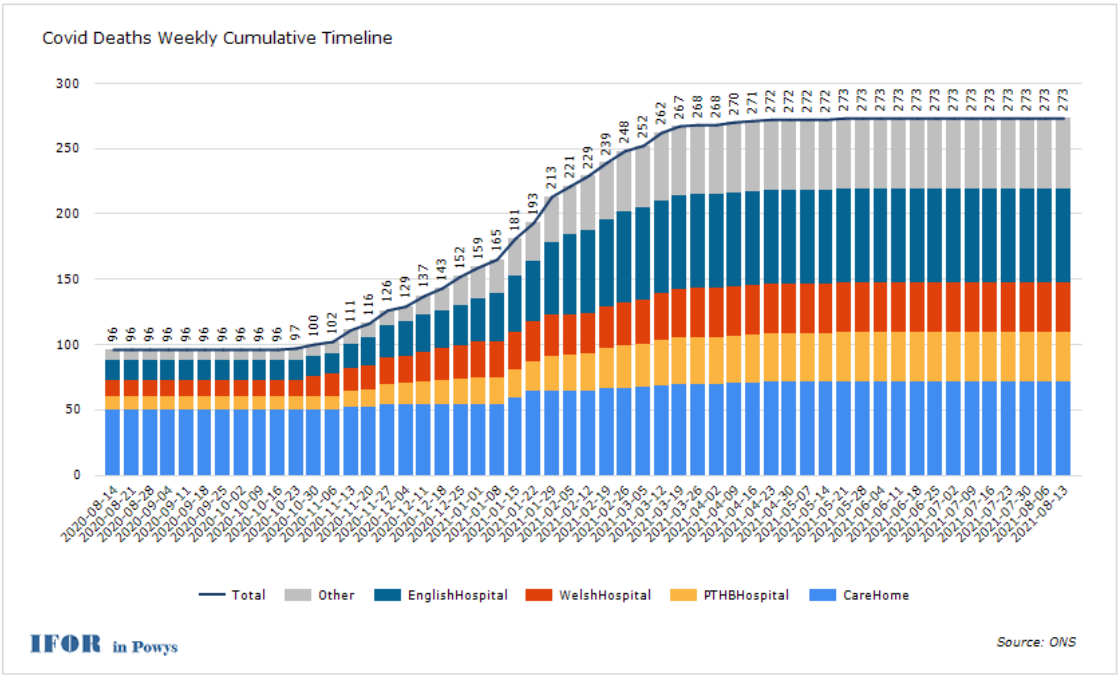
**N.B Incomplete data for week 13/08/2021*

Using a health board residency breakdown, PTHB has the lowest rate of unique **cumulative** positive cases per 100k in Wales (graph below).



Resident Deaths – Source ONS

The ONS source death data includes any COVID deaths with a mention of COVID as either primary cause or a related factor, this differs from the PHW report which excludes deaths that do not have a confirmed positive test for COVID within 28 days of the date of death. For consistency the health board has used ONS/MPI data throughout the COVID pandemic to provide the most timely and accurate review of the situation.



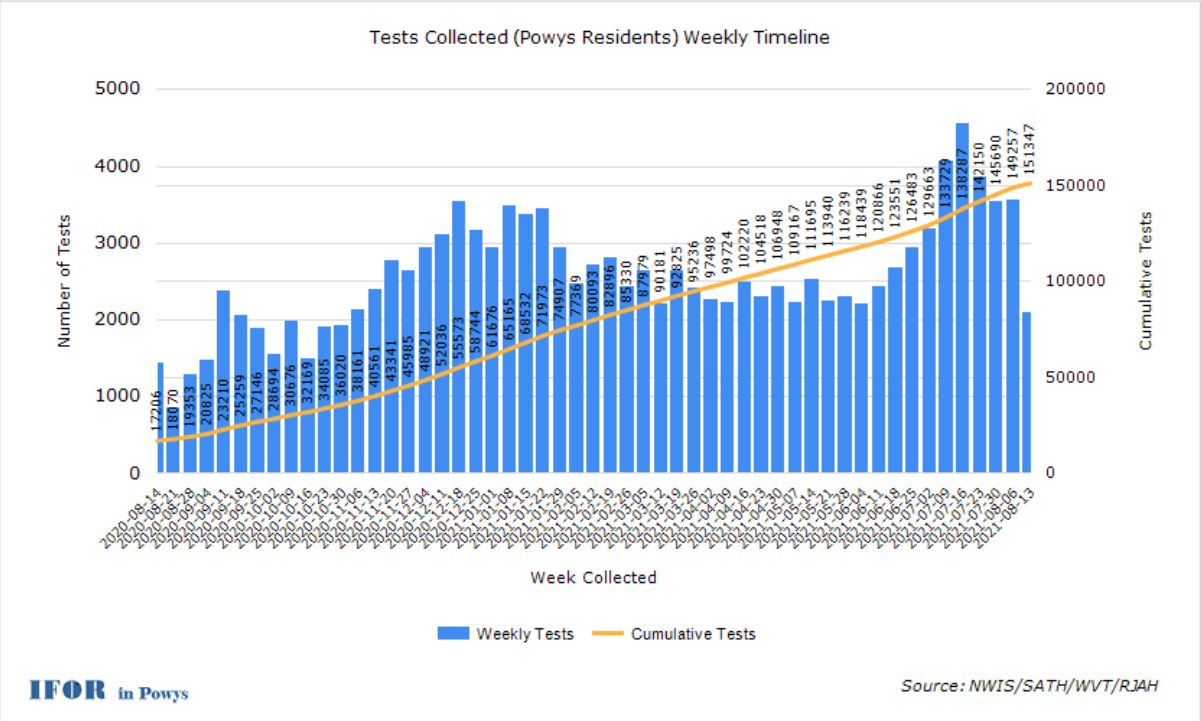
In Powys the cumulative total deaths from COVID is **273** since the pandemic started, this is the latest snapshot (12/08/2021). For the last 13 reported weeks no deaths have been reported from COVID-19.

TEST, TRACE, PROTECT

The test positivity rate for the period 31/07/21 to 06/08/21 was **5.4%.**

Approximately **3567** tests were performed on Powys residents during the week ending 6th August. A timeline of weekly testing is shown below.

Figure 1: Weekly and cumulative number of antigen tests, Powys residents March'20 to date.



**N.B Incomplete data for week 13/08/2021.*

Between the 31st of July and 6th of August, **208 new positive cases** were identified for contact tracing, of the **208** cases **198** were eligible for follow up, of which **94%** were followed up within 24 hours and **96%** were contacted within 48hrs. Contact tracing identified **1021 total** contacts but only **873** were eligible to contact, of which **86%** were followed up within 24 hours and **92%** contacted within 48hrs.

Data source: PTHB Information Team

MASS VACCINATION PROGRESS

Please find below a brief summary of the vaccination progress for Powys responsible patients.

A total of **212,785** doses of vaccine have been administered since the week starting the 07/12/2020.

- **109,101 1st doses – *93.18% of the Welsh Immunisation System estimated responsible population cohorts.**
- **103,668 2nd doses – *88.54% of those having received a first dose.**

Data is accurate as of 12/08/21 14:25pm – Source WIS.

*Please note that denominator cohorts have increased with the additional age range inclusion of <18s, this has reduced percentage of uptake when compared to previous documents.

NHS DELIVERY FRAMEWORK PERFORMANCE

This document provides an update aligned to the existing 2019/20 delivery framework, this is due to be replaced during Q3 2021/22 by a revised and updated version for 2021/22.

The 2019/20 framework reports against **84** delivery measures mapped to the Healthier Wales quadruple aims.

- **Quadruple Aim 1:** People in Wales have improved health and well-being and better prevention and self-management.

- **Quadruple Aim 2:** People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement.

- **Quadruple Aim 3:** The health and social care workforce in Wales is motivated and sustainable.

- **Quadruple Aim 4:** Wales has a higher value health and social care system that has demonstrated rapid improvement and innovation and enabled by data and focused on outcomes.

It should be noted that the Delivery Framework and its measures were set out prior to the pandemic. Performance reporting against key measures has been challenging with the backdrop of COVID. Some data collections, and reports have been stopped or temporarily suspended.

Performance document notes

This section contains performance figures and narrative against recent data. Some information and narrative will not change between reports, this is a result of the frequency of update for that specific measure e.g. monthly,

quarterly, bi-annual or annual. If the data has not changed for a significant period a narrative or analysis may not be included.
Work continues with the "Making Data Count Approach" ethos, and continual rollout of new statistical information, and further data detail.

Most access measures now have statistical process control charts (SPC) to help support performance discussions, but may not be included within this document due to size.
Please note that when reporting data in some metrics an <5 symbol may replace the actual due to low number identifiability.

And Icons may be used to explain targets etc.

- < less than
- = equal to
- > Greater than

A brief introduction to statistical process control charts (SPC)

SPC charts are used as an analytical technique to understand data (performance) over time. Using statistical science to underpin data, and using visual representation to understand variation, areas that require appropriate action are simply highlighted. This method is widely used within the NHS to assess whether change has resulted in improvement. The use of SPC allows us to view the information with an understanding of the Covid-19 pandemic in Wales. Covid caused a significant event altering the normal working practices for health care, in Wales this escalated at the end of March 2020, for consistency this will be used as the default step change as a special cause point for measures linked predominately to patient access.

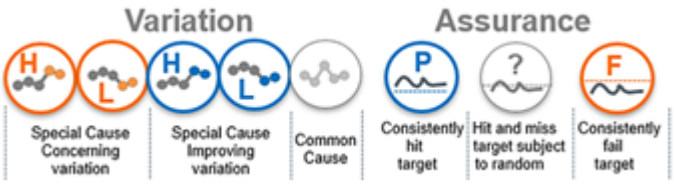
SPC charts

The charts used will contain a variation of icons and coloured dots, these do not link directly to the existing RAG based measurement currently used within the outcome framework but provide a guide. SPC charts provide an excellent view of trends, highlighting areas of improvement, or concern over a significant time period (e.g. common or special cause variation). The graphs also contain a mean (average) value, and two process control limits UCL & LCL (expected maximum & minimum performance).

Work to integrate this approach into Powys Teaching Health Board performance reporting, and assurance will be ongoing and will mature throughout 2021/22.

For further information on the process please go to the below weblink **https://www.england.nhs.uk/a-focus-on-staff-health-and-wellbeing/publications-and-resources/making-data-count/**

Key of SPC chart icons



Key of SPC chart dots

- **orange = area of concern**
- **grey = within expected limits**
- **blue = area of improvement**

Further information will be provided in the narrative to provide context.

Quadruple Aim 1: People in Wales have improved health and well-being and better prevention and self-management.

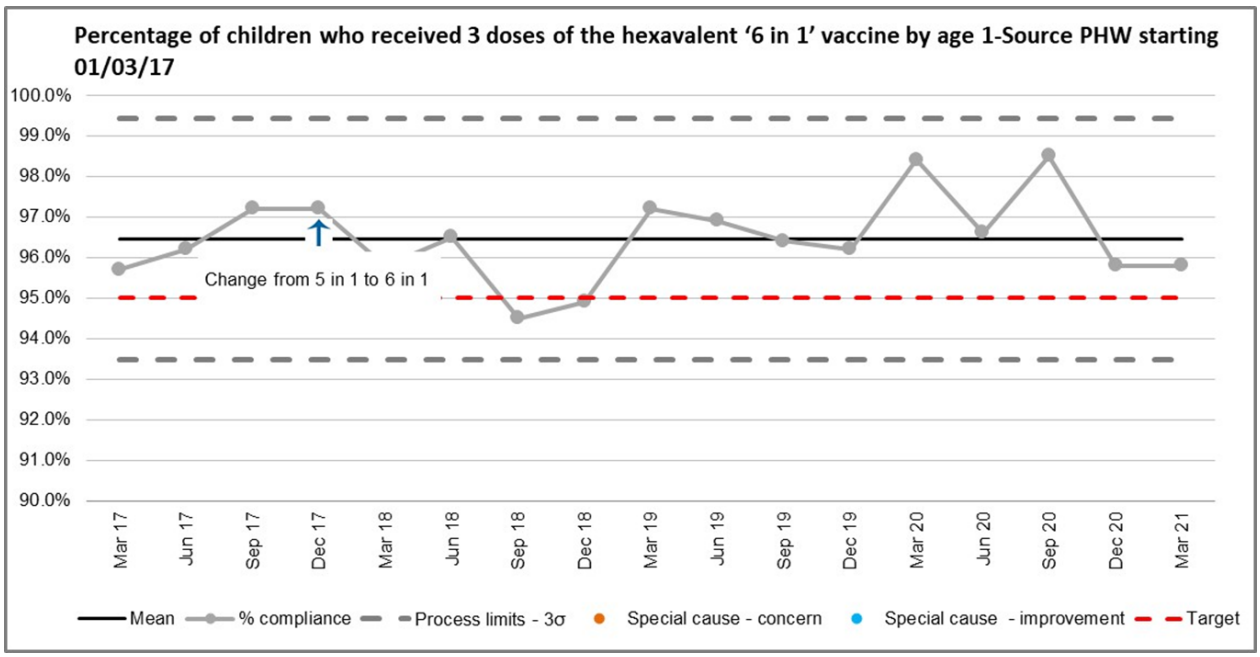
Please find below a table of the outcome measures for aim 1:

2020/21 NHS Outcome Framework Summary - Key Measures - Provider				Performance			Welsh Government Benchmarking (*in arrears)	
No.	Abbreviated Measure Name	Target	Latest Available	12month	Previous Period	Current	Ranking	All Wales
1	Percentage of babies who are exclusively breastfed at 10 days old	Annual Improvement	2019/20	49.8%		52.4%	1st	35.3%
2	'6 in 1' vaccine by age 1	95%	Q4 20/21	98.4%	95.8%	95.8%	3rd	95.1%
3	2 doses of the MMR vaccine by age 5	95%	Q4 20/21	94.1%	91.3%	90.3%	7th	92.8%
4*	Attempted to quit smoking - Cum	5%	Q4 20/21	3.25%		2.79%	6th	3.31%
5	CO-validated as quit at 4 weeks - Cum	40%	Q4 19/20	36.4%	42.3%	37.7%	6th	41.6%
6	Standardised rate of alcohol attributed hospital admissions	4 quarter reduction trend	Q3 20/21	451.6	354.9	381.7	6th	356.6
7	Percentage of people who have been referred to health board services who have completed treatment for alcohol misuse	4 quarter improvement trend	Q1 21/22	58.6%	75.0%	61.3%	5th	76.4%
8a	Flu Vaccines - 65+	75%	2020/21	67.1%		73.5%	7th	76.5%
8b	Flu Vaccines - under 65 in risk groups	55%	2020/21	44.3%		52.2%	3rd	51.0%
8c	Flu Vaccines - Pregnant Women	75%	2020/21	93.3%		92.3%	2nd	81.5%
8d	Flu Vaccines - Health Care Workers	60%	2020/21	64.3%		56.5%	7th	65.6%
9a*	Coverage of cancer screening for: bowel	60%	2018/19	54.1%		56.4%	1st	55.7%
9b*	Coverage of cancer screening for: breast	70%	2018/19	73.7%		69.1%	7th	72.8%
9c*	Coverage of cancer screening for: cervical	80%	2018/19			76.1%	1st	73.2%
10a	MH Part 2 - % residents with CTP <18	90%	Jun-21	88.9%	88.9%	76.5%	5th	86.9%
10b	MH Part 2 - % residents with CTP 18+	90%	Jun-21	91.2%	91.6%	92.0%	1st	88.0%
11	% People aged 64+ who are estimated to have dementia that are diagnosed by GP	Annual improvement	2019/20	44.7%		42.4%	7th	53.1%

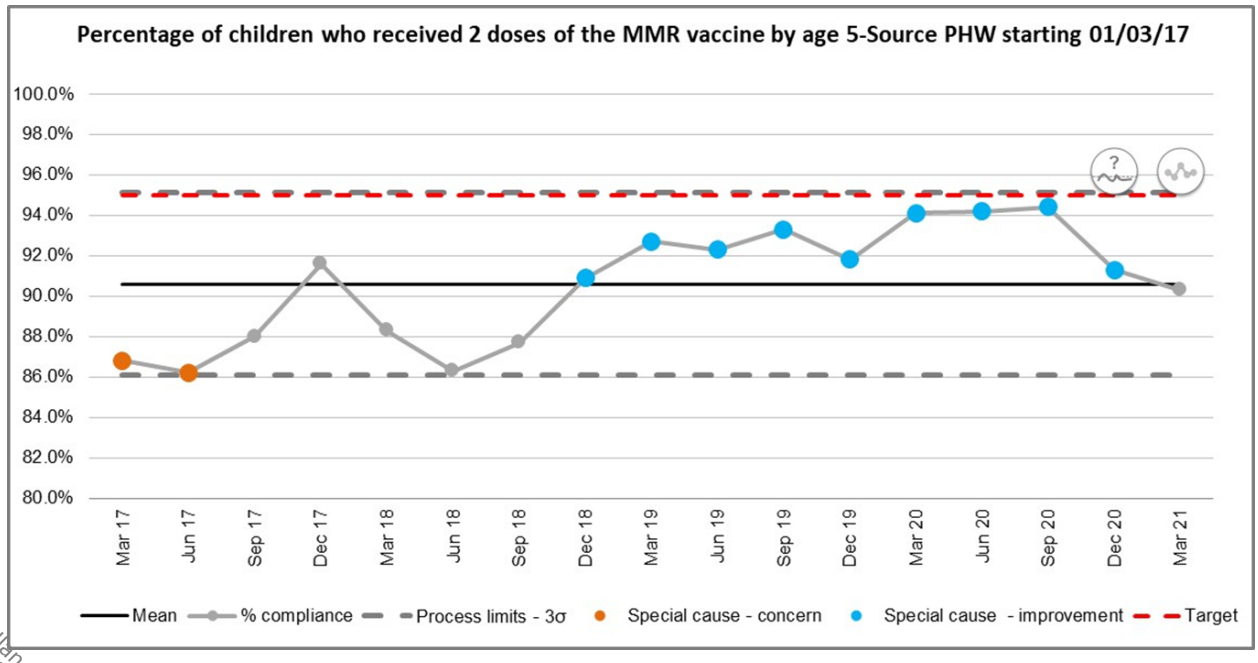
*Screening measures 9a, 9b & 9c revised as of 30/06/2021

Childhood immunisations

The percentage of children who received 3 doses of the hexavalent '6 in 1' vaccine by age 1 met the nationally set target in Q4 2020/21. Performance has remained stable even with the COVID-19 challenge, this measure consistently meets the national target. When compared nationally the health board ranks 3rd slightly above the average of 95.1%. The SPC chart below shows the performance from Q4 2016/17 to Q4 2020/21, and the variation is common cause .

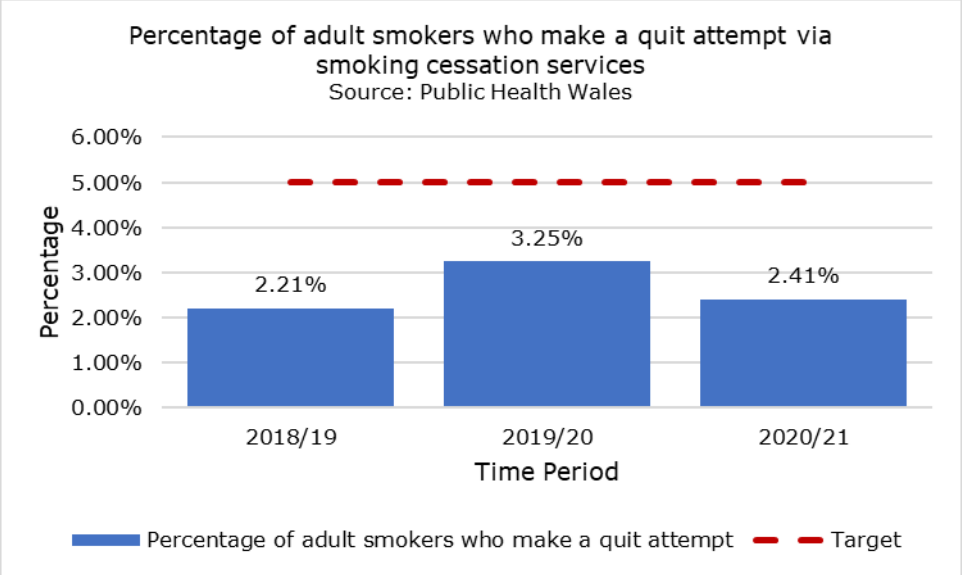


The percentage of children who received 2 doses of the measles mumps & rubella (MMR) vaccine by age 5 has not met the national target. Performance has fallen slightly below the mean value (90.6%), the current rate is below the Wales average and the rate in other health boards. The SPC chart below shows common cause variation, however without system change it is unlikely that this measure will reach target. The key impacts that challenge MMR2 are multifactorial, these include COVID impact in general practice (children not able to access vaccination), and health visitor & school nurse capacity/access for following up missed doses during the pandemic.



Smoking cessation

The cumulative performance for smoking cessation services shows that PTHB did not meet the Welsh Government annual target of 5%. Performance in 2020/21 (2.41%) was lower than 2019/20 (3.25%) due to the effect of Covid-19.



For the metric of patients being CO-validated, the COVID pandemic has stopped this work being carried out within pharmacies, and the data is not available.

Alcohol Misuse Treatment

Performance against the metric "*Percentage of people who have been referred to health board services who have completed treatment for alcohol misuse*" shows compliance against the four-quarter improvement trend target finishing 2020/21 at 92%. It should be noted that the performance data for the year has been revised following data quality checks. This has been confirmed by the source Digital Health and Care Wales (DHCW) as a regular end of year process, and retrospectively adjusted prior quarterly performance.

Influenza Vaccinations

The latest performance for uptake of influenza vaccination in Powys is now available for 2020/21 financial year. Of the measures, uptake in 65+ cohort improved to 73.5%, an increase of 6.4% when compared to 2019/20. This performance however fell below the All Wales average of 76.5% with the health board ranked 7th. For residents aged <65 at risk performance improved to 52.2%, this increased by 8% from 2019/20 ranking 3rd in Wales against the All Wales average of 51.0%. Uptake in pregnant women reported at 92.3% fell 1% compared to 2019/20, but exceeded the 75% target, and All Wales average of 81.5% (ranked 3rd). Vaccination of health care workers

showed a large reduction when compared to the previous period down 7.8% to 56.5%. When compared nationally the health board ranks 7th against an All Wales average of 65.6%.

Cancer Screening

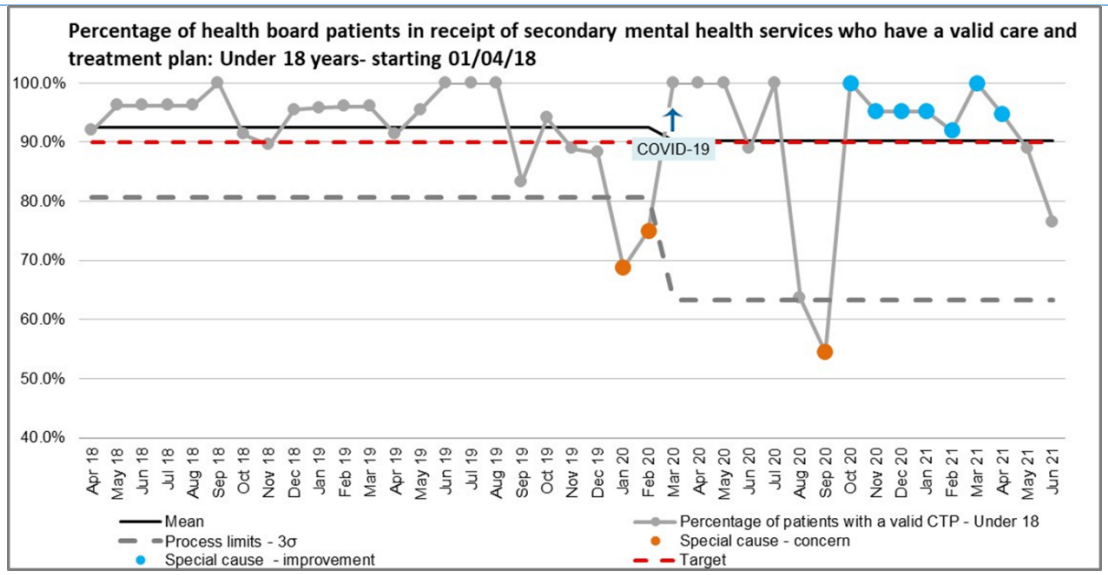
Following health board investigations into the reported performance for screening uptake, the health board highlighted to Welsh Government an in-consistency within national reporting. The raised problem involved miss reporting of 2 screening metrics, these metrics reported coverage rather than uptake. On the 30th of June Welsh Government updated the Powys performance team that all three measures are aligning to represent coverage, the revised metrics are as below.

- Cervical Screening, age appropriate coverage: At least 80% of eligible people aged 25-49 will have participated in the screening programme within the last 3.5 years and eligible people aged 50-64 within the last 5.5 years
- Bowel screening coverage: At least 60% of eligible people will have participated in the screening programme within the last 2.5 years
- Breast screening coverage: At least 70% of women resident and eligible for breast screening at a particular point in time will have been screened within the previous three years.

Coverage performance for bowel screening in 2018/19 was 56.4%, ranking 1st in Wales against a 60% target. Breast screening performance for the same year was 69.1% ranking 7th in Wales (all Wales average 72.8%) against a 70% target. Finally, cervical screening performance for the same period was 76.1% ranking 1st in Wales against an 80% target (all Wales average 73.2%). At the writing of this document 2020/21 data is not due to be available until July 2021.

Mental Health Part 2

Monthly <18 performance for CTP's has not met the national target with a drop to 76.5% compliance in June. The below SPC shows common cause variation and "hit and miss" assurance . A key factor to the variance of compliance is linked to low numbers e.g. 13 out of 17 patients having a CTP.



+18 category performance has continued to meet the target in June 2021 (92%). The SPC chart below shows a common cause variation over the time period, but this measure consistently meets the national target.

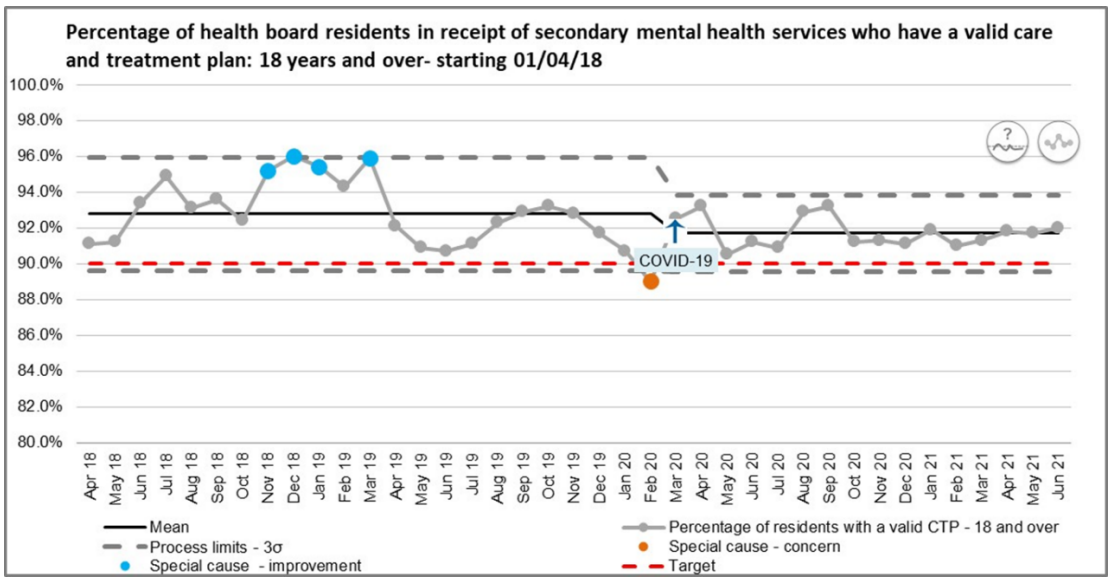


Table of part 2 performance 2021/22

Measure		Target	Apr-21	May-21	Jun-21
Part 2: Percentage of health board residents in receipt of secondary mental health services who have a valid care and treatment plan: Under 18 years	Percentage Compliance	90%	94.7%	88.9%	76.5%
	Number of patients with a valid CTP		18	16	13
	Total number of patients		19	18	17
Part 2: Percentage of health board residents in receipt of secondary mental health services who have a valid care and treatment plan: 18 years and over	Percentage Compliance	90%	91.8%	91.7%	92.0%
	Number of patients with a valid CTP		1194	1198	1191
	Total number of patients		1299	1307	1295

Quadruple Aim 2: People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement.

Please find below a table of the Powys applicable outcome measures for aim 2:

2020/21 NHS Outcome Framework Summary - Key Measures - Provider				Performance			Welsh Government Benchmarking (*in arrears)	
No.	Abbreviated Measure Name	Target	Latest Available	12month Previous	Previous Period	Current	Ranking	All Wales
17	% of GP practices that have achieved all standards set out in the National Access Standards for In-hours GMS	100%	2019/20			56.3%	5th	59.7%
18	Percentage of children regularly accessing NHS primary dental care within 24 months	4 quarter improvement trend	Q3 20/21	63.0%	57.9%	55.5%	6th	61.2%
19	(Data reported from April-21) Percentage of Out of Hours (OoH)/111 patients prioritised as P1CHC that started their definitive clinical assessment within 1 hour of their initial call being answered	90%	May-21	Not reported for this period	92.3%	89.8%	6th	No national compliance figure available
20	Percentage of emergency responses to red calls arriving within (up to and including) 8 minutes	65%	Jul-21	60.3%	47.2%	52.6%	5th	57.8%
22	MIU % patients who waited <4hr	95%	Jun-21	100.0%	100.0%	100.0%	1st	70.6%
23	MIU patients who waited +12hrs	0	Jun-21	0	0	0	1st	5,950
32	Number of diagnostic breaches 8+ weeks	0	Jun-21	308	194	246	1st	42,207
33	Number of therapy breaches 14+ weeks	0	Jun-21	986	7	21	1st	2,630
34	RTT patients waiting less than 26 weeks (excluding D&T)	95%	Jun-21	71.1%	75.9%	78.6%	1st	53.9%
35	RTT patients waiting over 36 weeks (excluding D&T)	0	Jun-21	239	554	504	1st	233,210
36	Number of patients waiting for a follow-up outpatient appointment	<=3,864	Jun-21	6611	6707	6671	1st	769,215
37	Number of patient follow-up outpatient appointment delayed by over 100%	< 201	Jun-21	382	474	506	1st	194,802
38	Percentage of ophthalmology R1 patients who are waiting within their clinical target date (+25%)	95%	Jun-21	82.7%	64.5%	62.4%	2nd	47.0%
Local	Percentage of patient pathways without a HRF factor	<= 2.0%	Jun-21	4.8%	0.3%	0.7%		
39	Rate of hospital admissions with any mention of self-harm from children and young people per 1k	Annual Reduction	2019/20	4.45		4.86	5th	3.97
40	CAMHS % waiting <28 days for OPA	80%	Jun-21	90.9%	98.0%	77.5%	4th	57.7%
41a	MH Part 1 - Assessments <28 days <18	80%	Jun-21	100.0%	97.5%	83.0%	2nd	49.3%
41b	MH Part 1 - Assessments <28 days 18+	80%	Jun-21	97.3%	94.0%	97.3%	3rd	71.0%
42a	MH Part 1 - Interventions <28 days <18	80%	Jun-21	100.0%	96.0%	85.7%	2nd	68.9%
42b	MH Part 1 - Interventions <28 days 18+	80%	Jun-21	71.1%	71.8%	85.6%	4th	80.3%
43	Children/Young People neurodevelopmental waits	80%	Jun-21	59.9%	52.0%	48.1%	2nd	34.6%
44	Adult psychological therapy waiting < 26 weeks	80%	Jun-21	93.7%	95.7%	95.8%	2nd	70.7%
45a	Number of health board delayed transfer of care for: Mental Health	12m↓	Feb-20	6	< 5	< 5	2nd	63
45b	Number of health board delayed transfer of care for: Non Mental Health	12m↓	Feb-20	29	15	20	1st	20
46a	HCAI - E.coli per 100k pop cum	TBC	Jun-21			3.03	PTHB is not nationally benchmarked for infection rates	
46b	HCAI - S.aureus bacteraemia's (MRSA and MSSA) per 100k pop cum	TBC	Jun-21			0.00		
46c	HCAI - C.difficile per 100k pop cum	TBC	Jun-21			9.09		
47a	HCAI - Klebsiella sp per 100k pop cum	TBC	Jun-21			0.00		
47b	HCAI - Aeruginosa per 100k pop cum	TBC	Jun-21			0.00		
48	Number of potentially preventable hospital acquired thromboses	4 quarter reduction trend	Q3 20/21	0	0	0	1st	7
* Benchmark provided from previous period (national benchmark outdated)								
**Ranking for RTT nationally includes D&T Specialties								

Primary Care

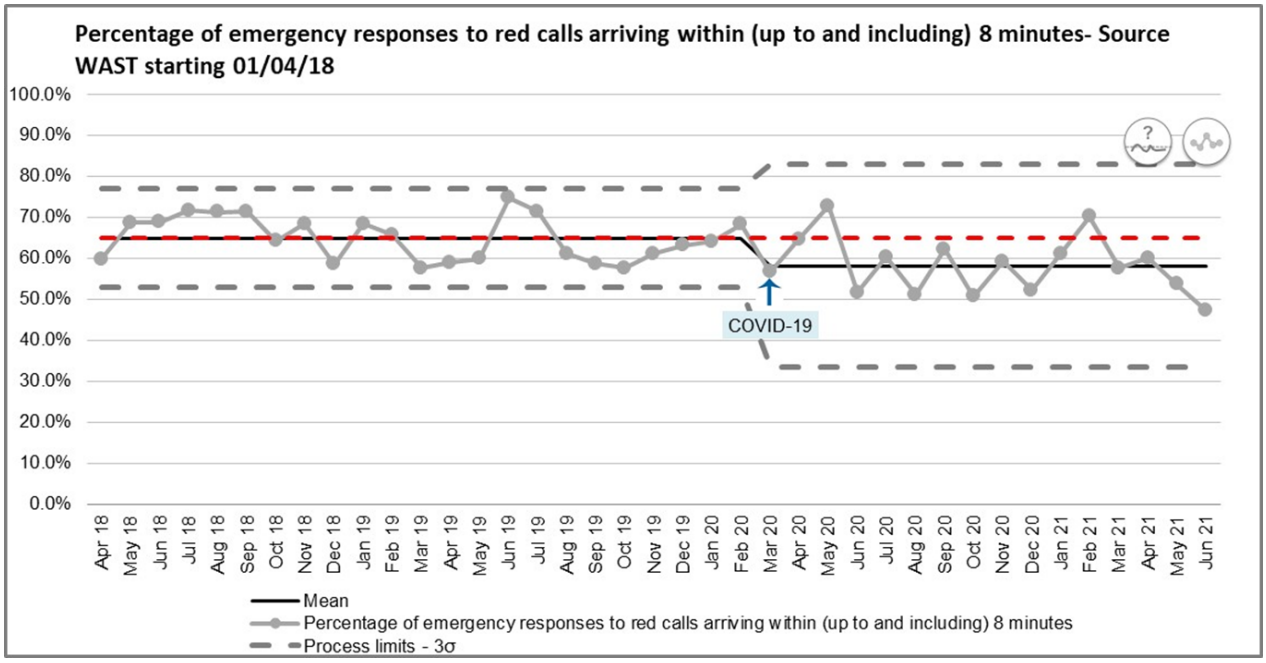
Of the Powys GP's during 2019/20 56.3% met the national access standards. Powys ranks 5th with an All Wales average of 59.7%, with only one available data point against this measure analysis is limited, COVID complications will affect performance for the pandemic year if reported.

For dental care Q3 20/21 performance fell slightly to 55.5% with Powys ranking 6th in Wales (All Wales average 61.2%). It should be noted that with the impact of COVID access was disrupted, and the national and local process is access on a basis of clinical need, rather than regular access.

As a newly reported measure (data available from April-21) the health board has performed robustly against the metric *"Percentage of Out of Hours (OoH)/111 patients prioritised as P1CHC that started their definitive clinical assessment within 1 hour of their initial call being answered"*. This target is set at 90% nationally, although benchmarking is not available. In Powys May performance narrowly missed this target (89.8%) falling slightly from April.

Unscheduled Care

Welsh Ambulance Services NHS Trust (WAST) Red <=8-minute ambulance response time performance did not meet the target during June (52.6%), ranking 5th against 57.8% national average. This measure has only exceeded the 65% target twice during 2020/21. The impact of COVID has adversely affected compliance with mean performance falling to 58.2%, this measure continues to have common cause variation. In response to this performance meetings have been held with senior officers of WAST, escalating the continued inability to deliver the red target in Powys. A firm plan and proposals from WAST, informed by the analysis of the challenges is awaited as a consequence of the most recent meeting for consideration by Powys Teaching Health Board and the Chief Ambulance Services Commissioner.



Minor injury units (MIU)

Unscheduled care performance for Powys provided services e.g. minor injury units (MIU) has remained consistently good throughout 2020/21, the health boards assurance is that MIU's exceeded the required target every month for patients waiting less that 4 hrs, and zero patients waited 12+ hours during the 2020/21 financial year.

Planned Care

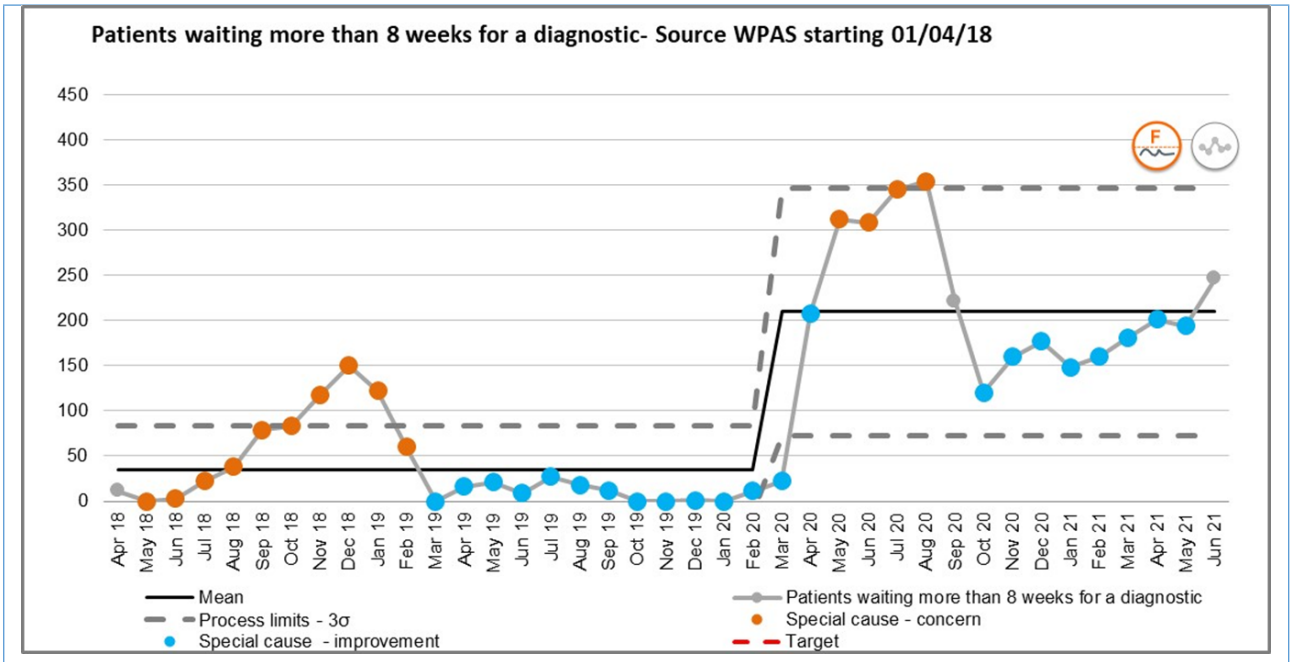
Diagnostics

The latest June position shows an increase in total patients breaching the 8 weeks wait target to 246. Key specialties breaching the target include diagnostic endoscopy (131 breaches), non-obstetric ultrasound (97 breaches) and echo cardiogram (17 breaches). When looking at long term trends and the impact of COVID pandemic the resulting suspension of services created a significant backlog. The provider breaches have shifted above mean with common cause variation  . The health board consistently fails  to meet the target of zero as an expected, and without a system change current performance is expected to worsen.

During June further challenges impacted endoscopy, staff sickness, in-reach fragility, and increased urgent referrals. This increase in demand and significant reduction in capacity has caused the health board's recovery to slow. The impact of this service fragility includes increased breaches of routine access, longer waits and enhanced clinical prioritisation. The health board is currently linking with regional teams/centres to strengthen the service, unfortunately patients in South and Mid Powys may have to travel for diagnostics in commissioned providers instead of provider run diagnostic units in Brecon and Llandrindod Wells unless the workforce challenges are resolved.

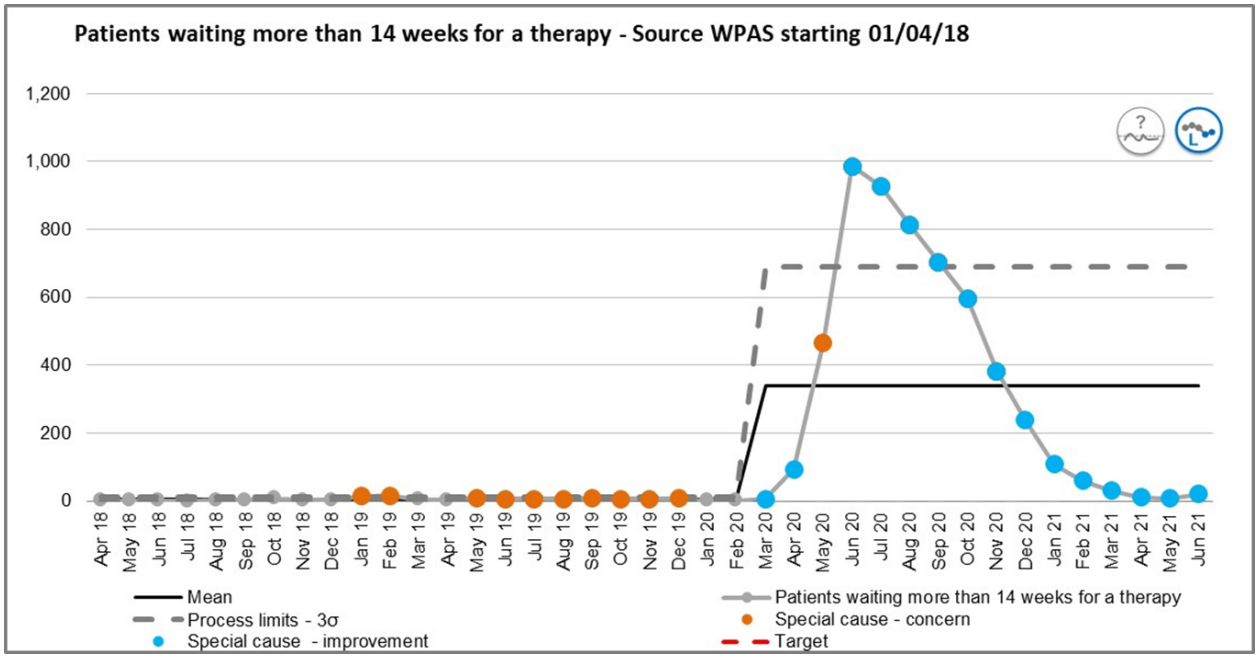
The other key breaching specialty is non-obstetric ultrasound (NOUS), this service has challenges linked to staff sickness, and in-reach service availability. To address this, locum sessions are being provided to cover staffing fragility, and in the north of Powys work with Betsi Cadwaladr University health board to resolve in-reach fragility of radiology support. The service plans to recover its position by Q3 2021/22.

Powys ranks 1st and continues to have the least breaches in Wales, the All Wales position is 42,207 total patients waiting over 8 weeks in June.



Therapies

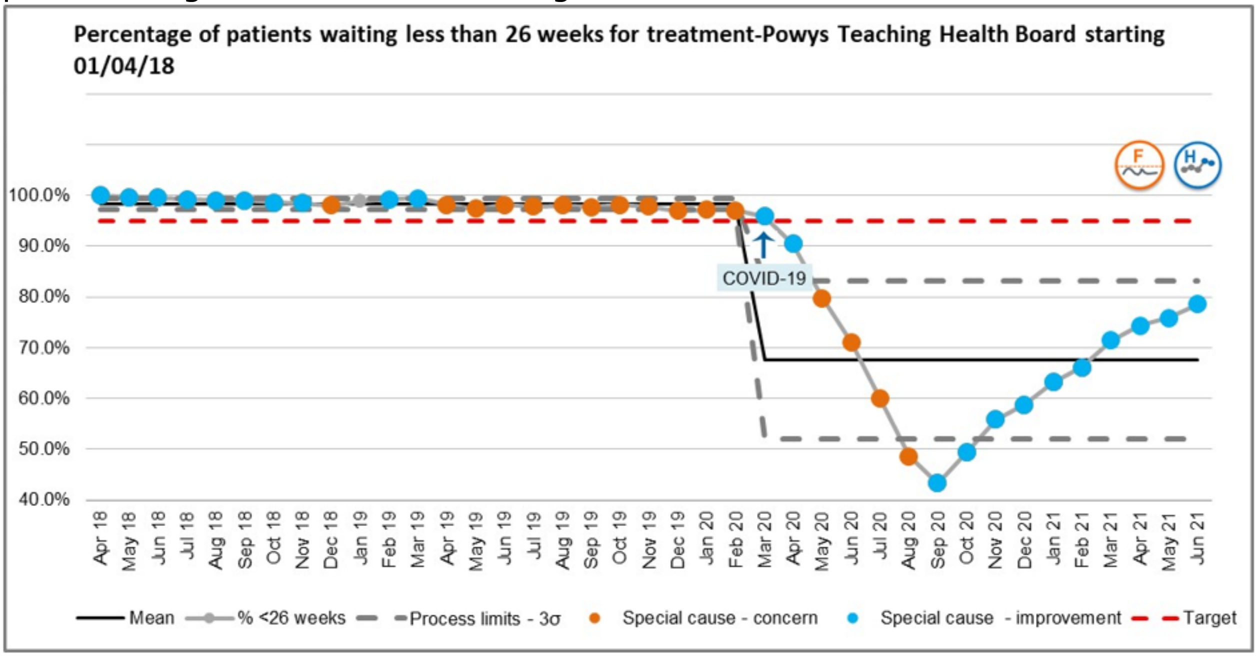
The latest June position for therapies shows an increase to 21 breaches predominately in adult physiotherapy (12 breaches) and routine podiatry (9 breaches) of the <14 week wait target. Even with the slight increase the SPC continues to show an improving trend ,but the service as expected has not met the national target of zero.



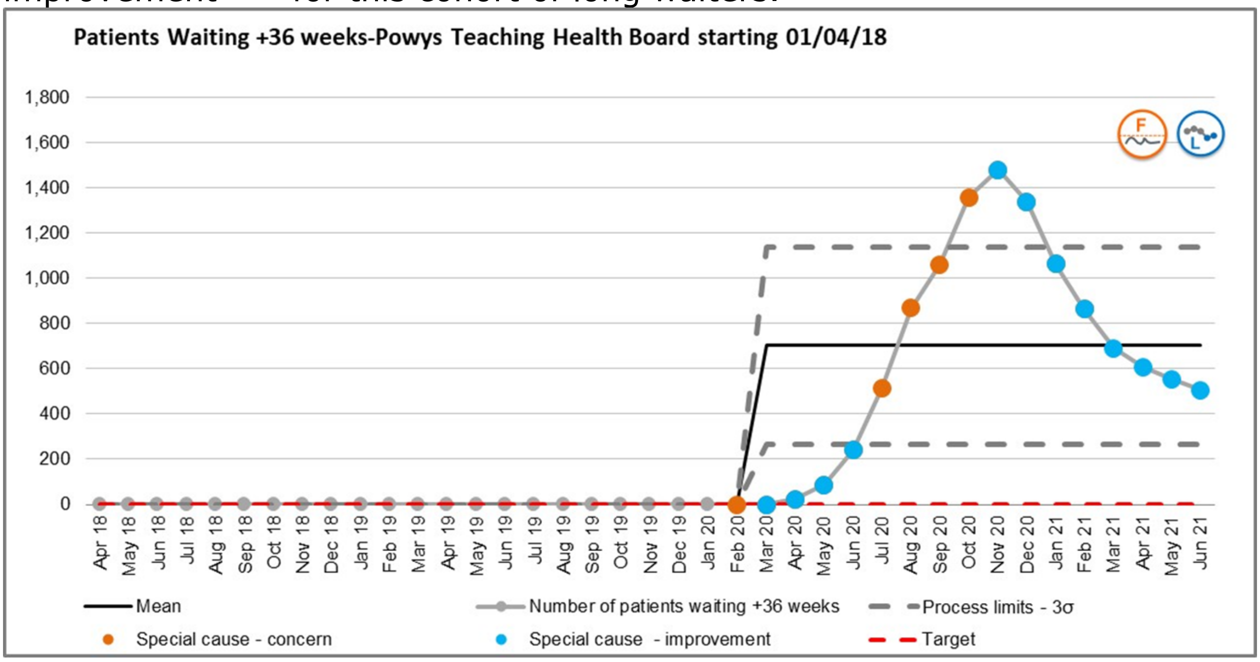
Powys Provider Referral to Treatment (RTT)

The Powys provided RTT waits position for June has improved with 78.6% of 3683 patients waiting less than 26 weeks on an open pathway (excluding diagnostics and therapies). The number of patients waiting over 36 weeks has decreased from 554 to 504 in June, of those 292 (370 in May) are

waiting longer than 52 weeks (part of the original suspension cohort). The SPC chart below shows improving special cause variation. Although continuing to miss the target Powys has the best recovery of all Welsh providers against a national average of 53.9%.



The SPC chart below for those patients waiting over 36+ weeks shows that although consistently not meeting the target there is assured improvement for this cohort of long waiters.



Below is a summary table of the complete waiting list by Digital Health and Care Wales (DHCW) aligned banding. The challenge can be seen within 53-104 week wait bands, and consists predominantly of routine patients who were waiting during the suspension period. Both the backlog, and new referral increase into the service challenge the system.

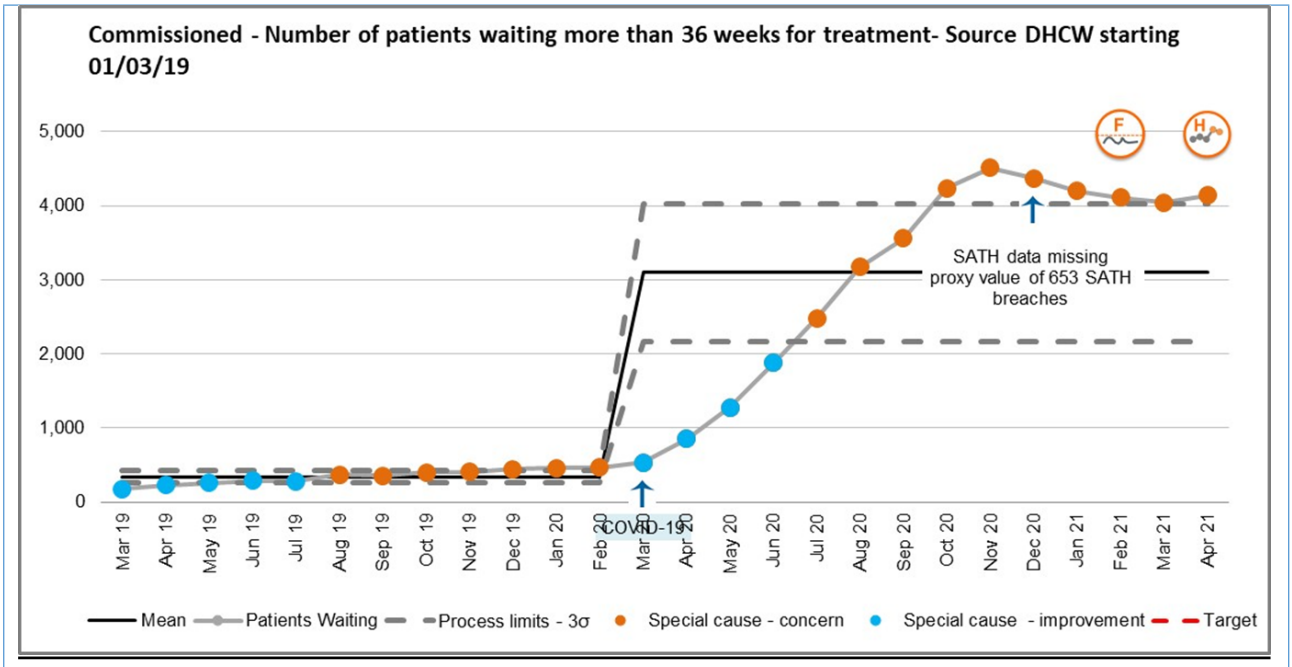
Tables summarising RTT performance as a provider – source DHCW:

RTT waits by specialty and band	Weeks wait band					
Main Specialty	0 to 25 Weeks	26 to 35 Weeks	36 to 52 Weeks	53 to 76 Weeks	77 to 104 Weeks	Grand Total
100 - GENERAL SURGERY	379	30	17	17	9	**452**
101 - UROLOGY	104	17	24	2	4	**151**
110 - TRAUMA & ORTHOPAEDICS	461	46	64	71	41	**683**
120 - ENT	380	40	18	3	1	**442**
130 - OPHTHALMOLOGY	703	78	30	11	0	**822**
140 - ORAL SURGERY	153	35	46	75	53	**362**
143 - ORTHODONTICS	14	3	2	1	1	**21**
191 - PAIN MANAGEMENT	69	0	0	0	0	**69**
300 - GENERAL MEDICINE	67	7	0	0	0	**74**
320 - CARDIOLOGY	119	4	3	1	1	**128**
330 - DERMATOLOGY	21	0	0	0	0	**21**
410 - RHEUMATOLOGY	93	13	8	0	0	**114**
420 - PAEDIATRICS	31	0	0	0	0	**31**
430 - GERIATRIC MEDICINE	23	0	0	0	0	**23**
502 - GYNAECOLOGY	278	11	0	1	0	**290**
Grand Total	**2895**	**284**	**212**	**182**	**110**	**3683**

The continuing challenge through 2021/22 will be clearing this cohort of patients, and the continued increase in new referrals, for the provider these longer waits are found predominately in general and oral surgery, and T&O. As a provider the services continue to minimise patient harm using risk stratification, clinical triage and use of new national drivers e.g. outpatient transformation work. The health board is targeting specific areas utilising the funds provided by Welsh Government to tackle planned care access in the provider and commissioner services.

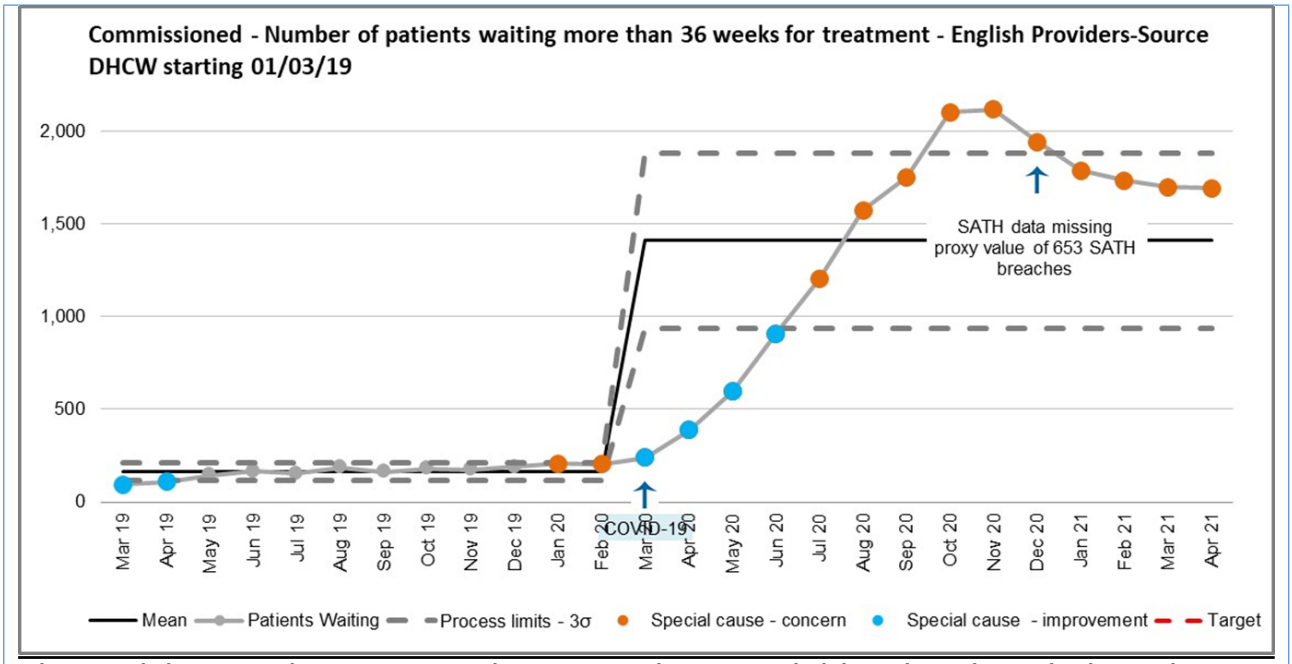
Commissioned Services Referral to Treatment (RTT)

The position of commissioned RTT waits for Powys residents does not show the same improvement levels as the provider. The latest combined position in April exc. D&T, and for open pathways displays that 59.5% of 14,502 patients wait under 26 weeks on an RTT pathway, and 4137 patients wait 36 weeks and over. This is the latest combined snapshot to include both English and Welsh providers available as Wye Valley Trust were unable to meet the DHCW data deadline.

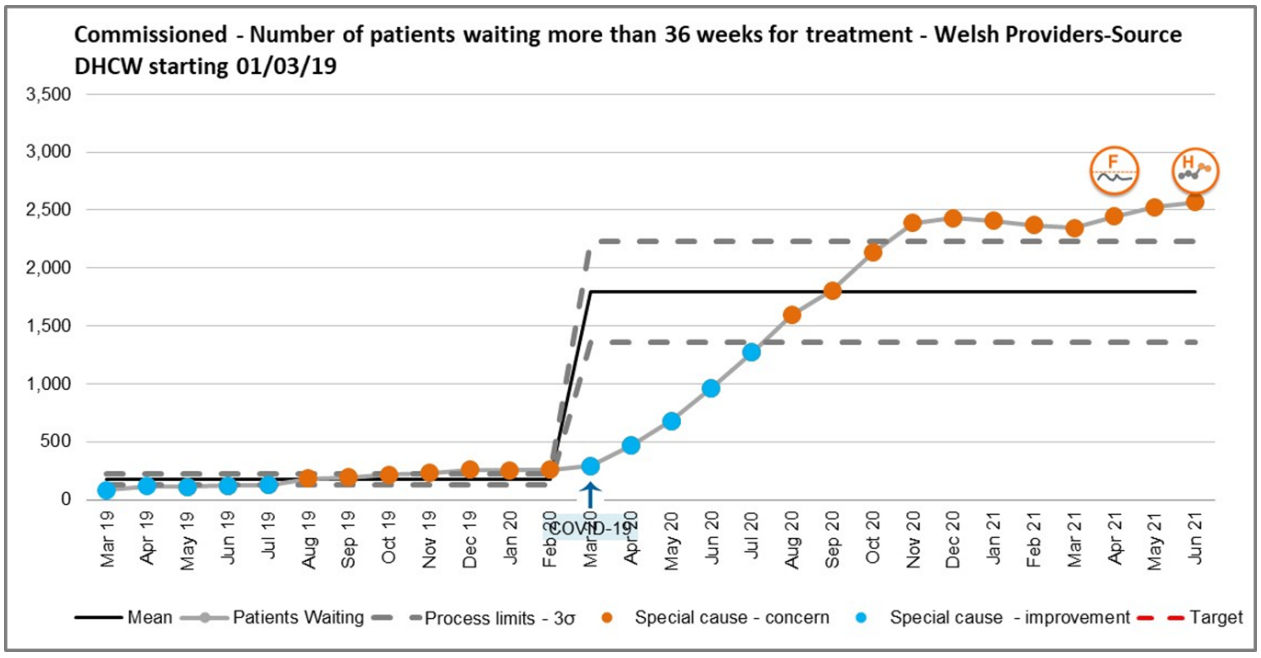


The above SPC chart clearly shows the impact of service suspensions on Powys residents which started at the end of March 2020. The impact of this suspension and further backlog is universal across the commissioned system affecting most specialties and providers. At a high-level health care is not meeting the target with ongoing special cause variation, as the number of breaches remain close to the upper control limit. If improvement does not occur during quarter 1 there will be a required further shift change.

Recovery of services at a country comparison level shows that England has slowed its recovery with a slight increase in +36 week waiters for the available data in May for Robert Jones and Agnes Hunt (RJAH), Shrewsbury and Telford (SATH) and English other minor providers (please note the below SPC remains at an April position).



The Welsh provider situation has June data available, the chart below shows the number of Powys residents waiting over 36 weeks increasing in April, May and June. The providers with the highest levels of long waits by quantity are Swansea Bay, and Aneurin Bevan University Health Boards. The Welsh provider with the highest waits as a percentage of the total list is Cwm Taf where 49.8% of the total waiting list are 36+ weeks.



The commissioning assurance process continues in Powys to assess and ensure the best possible care for residents and all long waiters are risk stratified by the relevant care provider.

Commissioned Provider wait details by week bands

The below summary tables show the position of Powys main commissioned care providers. Please note that DHCW individual weeks waits reporting stops at 104 weeks, patients waiting over this are amalgamated into an over 104 weeks band. The latest snapshot for Welsh Providers is June 2021, and May 2021 for three English providers RJAH, SATH and English other. Wye Valley Trust data latest is an April snapshot.

Table of Providers

Jun-21		Patients Waiting						
Welsh Providers*	Powys residents waiting under 26 weeks (%)	0-25 Weeks	26-35 Weeks	36-52 Weeks	53 to 76 Weeks	77 to 104 Weeks	Over 104 Weeks	Total Waiting
Aneurin Bevan Local Health Board	56.8%	1191	208	203	261	216	16	2095
Betsi Cadwaladr University Local	44.3%	223	40	36	100	80	24	503
Cardiff & Vale University Local	53.5%	207	26	38	55	57	4	387
Cwm Taf Morgannwg University	43.1%	188	31	58	61	87	11	436
Hywel Dda Local Health Board	53.3%	714	157	186	152	124	6	1339
Swansea Bay University Local	44.4%	763	162	221	226	264	84	1720
Total	50.7%	3286	624	742	855	828	145	6480

May-21		Patients Waiting						
English Providers	Powys residents waiting under 26 weeks (%)	0-25 Weeks	26-35 Weeks	36-52 Weeks	53 to 76 Weeks	77 to 104 Weeks	Over 104 Weeks	Total Waiting
English Other	79.4%	223	24	15	11	8	0	281
Robert Jones & Agnes Hunt	65.9%	1488	262	205	224	77	2	2258
Shrewsbury & Telford Hospital NHS	68.9%	2071	361	255	200	119	0	3006
Total	68.2%	3782	647	475	435	204	2	5545

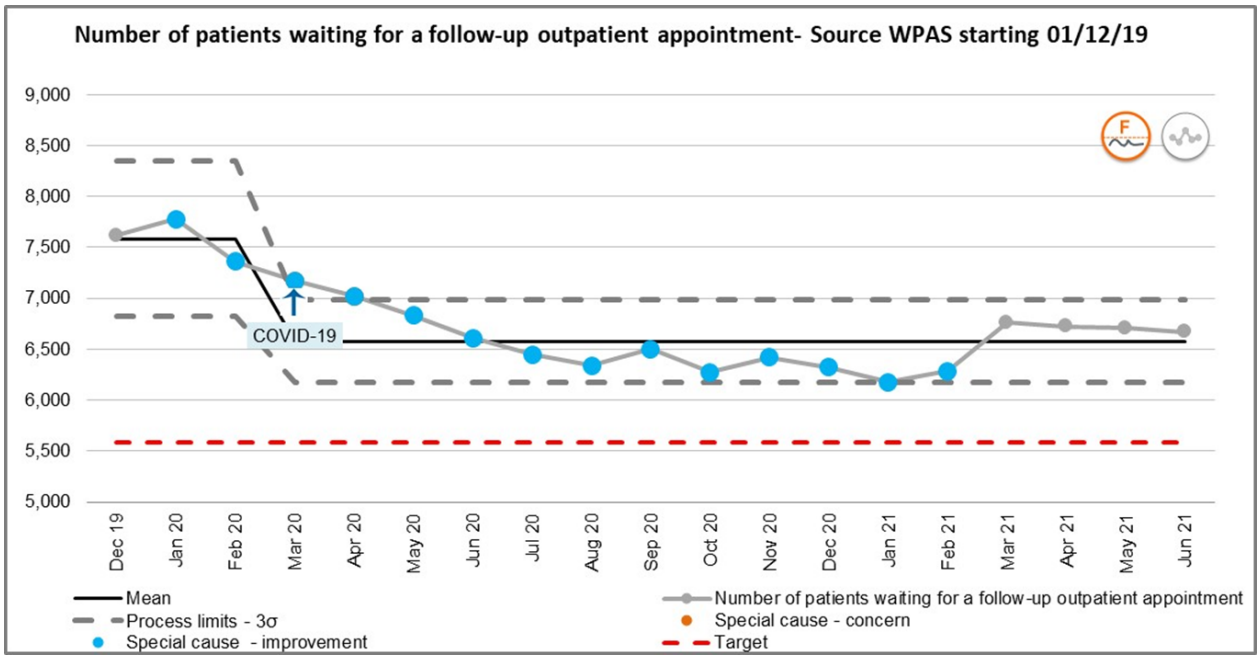
Apr-21		Patients Waiting						
English Providers	Powys residents waiting under 26 weeks (%)	0-25 Weeks	26-35 Weeks	36-52 Weeks	53 to 76 Weeks	77 to 104 Weeks	Over 104 Weeks	Total Waiting
Wye Valley NHS Trust	62.7%	1814	432	333	234	75	5	2893
Total	62.7%	1814	432	333	234	75	5	2893

The commissioned RTT position for our residents in Welsh providers is significantly challenging, two of our three main providers Aneurin Bevan UHB and Swansea Bay LHB reporting a considerable over 52-week backlog. The position of the English providers is improved with RJAH improving with services steadily returning to pre-covid position. Key drivers to English recovery include NHSEI improvement targets using 2019/20 as a baseline e.g. expecting RTT improvement of 5% per month, and the utilisation of an elective recovery fund to financially support provider recovery activity above normally funded levels.

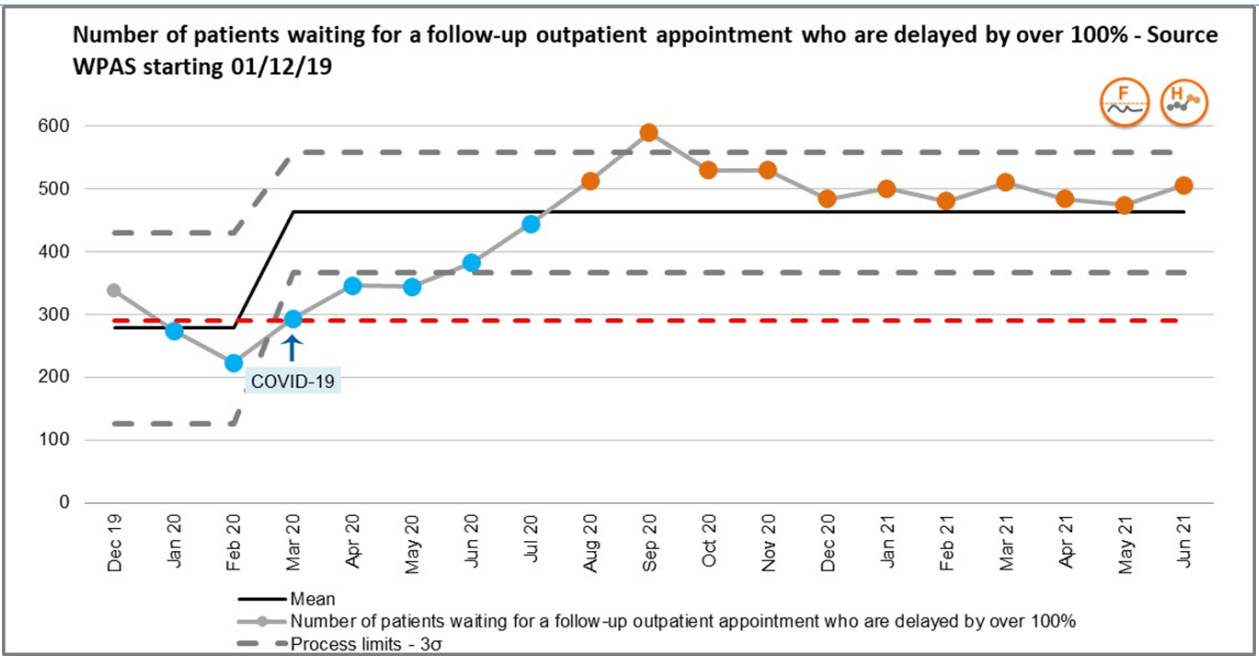
Follow-ups

Follow-up (FUP) outpatient measure for total waiting is not meeting the 2021/22 reduction target of 55% from the March 19 baseline (3,864 or less total waiters), it has been noted that the existing target is not compatible with the current service position and this has been raised with the outpatient transformation workstream and Welsh Government. PTHB has managed its

total patients waiting FUP position well during COVID with relatively good levels of activity via non-face to face contact, and undertaken list validation all working towards reducing the total waiters. Although June has seen a slight decrease again of patients on a FUP pathway Q1 of 2021/22 has remained above mean. Challenges remain with service overall capacity, and clinic slots prioritising clinically at-risk patients, the health board will not meet its target of total FUP reduction without a system or national target change.

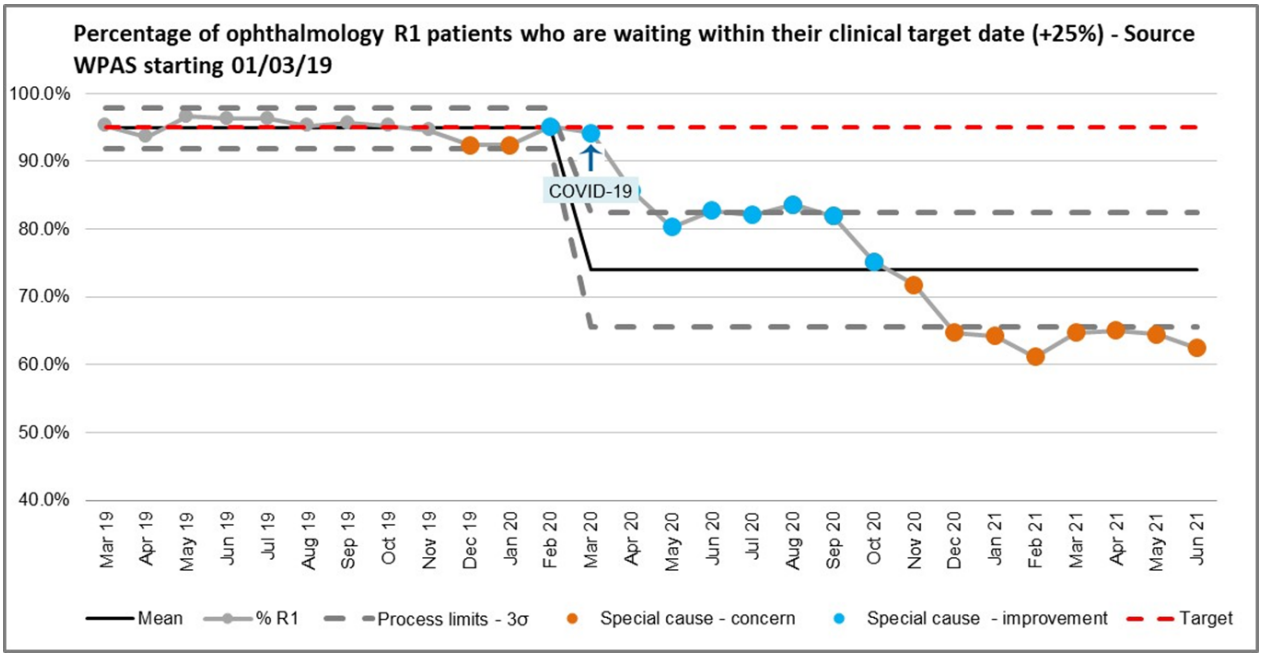


For long waiting FUP's e.g. patients waiting beyond 100% performance is consistently not meeting the target of 201 or less, this target is again set prior to the COVID pandemic, and will be unattainable with current service pressures. As above the challenge is around capacity and in-reach fragility across key specialties, general surgery and medicine, T&O, ophthalmology and mental health e.g. adult mental health and old age psychiatry.



Eye Care

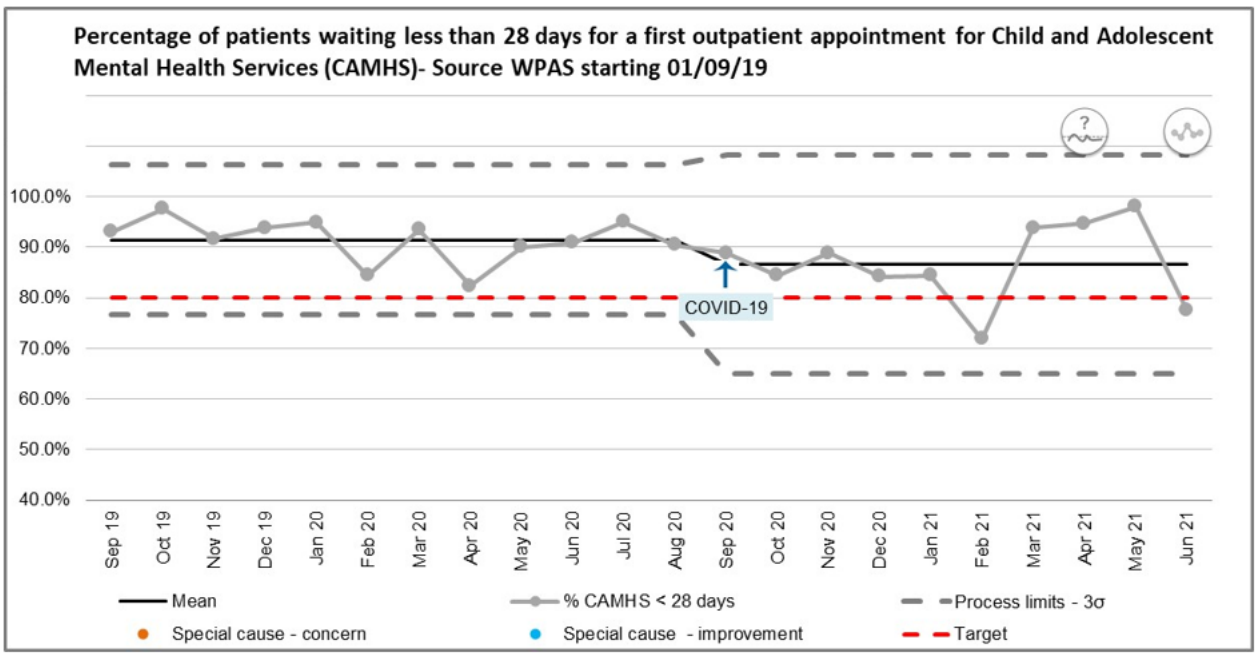
As an essential service the Eye Care provision in Powys has remained robust when compared to the All Wales performance this year. Maintaining performance however has been challenging and remains a special cause for concern consistently does not meet the target. Although not meeting the target the provider ranks 2nd in Wales against an average of 47%, and continues to provide leading cataract activity within the day-case unit compared to other Welsh health boards. Without system or process change the performance is unlikely to improve before the end of the financial year.



For the local HRF measure "Percentage of patient pathways without an HRF factor" performance has remained strong meeting the <2% target, reporting 0.7% for May.

CAMHS

The CAMHS measure performance has not met the target in June (77.5%). The service was impacted by COVID but performance remains within expected limits with common cause variation, and random hit and miss assurance of target. Further support for young people is now available via the SilverCloud online mental health interactive tool.



Measure			Apr-21	May-21	Jun-21
Percentage of patients waiting less than 28 days for a first outpatient appointment for Child and Adolescent Mental Health Services (CAMHS)	Percentage Compliance	80%	94.7%	98.0%	77.5%
	Number of patients waiting <28 days		36	49	31
	Total Number of patients		38	50	40

Mental Health Part 1

The latest performance in June shows that part 1 measures for assessments, of both the +18 (97.3%) and under 18 (82.9%) age ranges is meeting the 80% target. For interventions +18 performance is 85.6% and<18 performance for the same period is 85.7% both exceeding the 80% national target.

Nationally the health board benchmarks;

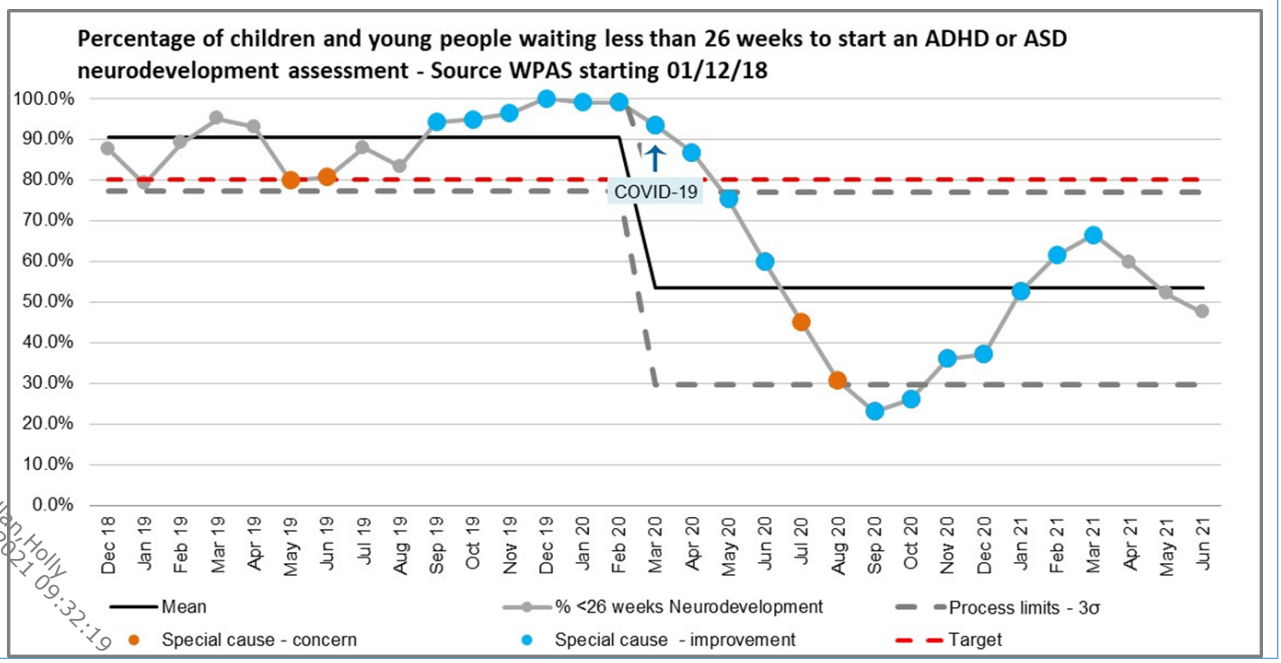
- 2nd for <18 assessments (All Wales 49.3%)
- 3rd for +18 assessments (All Wales 71.0%)
- 2nd for <18 interventions (All Wales 68.9%)
- 4th for +18 interventions (All Wales 80.3%)

Table of 2021/22 part 1 performance

Measure			Apr-21	May-21	Jun-21
Part 1: Percentage of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral : Under 18 years	Percentage Compliance	80%	100.0%	97.5%	82.9%
	Number of patients waiting up to and including 28 days		37	39	39
	Total number of assessments		37	40	47
Part 1: Percentage of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral: 18 years and over	Percentage Compliance	80%	99.0%	94.0%	97.3%
	Number of patients waiting up to and including 28 days		109	126	145
	Total number of assessments		110	134	149
Part 1: Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS : Under 18 Years	Percentage Compliance	80%	100.0%	96.0%	85.7%
	Number of patients waiting up to and including 28 days		22	24	24
	Total number of therapeutic interventions		22	25	28
Part 1: Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS: 18 years and over	Percentage Compliance	80%	83.0%	71.8%	85.6%
	Number of patients waiting up to and including 28 days		141	117	155
	Total number of therapeutic interventions		172	163	181

Neurodevelopmental waits (ND) - children and young people

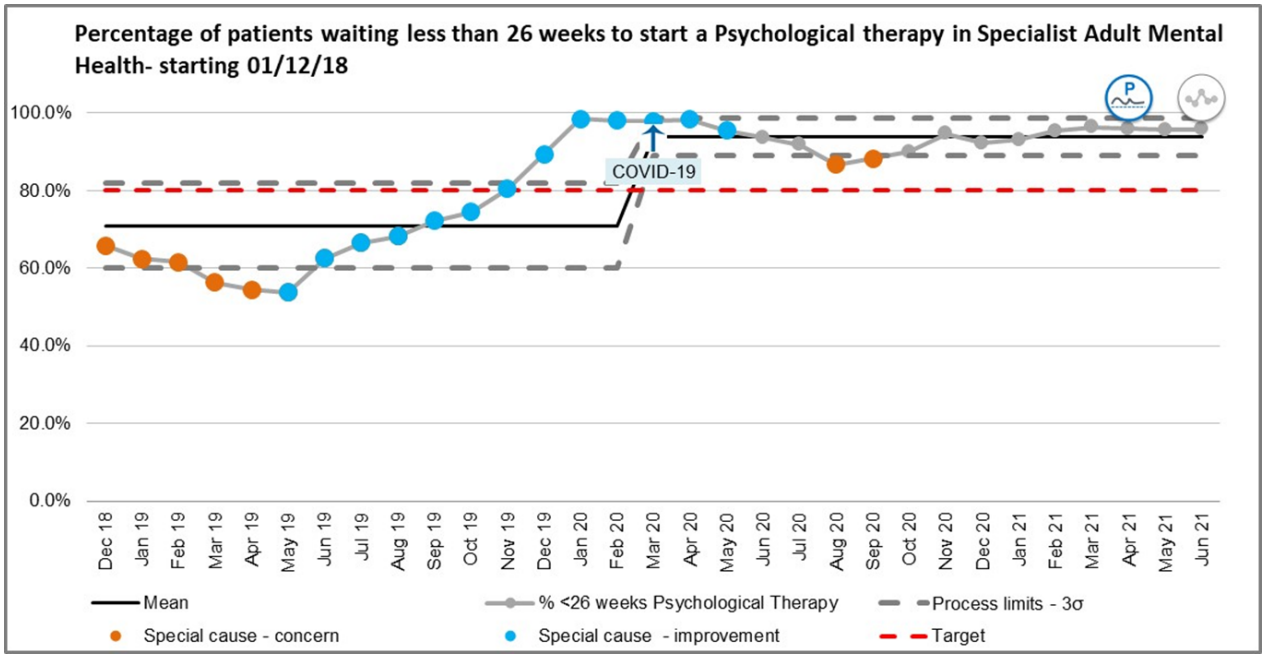
Due to the impact of COVID the service was suspended from March to September, and performance compliance has been significantly affected (47.4% June-21). During the resumption of the service there has been an increase in referral demand month on month. This has coincided with a reduction in capacity within the ND service. This is in addition to a high level of demand already within the system. ND services are a priority under the PTHB renewal portfolio for 2021/22, and an in-depth review of the service has been undertaken with a view to implementing a further improvement plan.



Measure		Target	Apr-21	May-21	Jun-21
43) Percentage of children and young people waiting less than 26 weeks to start an ADHD or ASD neurodevelopment assessment	Percentage compliance	80%	59.6%	52.0%	47.4%
	Number of patients waiting < 26 weeks		112	102	91
	Total number of patients		188	196	192

Adult psychological therapy waiting < 26 weeks

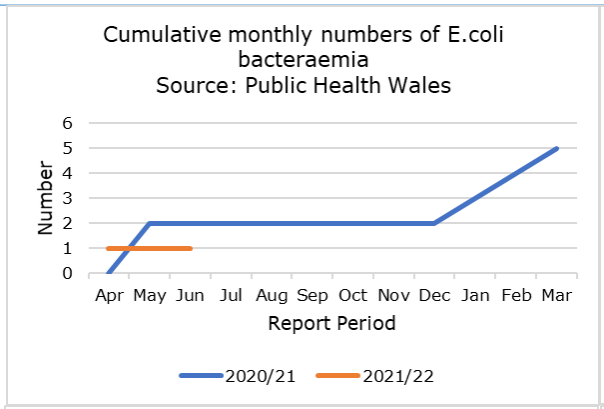
Powys continues to have robust performance against this measure with 95.8% compliance in June, this compares to an All Wales average of 70.7%. The health board has consistently exceeded the 80% target for the 2020/21 financial year.

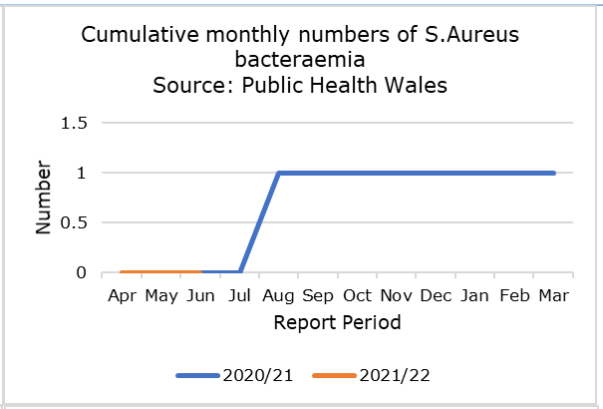


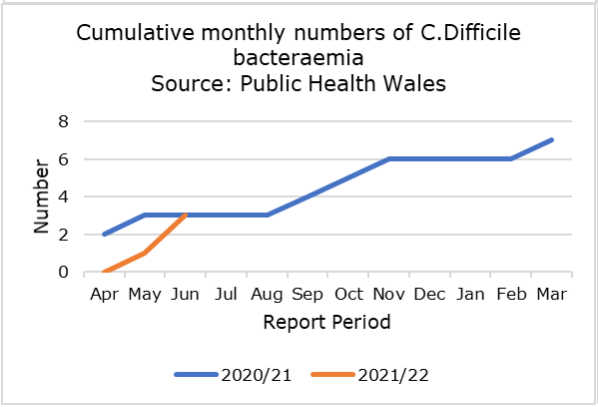
Measure			Apr-21	May-21	Jun-21
Percentage of patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult Mental Health	Percentage compliance	80%	95.9%	95.7%	95.8%
	Number of patients waiting < 26 weeks		140	132	136
	Total number of patients		146	138	142

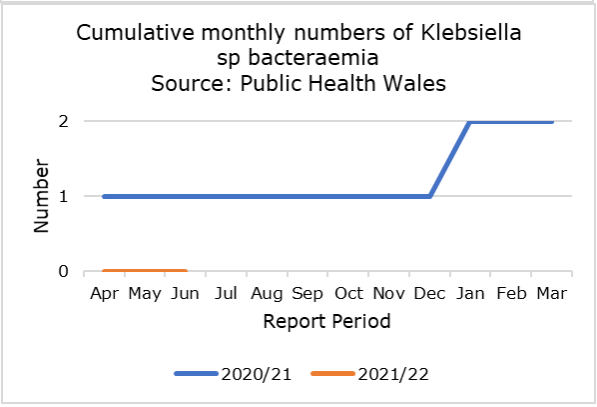
Health Care Acquired Infections

For the safety and quality measures around infections PTHB continues to report low levels of incidence, and the health board is not nationally benchmarked. Although the national measure looks at per 100k infection rates, below are graphs comparing actual reported infection numbers 2020/21 and 2021/22 by infection type.



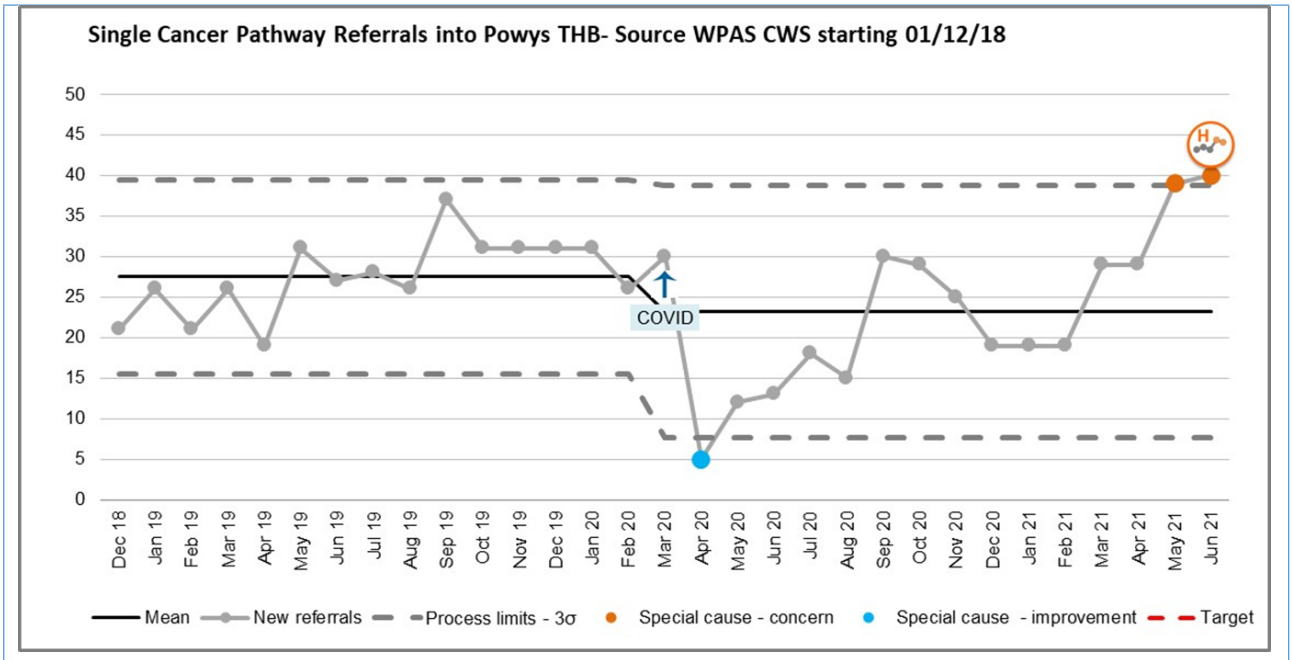






Cancer

The COVID pandemic continues to significantly challenge cancer services across Wales, this disruption impacts outpatients, diagnostics, surgery and treatments. Significant work both nationally and locally has been undertaken to minimise patient harm including risk stratification, regular national operational group meetings and waiting list assurance. As a provider of USC endoscopy diagnostics, the health board has maintained a zero-backlog position even with the further increased referral rates during June, this is also the national picture for Cancer referrals. Although PTHB does not carry out acute care e.g. treatment we are still responsible for reporting our part of the cancer pathway as agreed with Welsh Government. The below SPC chart shows the number of USC referrals into Powys as a provider since the health board started reporting the evolved cancer measure. The start of COVID in Wales resulted in a significant drop in Powys GP referrals into the service, this mirrored the All Wales picture for cancer. The latest data now shows for a special cause for concern with referral numbers above upper control limits (this has also been seen nationally).



During June **40** Urgent Suspected Cancer (USC) referrals were recorded on the tracking system, and during the same period **31** patients were downgraded following a cancer referral. The compliance for downgrade within the recommended 28-day period was reported as **58%.**

Please note that Powys residents that require treatment have their care pathway compliance reported by that acute provider.

Cancer - Welsh provider performance

PTHB now has access to the All Wales Single Cancer Pathway (SCP) minimum data set for *closed pathways via the DHCW warehouse, this required an extensive escalation process by the Powys Performance team with Executive, Welsh Government, and Delivery Unit support to achieve. This information provides a new level of access to Powys residents waiting in Commissioned Welsh providers only, and does not support cross border patient flows into England and their data.

There are several key differences to cancer wait times under the SCP compared to the retired USC & NUSC pathways in Wales;

- The SCP sets out to merge both the urgent and non-urgent pathways with one standardised waiting time of 62 days.
- The pathway (wait clock) starts at the point of suspicion
- Reporting provides an unadjusted wait time against the 62-day target e.g. as an example the clock continues even if a patient delays their pathway for a holiday.
- Target of 75% for patients to start treatment with 62 days of first suspecting a cancer diagnosis (metric currently unavailable as a resident view).
- *data reporting is based on a validated closed pathway, this means they are reported in the month that the patient either receives

treatment, or is downgraded (previously downgrades were not included).

As high-level information, since December 2020 **1,105** Powys residents have been reported on the SCP tracker across Welsh providers, of these 15% had a closed pathway clock stop recorded as treatment.

Table of pathways, that breached their SCP target date (62 days) by Provider

Number of pathways that breached their SCP target (62 days) for treatment - Source DHCW					
Providers	Pathway Stop Month				Grand Total
	2021-04	2021-05	2021-06	2021-07	
Aneurin Bevan Local Health Board	8	2	4	3	**17**
Cwm Taf Morgannwg University Local Health Board	3		3	1	**7**
Hywel Dda Local Health Board	5	2	4	5	**16**
Swansea Bay University Local Health Board	2	3	2	7	**14**
Grand Total	**18**	**7**	**13**	**16**	**54**

It should be noted that at the time of writing this document this data has been available in a reportable format for less than one week. Validation work is ongoing including alignment to Welsh Government reporting metrics. Further work will be undertaken to utilise the integration of this data for use within the Commissioning Assurance Process and associated cancer pathway development.

Cancer - English provider performance

For our main providers via direct breach reporting, three breaches were reported in Wye Valley NHS Trust during May 2021. Within SATH ten 62-day breaches were reported to the health board in the August update 2021. All English breaches had a root cause analysis carried out to provide quality and safety assurance.

There is a risk that all cancer breaches are reported from a closed pathway position e.g. patients will be currently breaching but not yet reported. All cancer breaches reported are reviewed via the Commissioning Assurance process.

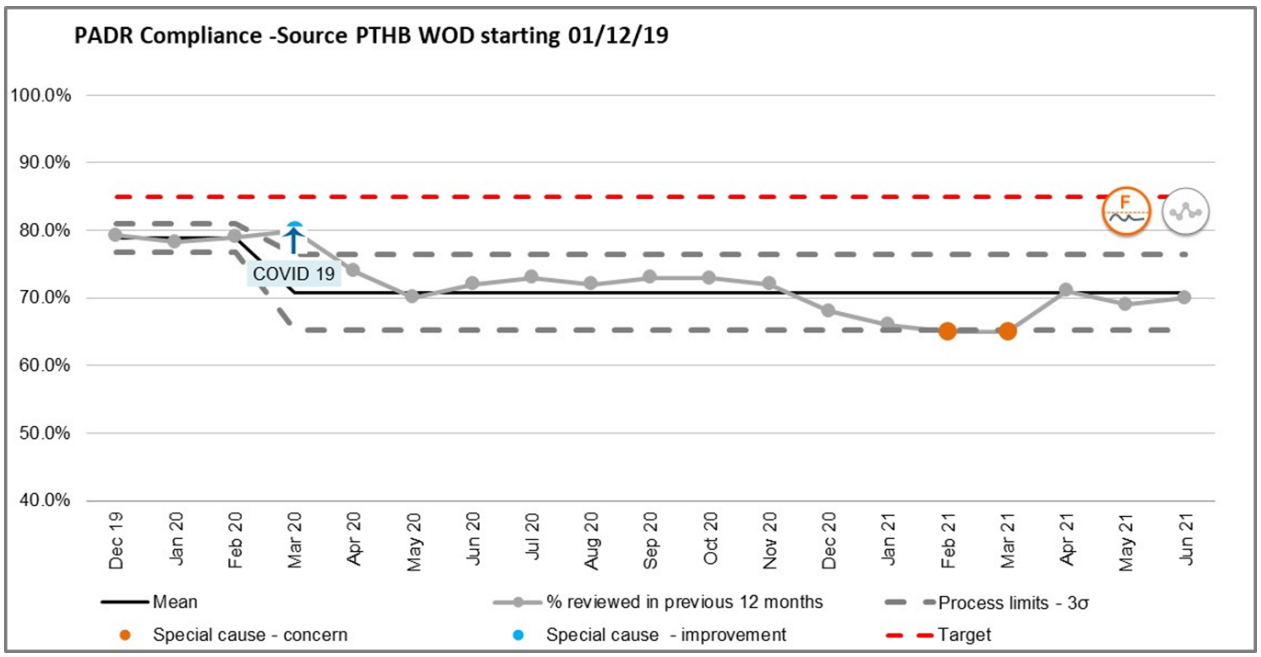
Quadruple Aim 3: The health and social care workforce in Wales is motivated and sustainable.

Please find below a table of the Powys applicable outcome measures for aim 3:

2020/21 NHS Outcome Framework Summary - Key Measures - Provider				Performance			Welsh Government Benchmarking (*in arrears)	
No.	Abbreviated Measure Name	Target	Latest Available	12month	Previous Period	Current	Ranking	All Wales
49	Average rating given by the public (age 16+) for the overall satisfaction with health services	Improvement	2018/19	5.98	5.98	6.19	6th	6.31
50	Percentage satisfied or fairly satisfied about the care that is provided by their GP/family doctor (16+)	Annual Improvement	2019/20	93.1%		87.9%	5th	88.60%
52	Overall staff engagement score	Annual Improvement	2020	79.0%	79.0%	78.0%	1st	75.00%
53	Performance Appraisals (PADR)	85%	Jun-21	72.0%	69.0%	70.0%	5th (Mar-21)	57.7% (Mar-21)
55	Core Skills Mandatory Training	85%	Jun-21	85.0%	78.9%	79.8%	2nd (Mar-21)	78.9% (Mar-21)
57	(R12) Sickness Absence	12m↓	Jun-21	5.11%	4.85%	4.94%	3rd (Mar-21)	5.94% (Mar-21)
58	Percentage of staff who would be happy with the standard of care provided by their organisation if a friend or relative needed treatment	Annual Improvement	2020	91.0%	91.0%	88.6%	1st	67.8%
60	Concerns & Complaints	75%	Q4 20/21	35.5%	37.9%	44.9%	10th	67.2%

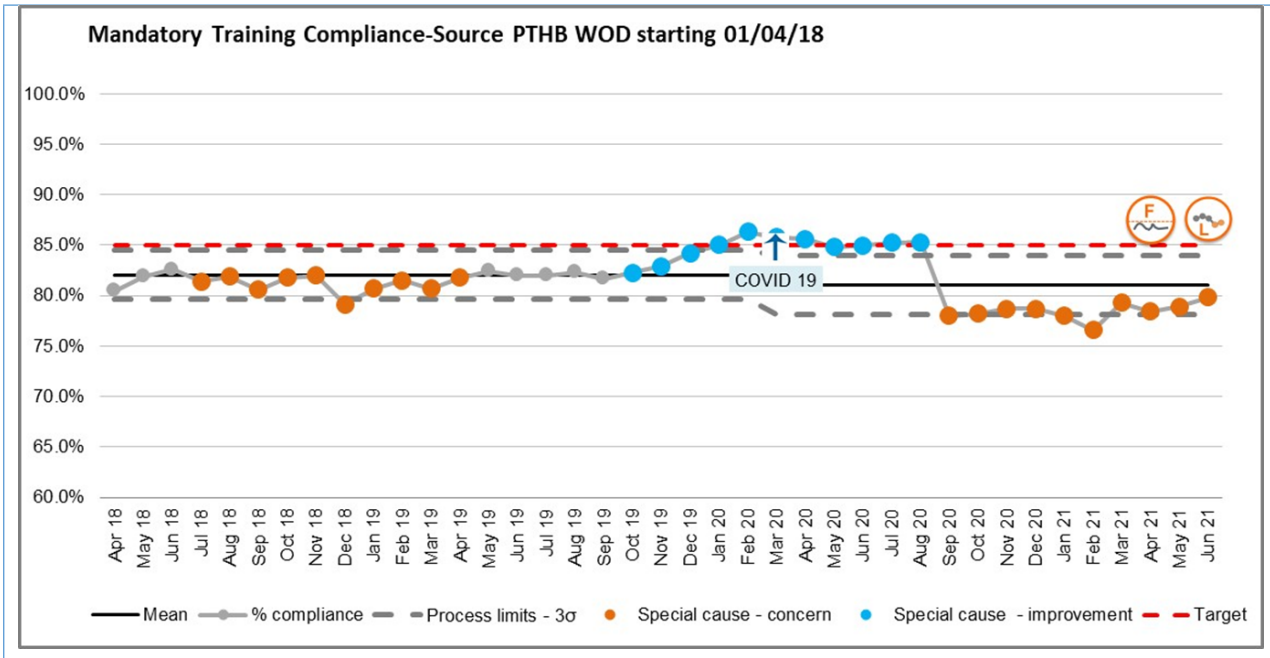
Personal appraisal and development reviews (PADR)

The health board has improved to 70% compliance in June for staff to have a personal appraisal and development review in the previous 12 months. Although benchmarking positively against the All Wales average, the health board has met the target once since December 2019.



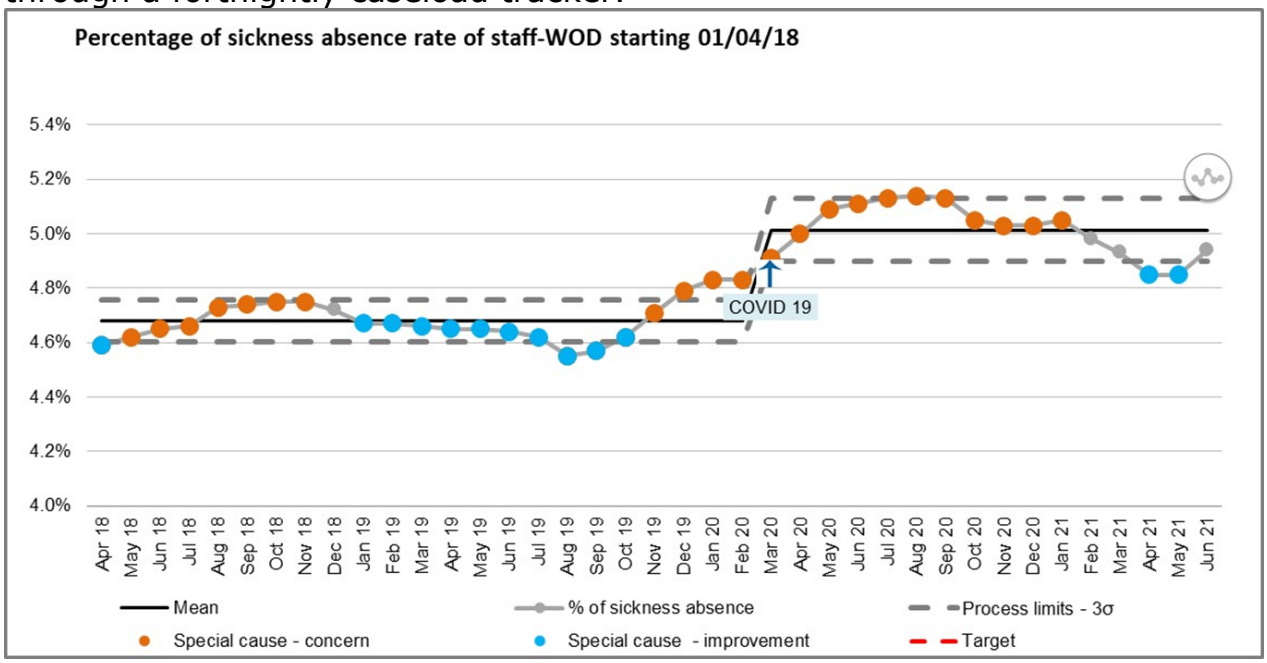
Mandatory core skills training

For May the health board has missed the 85% target, it should be noted that performance has improved slightly to 79.8% as a result of proactive work with managers to improve compliance. Although improved this is still a special cause for concern, the last 10 months show that without a system change compliance is unlikely.



Sickness

The rolling 12 figure for sickness is reported at 4.94% in June meeting the rolling 12-month reduction target. Actual monthly sickness has reduced slightly to a reported rate of 5.44% (1.27% short term and 4.17% long term). There is a continued focus by the Business Partners and HR Advisors in monitoring and reviewing long term sickness cases. These are highlighted through a fortnightly caseload tracker.



Concerns & Complaints

The health board's compliance to complaints that receive a final reply within 31 days has remained non-compliant against target. In Q4 we have seen

improvement and the health board was 44.9% compliant (data source Welsh Government Performance) against the 75% national target. In comparison to other health boards in Wales, PTHB ranks 10th below the national average of 67.2%.

Quadruple Aim 4: Wales has a higher value health and social care system that has demonstrated rapid improvement and innovation and enabled by data and focused on outcomes

Please find below a table of the Powys applicable and timely outcome measures for aim 4:

2020/21 NHS Outcome Framework Summary - Key Measures - Provider				Performance			Welsh Government Benchmarking (*in arrears)	
No.	Abbreviated Measure Name	Target	Latest Available	12month	Previous Period	Current	Ranking	All Wales
61	Number of patients recruited in Health and Care Research Wales clinical research portfolio studies	11	Q3 20/21			5	9th	12,366
62	Number of patients recruited in Health and Care Research Wales commercially sponsored studies	1	Q3 20/21			0	7th	940
63	Crude hospital mortality rate (74 years of age or less)	12m↓	May-21	2.68%	3.55%	3.28%	Not applicable	1.44%
68	New medicine availability where clinically appropriate, no later than 2 months from the publication of the NICE Final Appraisal	100%	Q4 20/21	96.0%	97.0%	97.2%	6th	98.5%
69	Total antibacterial items per 1,000 STAR-PUs	247.7	Q4 20/21	260.6	206.7	195.6	1st	242
70	Number of patients age 65 years or over prescribed an antipsychotic	Quarter on quarter reduction	Q4 20/21	483	491	487	1st	10,033
71	Number of women of child bearing age prescribed valproate as a percentage of all women of child bearing age	Quarter on quarter reduction	Q4 20/21	Not reported for this period	0.13%	0.11%	2nd	0.15%
72	Opioid average daily quantities per 1,000 patients	4 quarter reduction trend	Q4 20/21	3926.2	4251.5	4068	2nd	4404
74	Percentage of adult dental patients in the health board population re-attending NHS primary dental care between 6 and 9 months	5 quarter reduction trend	Q4 20/21	33.2%	22.1%	27.4%	7th	26.20%
76	R12 Number of procedures postponed for specified non-clinical reasons	<=81 Mar-21	Jun-21	82	12	16	1st (Mar-21)	3630 (Mar-21)
77	Agency spend as a percentage of the total pay bill	12m↓	Jun-21	5.2%	9.4%	11.3%	10th (Mar-21)	6.5% (Mar-21)
78	Percentage of clinical coding accuracy attained in the NWIS national clinical coding accuracy audit programme	Annual improvement	2019/20	93.80%		95.9%	2nd	93.9%
*Benchmark provided from previous period (national benchmark outdated)								

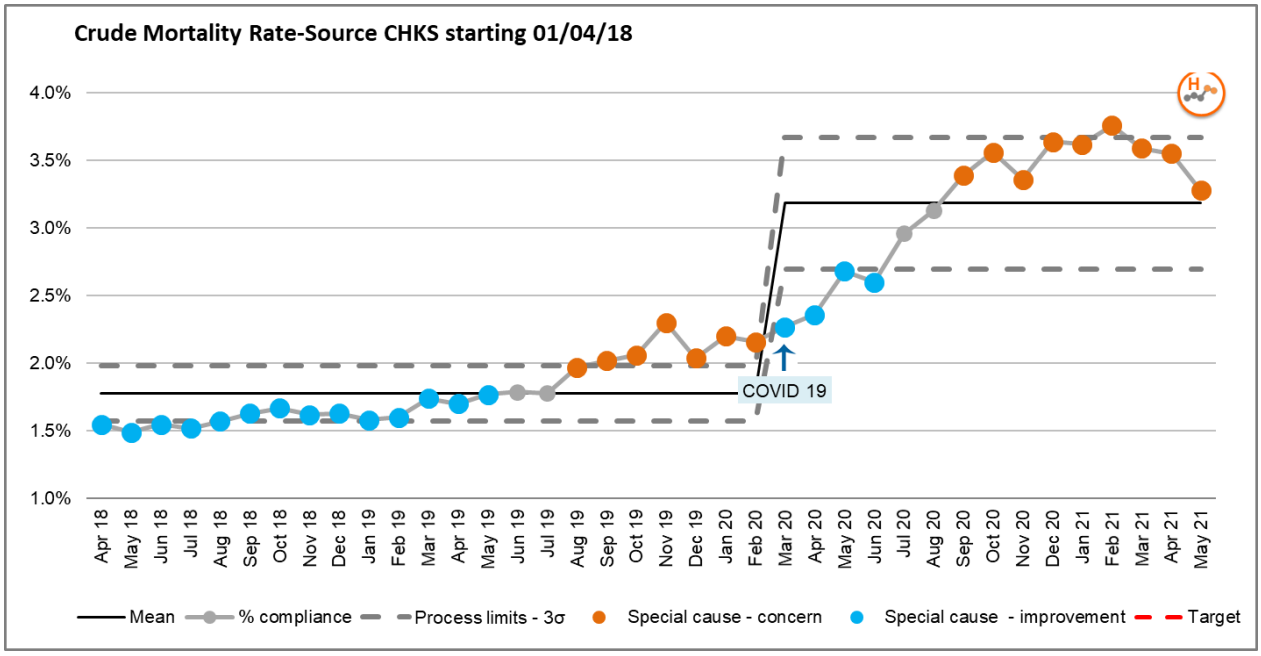
Health Care Research

The uptake of patients for health care research has not met the Welsh Government target, five patients have been recruited in Q3 2020/21.

Mortality

Crude Mortality rate in the health board has decreased slightly during May (3.28%). This is the highest reported position of any health board in Wales although PTHB is not benchmarked by Welsh Government as a non-acute care provider. This measure and achieving the reduction target is within the current climate unviable for Powys Teaching Health Board due to the service provided for inpatient care. Predominately the deaths of this under 75-year age group are linked to cancer diagnosis, and our services are used to support palliative care pathways. Another complication when measuring crude mortality is that regular admissions e.g. day case etc. have significantly reduced (lower denominator) this can be seen in the SPC chart

flagging special cause for concern . Detailed Mortality reporting is undertaken through the Experience, Quality and Safety Committee.



Medicines and prescribing

- Powys performance in relation to new medicines availability has improved slightly to 97.2% (Q4 2020/21). This does not meet the required performance level of 100% for new medicines recommended by AWMSG and NICE being made available within 2 months of publication of NICE Final Appraisal Determination or the AWMSG appraisal, but it is an improvement when compared to the equivalent time period 12 months prior (96%).

- For antibacterial prescribing, a rate of 195.6 in Q4 2020/21 meets the new quarterly adjusted national target for Powys (<=247.7), the health board is ranked 1st in Wales.

- Prescriptions for antipsychotics in the 65+ patient age group have met the quarterly reduction target in Q4 2020/21 to 487, this is a slight increase from the equivalent period in 2019/20. It should be noted that although we have prescribed the least in Wales and rank 1st, our resident population is smaller.

- Number of women of child bearing aged prescribed valproate as a percentage of all women of child bearing age has now been updated with reportable information. Powys meets the quarterly reduction target reporting 0.11% during Q4 2020/21 and benchmarks 2nd in Wales, the All Wales average is 0.15%.

- PTHB are not compliant against the new Opioid measure with 4068 per 1000 patients in Q4 2020/21, the national target is to achieve a 4-quarter reduction, the health board is ranked 2nd in Wales, All Wales average 4404.

Non-clinical procedures postponements

The number of procedures postponed for non-clinical reasons has increased slightly to 16 (R12) meeting the Welsh Government target of 81 or less. PTHB ranks 1st in Wales against a total of 3630 postponements (May-21)

Agency Spend

The provider agency spend as a percentage of total pay bill varies as a response to demand. The 12-month target of reduction has not been met with 11.3% expenditure during June-21.

Clinical Coding

Powys Teaching Health Board normally provides excellent compliance to coding requirements e.g. 99+% prior to COVID. In May, 97.9% of records were coded with a valid primary diagnosis code within the required target. For coding accuracy during 2019/20 the health board improved to 95.9% where it ranks 2nd in Wales, the national average is 93.9%.

NEXT STEPS:

COVID

In Powys COVID-19 infection rates remain high but slightly reduced from the first weeks in July. Although seeing a rise in COVID-19 related admissions at the end of July the numbers of infected patients in critical care beds remain relatively low. The speed, and uptake of vaccinations in Wales appears to have played a crucial role in the resilience of residents to the delta variant. Linked to COVID-19 however is the ongoing impact of long-term effects on the population, especially in the younger non, or single dose vaccinated cohorts. These patients potentially could require further support and rehabilitation following infection. This challenge remains unquantified at present.

Service recovery and restoration

Significant challenge remains with the ongoing impact of service suspension last year. Restoration and recovery of service will be a lengthy process, and to make a significant impact both short and long-term service change is required at both national, regional and health board level. COVID-19 wave three at present has had limited impact on the provider in regards to admissions, it has however caused increased fragility with the workforce due to increased infection or isolation procedures.

The ongoing backlog of patients in Wales and the UK remains the largest challenge coupled with an increase in new patients entering the system. Powys has shown to be leading the improvement in Wales around access, but this has significant risk as a result of in-reach fragility and a small specialised workforce.

Ongoing work from the Recovery Portfolio Strategic Board is working to focus on accelerating local recovery priorities, service restoration, innovation and work to help address waiting list pressures.

Commissioning assurance also remains a key workflow in helping manage and risk assess care pathways.

Further next steps will include review and development of the new Single Cancer Pathway data usage for PTHB and strengthening the English data flow with key providers.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda Item: 3.1b

Delivery & Performance Committee	**Date of Meeting: 2 September 2021**
Subject:	**COMMISSIONING ESCALATION REPORT**
Approved and Presented by:	Director of Planning and Performance
Prepared by:	Assistant Director Transformation and Value
Other Committees and meetings considered at:	Executive Committee Delivery and Performance Group on the 26th August 2021; Internal Commissioning Assurance Meeting on the 18th August 2021. This report provides supplementary information in relation to the two providers with services in Special Measures.

PURPOSE:

The purpose of this paper is to highlight to the Delivery & Performance Committee the providers in Special Measures or scored as Level 4 and above under the PTHB Commissioning Assurance Framework.

RECOMMENDATION(S):

It is recommended that the Delivery & Performance Committee DISCUSS this Commissioning Escalation Report.

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

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

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

EXECUTIVE SUMMARY:

This report highlights providers in Special Measures or scored as Level 4 and above following the 18th August 2021 PTHB Internal Commissioning Assurance Meeting (ICAM). At the time of the last meeting there were:

- 2 providers with services in Special Measures;
- 1 provider at Level 4;

The report also provides:

- A high level summary of key issues in relation Shrewsbury and Telford Hospitals NHS Trust (SaTH) and Cwm Taf Morgannwg University Health Board (CTMUHB);
- Referral to treatment times (RTT) times.

DETAILED BACKGROUND AND ASSESSMENT:

PTHB's Commissioning Assurance Framework (CAF) helps to identify and escalate emerging patterns of poor performance and risk in health services used by Powys patients.

It considers patient experience, quality, safety, access, activity, finance governance and strategic change. It is a continuous process, considering information from a broad range of sources including "credible soft intelligence". It is not a performance report between fixed points.

Each PTHB Directorate is invited to contribute information to the CAF and to attend the ICAM.

Formal inspection reports for the NHS organisations commissioned are available on the websites of Health Inspection Wales (HIW) and the Care

Quality Commission (CQC). PTHB attempts to draw from providers' existing Board reports, plans, returns to Government and nationally mandated information wherever possible.

The usual commissioning arrangements have not been in place since March 2020 due to pandemic. Since July 2020, PTHB has been working to restore the CAF, although there remain significant limitations due to the national position. It is not possible to score all domains, for example "block" financial arrangements do not reflect pre-COVID budgets or Long term Agreements. Escalation processes cannot operate in the usual way, for example, elective care delays are at an unprecedented level due to the pandemic. The Public Health resource assisting with the interpretation of the Clinical Health Knowledge System results which was diverted to COVID 19 outbreak is being restarted focusing on maternity services.

Special Measures					
Provider	**Area of Measure**	**June 2021**	**July 2021**	**August 2021**	**Change in Status**
Shrewsbury and Telford Hospital NHS Trust	Quality & Safety				↔
	Patient Experience				
	Access				
	Finance	BLOCK AGREEMENT			
	Governance & Strategic Change	NOT RATED			
Cwm Taf Morgannwg University Health Board	Quality & Safety				↔
	Patient Experience				
	Access				
	Finance	BLOCK AGREEMENT			
	Governance & Strategic Change	NOT RATED			

Level 4					
Provider	**Area of Measure**	**June 2021**	**July 2021**	**August 2021**	**Change in Status**
Wye Valley NHS Trust	Quality & Safety				↔
	Patient Experience				
	Access				
	Finance	BLOCK AGREEMENT			
	Governance & Strategic Change	NOT RATED			

Shrewsbury and Telford Hospitals NHS Trust (SATH)

As previously reported to the Performance and Resources Committee SATH is in special measures and is rated as "inadequate" overall. There have been a series of concerning reports following inspections by the Care Quality Commission (CQC) resulting in Section 31 Notices imposing conditions on the regulated activity there. The full reports can be accessed via the CQC website (**www.cqc.org.uk**) but include concerns in relation to the management of:

- Pressure area care
- Falls
- Nursing documentation
- Learning from previous incidents
- Mental Capacity Act and Deprivation of Liberty Safeguards
- Children and young people with mental health needs, learning disabilities and behaviours that challenge
- End of life care
- Maternity Services
- the oversight of audits and the improvement of outcomes
- the culture.

Reports on these matters have been considered by the Experience, Quality and Safety Committee (EQS) on the 15th April, 2021; 3rd June, 2021; and 15th July 2021. The Performance and Resources Committee was updated on the 24th June, 2021.

Key issues reported to the SaTH Board on 5th August, 2021, are summarised below.

- The trust is continuing to focus on the implementation of its quality strategy and the delivery of its quality improvement plans, ensuring that those plans fully respond to the findings of recent reviews (including the Independent Review of Maternity Services).
- During July the CQC has carried out further inspections and the Trust is working to address the feedback and the formal inspection reports are awaited.
- The Trust reports that it has received positive feedback from GIRFT (Getting It Right First Time) on its acute medicine service and was commended for its length of stay and low readmission rates.
- The Trust is attempting to improve its response to patients when concerns are raised and is introducing a new simplified process with the aim of reducing delays.
- During June attendances at the Emergency Department have exceeded those seen prior to the pandemic. This is putting pressure on the ED and on ambulance handovers. The Trust has been maintaining infection control measures, but as a result has not been able to safely increase the occupancy in clinical areas to support the increased activity.

- There has been an increase in the restoration of elective activity and orthopaedic surgery has recommenced.
- Early indications are that the Trust's recovery across Outpatients, In-Patients and Day cases exceeded the 80% threshold set by NHSEI for June.
- A Vanguard theatre is being used to increase surgical capacity. There are theatre staffing shortages and in-sourcing is being secured. Recruitment is also underway and theatre apprentices are being developed for longer term sustainability.
- Expanded elective inpatient capacity was implemented at the end of June; which will put additional pressure on emergency care capacity but is vital to reduce waiting lists.
- The regional mobile CT scanner left SATH at the start of June, and the service is prioritising urgent and cancer activity (and any routine activity where possible) until new capacity comes on line at the start of September 2021. Radiology staffing is also pressured, and is limiting some restoration of services.
- Cancer activity has also returned to above pre-Covid-19 levels, and a number of specialty areas are challenged. The Breast service is steadily returning to a two week wait time (although it was at 16 days at start of June). Pressure remains in Urology, Colorectal and Lung services.
- The Trust's view is that diagnostic recovery is progressing well despite recruitment challenges. As well as a new CT and MRI pod which is due to open, improvements are being made to increase endoscopy capacity.
- During 2020/21 there were 13 confirmed inpatient deaths of people diagnosed with learning disabilities. The cases have undergone an internal speciality mortality review and have additionally been reviewed through the "Learning from Deaths" process. No preventable factors were identified through these reviews.

It is important for PTHB to understand the assurances being received by the SaTH Board. SaTH's Quality and Safety Assurance Committee was alerted, advised and assured in relation to the following matters*:*

Alert	Complaint response times remain a concern. The process is being revised and streamlined.
Assurance	The Management of Datix incidents is improving. The Committee is continuing to monitor this.
Advised	The Committee received a verbal report from the Director of Nursing in relation to the CQC visits. *"Whilst CQC continue to raise some concerns there is a greater confidence in the Trust's management to respond appropriately and work with the CQC to provide additional explanations, evidence and feedback."* The Committee was also advised about a 6.5% increase in A&E activity compared to June 2020. Ambulances are

	reporting activity on a par with winter demands. The Trust's public Board is to receive information about Serious incidents. The Badgernet maternity system will start a gradual implementation on the 9th August 2021.

"Freedom to Speak Up" Arrangements are in place for staff. Over half of the concerns raised in the most recent quarter were about behaviours, relationships, bullying and harassment. A behaviours framework has been launched and work is being undertaken in relation to values and culture. A range of initiatives are being undertaken to address the issues raised by staff including HR processes, mediation, leadership development, organisational development, and workshops on "courageous conversations" and "civility saves lives".

A Secretary of State initiated Independent Review of Maternity Services at the Trust, chaired by Donna Ockenden, is underway. The first report of the Independent Review was published on the 10th December 2020 and presents emerging findings and recommendations from 250 clinical reviews, highlighting significant failings in maternity care at the Trust between 2000 and 2018/19. The "*Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust*" (known as the first "Ockenden Report") recommended 52 actions in total. These include local actions (LAFL) which are specific requirements for SaTH, together with immediate and essential actions (IEA) for all NHS providers.

The Trust reports that "*good progress continues to be made against the required actions from the first Ockenden Report (2020) and this work continues at pace. There are some challenges; however, work continues to address all of the required action."* (A Maternity Services update is being provided to the next EQS Committee.)

PTHB is a member of a SaTH Oversight Assurance Group (SOAG) including regulators. The most recent meeting was on the 25th August, 2021, and PTHB was represented by the Nursing Directorate. In addition to the on-going inspection the following key issues were noted: further improvements are needed to end of life care, including across the system; and a Director of Midwifery post is being advertised.

SATH remains in an "Improvement Alliance" with the University Hospitals Birmingham NHS Foundation Trust (UHB) to help improve the quality and safety of its services. Work is underway within the trust including a "Getting to Good" improvement plan; a renewed focus on governance and culture; a revised Board Assessment Framework (BAF); and improved integrated performance reports.

The PTHB Deputy Medical Director attends the ICAM and feeds-in any concerns from North Powys GPs. Rather than just individual cases GPs have wider systemic concerns including the relationship between acute and out-patient services; scanning, particularly CT in relation to cancer; and the responsiveness of SaTH to concerns. SaTH is revising its process in order to ensure a timelier response to concerns, it is addressing CT capacity and states it is prioritising cancer patients.

SATH remains an escalated matter for PTHB. Following the Executive Committee deep dive meeting in relation to SaTH on the 23rd June, 2021 there has been further liaison with other stakeholders including UHB and the CQC and participation in the Oversight Group. Overall the metrics and intelligence show an organisation still addressing major difficulties. However, the view of other stakeholders appears to be that the appropriate improvement actions are underway although it will take time to fully turn this situation around. PTHB will seek to restore the regular CEO level escalation meetings which were disrupted by the COVID pandemic.

Cwm Taf University Health Board (CTMUHB)

The Experience, Quality and Safety Committee received updates on the 3rd June, 2021 and 15th July, 2021. The Performance and Resources Committee was updated on the 24th June, 2021.

CTMUHB's maternity services are in special measures. An Independent Maternity Oversight Panel (IMSOP) is in place, which provides independent oversight arrangements of maternity and neonatal services at CTMUHB. Whilst there has been neonatal expertise as part of the IMSOP's work in relation to the Clinical Review Programme and within the Quality Assurance Panel, there is now also neonatal expertise within the full Panel. Neonatal reviews are underway and as the learning emerges it will be fed into the wider improvement programme.

Alongside this the panel is also conducting a deep dive to take stock of the current neonatal service and its improvement plan to provide assurance that services are safe, effective, well led and importantly integrated with the maternity service to provide a seamless service for women and babies. This should help inform improvements CTMUHB is making on their journey to provide exemplar maternity and neonatal services.

Phase 2 of PTHB South Powys Programme is focused on Maternity and Neonatal pathways. A workstream is in place chaired by the Executive Director of Nursing and Midwifery for PTHB, with senior clinical involvement from CTMUHB and ABUHB.

Its scope is in relation to the outcome of the South Wales Programme approved by boards and WAST in 2014 following public consultation. It is understood that, due to logistical reasons, the outcome of the IMSOP review of Neonatal services will not be available until the new year. Thus, PTHB's Board will not be in a position to consider recommendations for the timing of a strategic change in pathway until then. Current maternity pathways are continuing and are being closely monitored. Work is continuing in relation to strengthening readiness and assurance.

Referral to Treatment Times (RTT)

As reported nationally there is now an unprecedented challenge in relation to timely access to routine services across the NHS as a result of the response to the pandemic. The Director General of Health and Social Services in Wales has warned that the situation may take a number of years to resolve.

Capacity was significantly reduced in order to care for the surge in COVID patients and to prevent the spread of infection. Private sector capacity has been used to maintain essential services, such as for those with suspected cancer. The situation has been exacerbated through the summer due to unscheduled care pressures, with activity exceeding pre-pandemic levels. There have also been considerable difficulties with flow in surrounding DGHs due to capacity and pressure on domiciliary care services, which are crucial to timely discharge from hospital.

Addressing this situation is a key focus of the approach to renewal in the PTHB Annual Plan for 2021/2022. Major renewal priorities emerged from a full appraisal of the impact of the pandemic. The renewal priorities focus on the things which will matter most to the wellbeing of the population of Powys and those things which will work best to address the critical challenges ahead. The scale of the challenge will not be met by existing approaches and will require new, radical solutions bounded in a value-based healthcare.

A portfolio of renewal work is being established across priority areas to transform services. The portfolio is working at pace across boundaries, but recognising that true transformation is a long term process. The priority areas are: frailty and community model; long term conditions and wellbeing; diagnostics, ambulatory and planned care; advice, support and pre-habilitation; children and young people; and tackling the Big 4 (respiratory, cancer, circulatory and mental health).

£2.5M non recurrent revenue and £550k capital has been secured from Welsh Government to take forward the first phase of priorities. A CEO chaired Renewal Strategic Portfolio Board has been established; executive leads for each priority identified and miles-stones built into the annual plan and delivery plan. Programmes for priority areas are at different points of development – some are building on well-established programmes, such as Breathe Well, whilst others

involve establishing new programmes such as for the crucially important frailty and community model.

Where other health boards have received funding directly from Welsh Government, PTHB will need an arrangement to take account of this within commissioning arrangements. The funding arrangements for additional recovery activity taking place in England is to be confirmed.

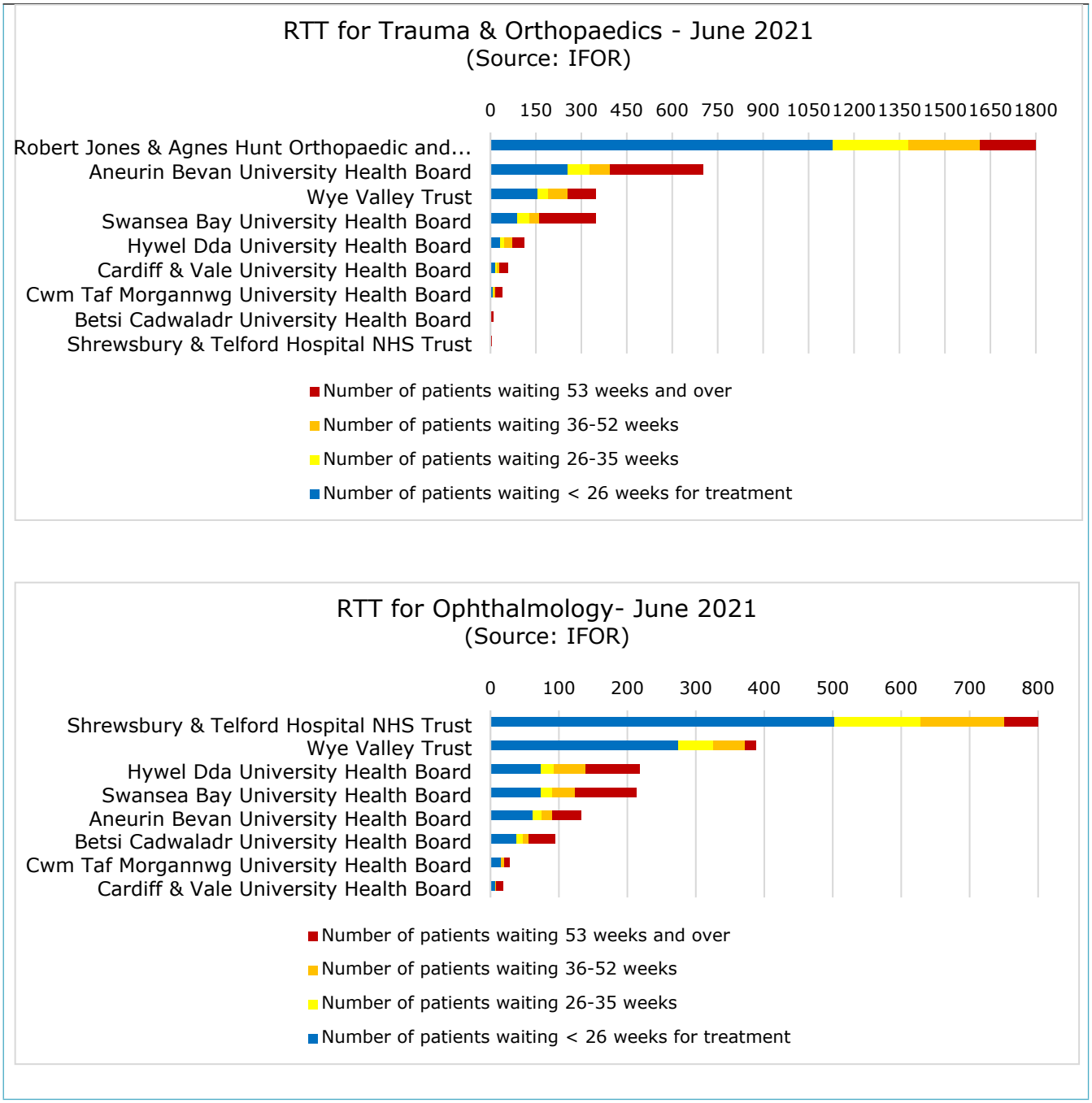
The Renewal Strategic Portfolio Board will be considering risk management in more detail, but key risks are recruitment to the support infrastructure including procurement capacity; operational recruitment, particularly in relation to theatre staff; the availability of additional external clinical capacity; and unscheduled care pressures.

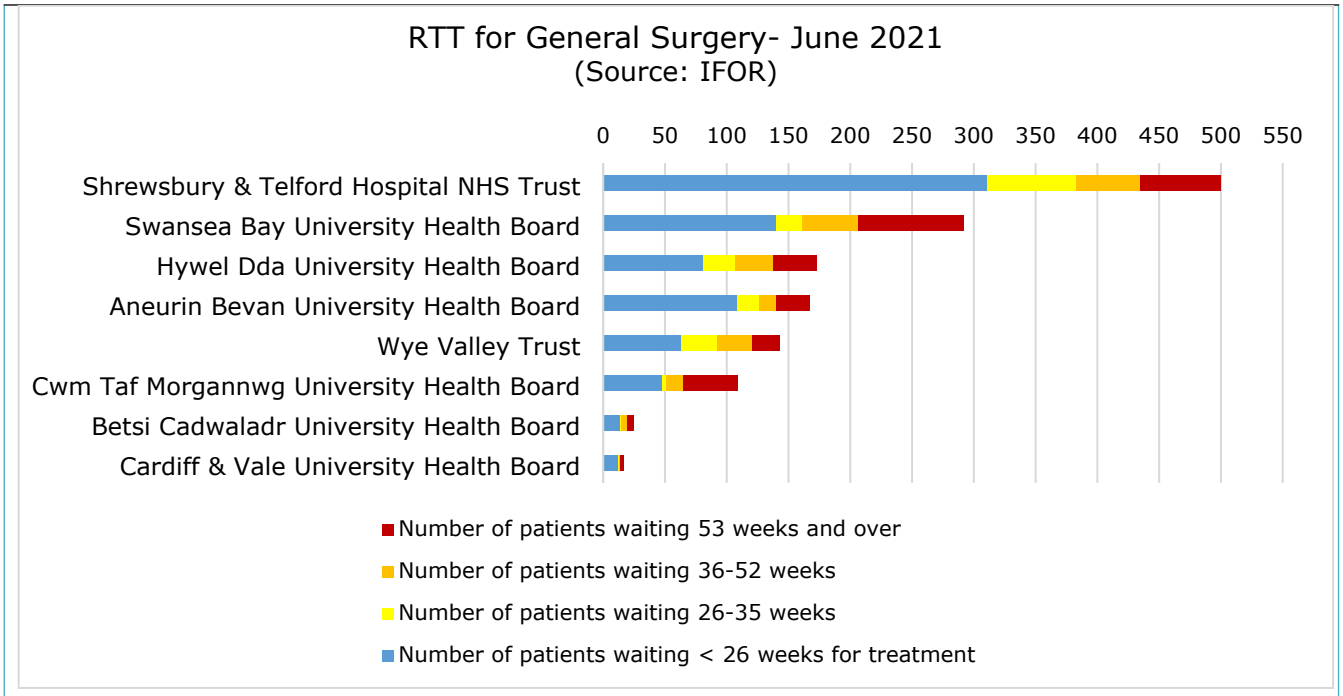
Annexe 1 provides the break-down of waiting times, by speciality, across each provider. Key areas of concern are orthopaedics, ophthalmology, general surgery and urology. The current COVID and unscheduled care situation is being monitored carefully due to the potential impact on the restoration of elective services.

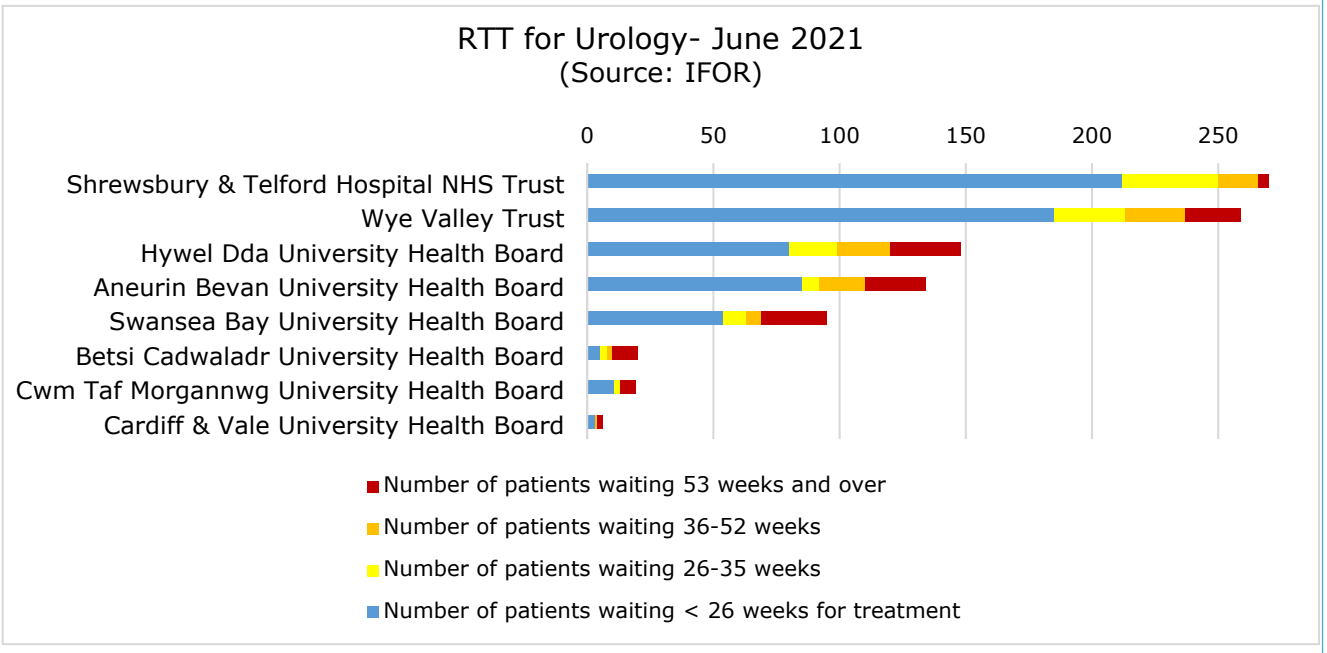
Welsh Providers		July 2021						
		Patients Waiting						
Provider	% of Powys residents waiting <26 weeks for treatment (Target 95%)	0-25 weeks	26-35 weeks	36-52 weeks	53-76 weeks	77-104 weeks	Over 104 weeks	Total Waiting
Aneurin Bevan University Health Board	57.2%	1219	162	248	220	255	27	**2131**
Betsi Cadwaladr University Health Board	42.3%	215	51	41	80	97	24	**508**
Cwm Taf Morgannwg University Health Board	43.8%	194	31	57	55	96	10	**443**
Hywel Dda University Health Board	54.9%	769	125	210	130	155	12	**1401**
Swansea Bay University Health Board	44.7%	777	163	234	165	297	101	**1737**
Powys Teaching Health Board	80.7%	3006	265	216	125	112	0	**3724**
Total		**6180**	**797**	**1006**	**775**	**1012**	**174**	**9944**

*Figures for Powys Teaching Health Board Provider include all Welsh residents

English Providers		June 2021						
		Patients Waiting						
Provider	% of Powys residents waiting <26 weeks for treatment (Target 95%)	0-25 weeks	26-35 weeks	36-52 weeks	53-76 weeks	77-104 weeks	Over 104 weeks	Total Waiting
English Other	77.0%	187	19	19	11	7	0	**243**
Robert Jones & Agnes Hunt	66.9%	1580	266	241	173	95	6	**2361**
Shrewsbury & Telford Hospital NHS Trust	67.2%	2043	400	311	153	131	0	**3038**
Wye Valley NHS Trust	69.8%	2002	307	300	152	102	5	**2868**
Total		**5812**	**992**	**871**	**489**	**335**	**11**	**8510**







Conclusion

There are two neighbouring NHS organisations with services in special measures. An update has been provided in relation to Shrewsbury and Telford Hospitals NHS Trust which remains at the highest level of escalation under the PTHB CAF. Maternity services in CTMUHB are in special measures and an Independent Oversight Panel is in place. Further work is underway to provide independent assurance that neonatal services are safe, effective, well led and importantly integrated with the maternity service to provide a seamless service for women and babies.

As reported nationally there is now an unprecedented challenge in relation to timely access to routine services across the NHS as a result of the response to the pandemic. This has been exacerbated this summer by unscheduled care pressures within surrounding DGHs, which exceed the pre-COVID levels.

Addressing this situation is a key focus of the renewal approach in the annual plan for 2021/2022. The renewal priorities focus on the things which will matter most to the wellbeing of the population of Powys and those things which will work best to address the critical challenges ahead. The scale of the challenge will not be met by existing approaches and will require new, radical solutions bounded in a value-based healthcare. £2.5million non recurrent revenue and £550,000 capital have been secured to help take forward Phase 1. However, at present, there are significant risks in relation to recruitment, procured solutions and the pace of recovery due to unscheduled care demand.

NEXT STEPS

In line with the PTHB Commissioning Assurance Framework providers scored as Level 4 or in Special Measures will continue to be reported to the relevant Board Committees.

<table>
<tr><th colspan="6">The following Impact Assessment must be completed for all reports requesting Approval, Ratification or Decision, in-line with the Health Board's Equality Impact Assessment Policy (HR075) IMPACT ASSESSMENT</th></tr>
<tr><td colspan="6">Equality Act 2010, Protected Characteristics:</td></tr>
<tr><td></td><td>No impact</td><td>Adverse</td><td>Differential</td><td>Positive</td><td rowspan="11">Reporting the outcome of the Internal Commissioning Assurance Meeting has no adverse impact on people with protected characteristics. It helps to ensure escalation and resolution of matters which could have a negative impact. However, at present, due to the COVID-19 pandemic, it is not possible to operate the Commissioning Assurance Framework in the usual way, meaning there is a reduced level of assurance. There is also a deteriorating position in relation to referral to treatment times.</td></tr>
<tr><td>Age</td><td></td><td>√</td><td></td><td></td></tr>
<tr><td>Disability</td><td></td><td>√</td><td></td><td></td></tr>
<tr><td>Gender reassignment</td><td></td><td>√</td><td></td><td></td></tr>
<tr><td>Pregnancy and maternity</td><td></td><td>√</td><td></td><td></td></tr>
<tr><td>Race</td><td></td><td>√</td><td></td><td></td></tr>
<tr><td>Religion/ Belief</td><td>√</td><td></td><td></td><td></td></tr>
<tr><td>Sex</td><td>√</td><td></td><td></td><td></td></tr>
<tr><td>Sexual Orientation</td><td>√</td><td></td><td></td><td></td></tr>
<tr><td>Marriage and civil partnership</td><td>√</td><td></td><td></td><td></td></tr>
<tr><td>Welsh Language</td><td></td><td>√</td><td></td><td></td></tr>
<tr><td colspan="6">Risk Assessment:</td></tr>
<tr><td></td><td colspan="3">Level of risk identified</td><td colspan="2">The reporting of the outcome of the Internal Commissioning Assurance Meeting is designed</td></tr>
</table>

	None	Low	Moderate	High	to help identify and reduce risks within commissioned services. However, due to the COVID 19 pandemic, there is a reduced level of assurance and a deteriorating position in relation to waiting times.
Clinical			√		
Financial			√		
Corporate			√		
Operational	√				
Reputational			√		

Commissioned RTT Report

Source- IFOR (Excl D&T)

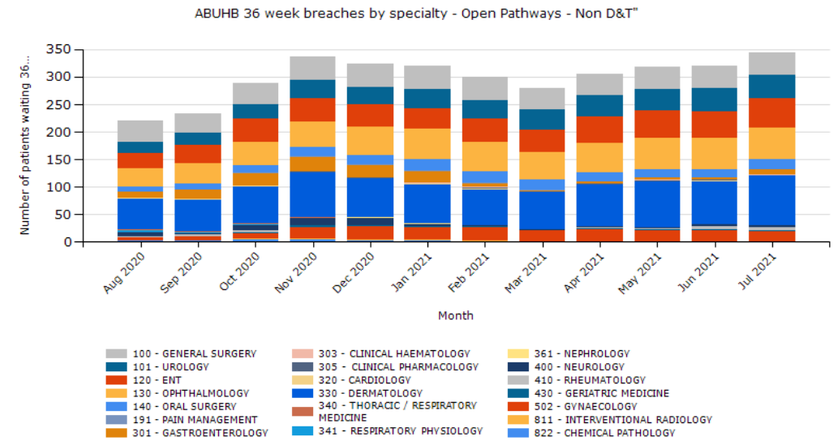
Welsh Providers		July 2021						
		Patients Waiting						
Provider	% of Powys residents waiting <26 weeks for treatment (Target 95%)	0-25 weeks	26-35 weeks	36-52 weeks	53-76 weeks	77-104 weeks	Over 104 weeks	Total Waiting
Aneurin Bevan University Health Board	57.2%	1219	162	248	220	255	27	**2131**
Betsi Cadwaladr University Health Board	42.3%	215	51	41	80	97	24	**508**
Cardiff & Vale University Health Board	52.6%	212	35	43	47	59	7	**403**
Cwm Taf Morgannwg University Health Board	43.8%	194	31	57	55	96	10	**443**
Hywel Dda University Health Board	54.9%	769	125	210	130	155	12	**1401**
Swansea Bay University Health Board	44.7%	777	163	234	165	297	101	**1737**
Powys Teaching Health Board	80.7%	3006	265	216	125	112	0	**3724**
Total		**6392**	**832**	**1049**	**822**	**1071**	**181**	**10347**

*Figures for Powys Teaching Health Board Provider include all Welsh residents

English Providers		June 2021						
		Patients Waiting						
Provider	% of Powys residents waiting <26 weeks for treatment (Target 95%)	0-25 weeks	26-35 weeks	36-52 weeks	53-76 weeks	77-104 weeks	Over 104 weeks	Total Waiting
English Other	77.0%	187	19	19	11	7	0	**243**
Robert Jones & Agnes Hunt	66.9%	1580	266	241	173	95	6	**2361**
Shrewsbury & Telford Hospital NHS Trust	67.2%	2043	400	311	153	131	0	**3038**
Wye Valley NHS Trust	69.8%	2002	307	300	152	102	5	**2868**
Total		**5812**	**992**	**871**	**489**	**335**	**11**	**8510**

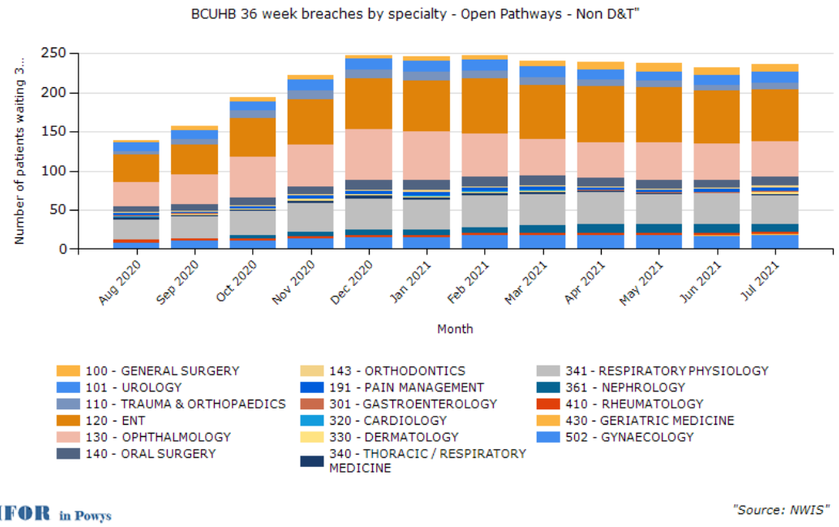
Aneurin Bevan University Health Board

Jul-21	Patients Waiting						
Specialty	**0-25 Weeks**	**26-35 Weeks**	**36-52 Weeks**	**53 to 76 Weeks**	**77 to 104 Weeks**	**Over 104 Weeks**	**Total Waiting**
100 - General Surgery	105	11	16	17	7	1	157
101 - Urology	85	16	15	14	14	0	144
107 - Vascular Surgery	9	0	0	0	0	0	9
110 - Trauma & Orthopaedics	257	45	96	104	181	24	707
120 - Ent	36	8	21	9	22	1	97
130 - Ophthalmology	70	12	16	18	23	1	140
140 - Oral Surgery	17	1	3	9	5	0	35
143 - Orthodontics	2	0	0	0	0	0	2
191 - Pain Management	7	3	0	0	0	0	10
301 - Gastroenterology	95	12	9	0	0	0	116
302 - Endocrinology	17	0	0	0	0	0	17
303 - Clinical Haematology	21	4	1	0	0	0	26
305 - Clinical Pharmacology	0	1	0	2	0	0	3
320 - Cardiology	49	0	0	0	0	0	49
330 - Dermatology	175	21	51	38	2	0	287
340 - Thoracic / Respiratory Medicine	26	0	0	0	0	0	26
361 - Nephrology	4	0	0	0	0	0	4
400 - Neurology	57	4	3	0	0	0	64
410 - Rheumatology	15	4	5	0	0	0	24
420 - Paediatrics	29	0	0	0	0	0	29
430 - Geriatric Medicine	17	0	0	1	0	0	18
502 - Gynaecology	110	19	11	8	1	0	149
811 - Interventional Radiology	7	1	0	0	0	0	8
822 - Chemical Pathology	9	0	1	0	0	0	10
Total	**1219**	**162**	**248**	**220**	**255**	**27**	**2131**



Betsi Cadwaladr University Health Board

Jul-21	Patients Waiting						
Specialty	**0-25 Weeks**	**26-35 Weeks**	**36-52 Weeks**	**53 to 76 Weeks**	**77 to 104 Weeks**	**Over 104 Weeks**	**Total Waiting**
100 - General Surgery	19	2	4	5	1	0	31
101 - Urology	6	2	2	4	5	3	22
110 - Trauma & Orthopaedics	2	1	0	1	7	0	11
120 - Ent	48	9	5	22	25	14	123
130 - Ophthalmology	39	10	9	12	24	1	95
140 - Oral Surgery	10	1	1	5	4	1	22
143 - Orthodontics	3	1	1	1	0	0	6
191 - Pain Management	0	1	1	2	2	0	6
301 - Gastroenterology	5	2	1	0	0	0	8
302 - Endocrinology	2	1	0	2	3	1	9
320 - Cardiology	6	0	0	0	0	0	6
330 - Dermatology	2	2	3	0	0	0	7
340 - Thoracic / Respiratory Medicine	1	0	0	1	0	0	2
341 - Respiratory Physiology	17	10	5	14	17	1	64
361 - Nephrology	34	8	6	4	0	0	52
410 - Rheumatology	0	0	0	0	2	1	3
420 - Paediatrics	7	0	0	0	0	0	7
430 - Geriatric Medicine	1	0	1	0	0	0	2
502 - Gynaecology	13	1	2	7	7	2	32
Total	**215**	**51**	**41**	**80**	**97**	**24**	**508**

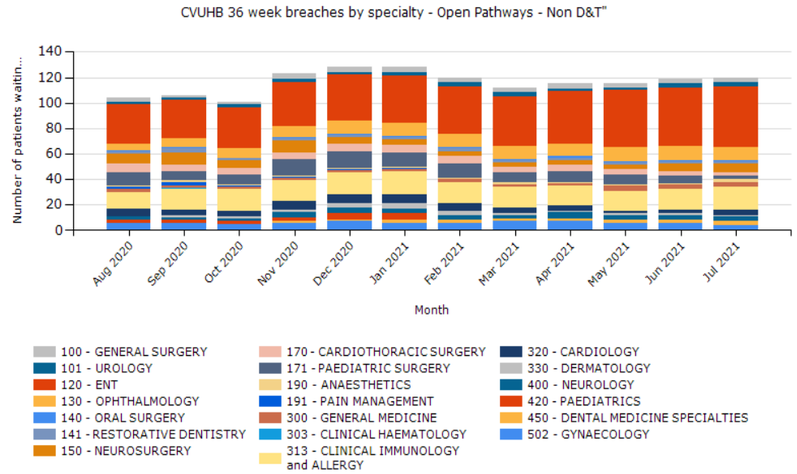


IFOR in Powys

"Source: NWIS"

Cardiff & Vale University Health Board

Jul-21	Patients Waiting						
Specialty	**0-25 Weeks**	**26-35 Weeks**	**36-52 Weeks**	**53 to 76 Weeks**	**77 to 104 Weeks**	**Over 104 Weeks**	**Total Waiting**
100 - General Surgery	13	3	0	1	3	0	20
101 - Urology	2	0	1	1	1	0	5
110 - Trauma & Orthopaedics	21	2	9	13	12	2	59
120 - Ent	38	16	13	12	20	3	102
130 - Ophthalmology	5	1	1	2	6	1	16
140 - Oral Surgery	3	1	0	1	0	0	5
141 - Restorative Dentistry	1	0	0	0	2	0	3
142 - Paediatric Dentistry	2	0	0	0	0	0	2
150 - Neurosurgery	12	1	5	2	0	0	20
170 - Cardiothoracic Surgery	9	0	0	1	1	0	11
171 - Paediatric Surgery	12	3	0	2	1	0	18
190 - Anaesthetics	4	0	1	1	0	0	6
191 - Pain Management	1	1	0	0	0	0	2
300 - General Medicine	4	0	2	0	2	0	8
301 - Gastroenterology	2	0	0	0	0	0	2
303 - Clinical Haematology	9	0	0	0	0	0	9
313 - Clinical Immunology And Allergy	15	2	2	6	10	0	35
320 - Cardiology	16	2	4	0	0	0	22
330 - Dermatology	1	0	1	0	0	0	2
361 - Nephrology	0	1	0	0	0	0	1
400 - Neurology	11	1	3	1	0	0	16
410 - Rheumatology	2	0	0	0	0	0	2
420 - Paediatrics	23	1	0	0	0	0	24
450 - Dental Medicine Specialties	0	0	1	2	0	0	3
502 - Gynaecology	6	0	0	2	1	1	10
Total	**212**	**35**	**43**	**47**	**59**	**7**	**403**

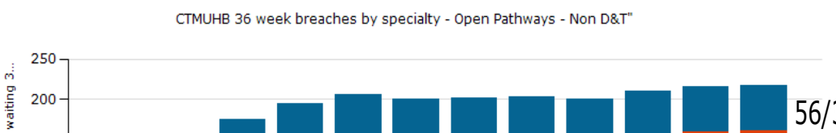


IFOR in Powys

"Source: NWIS"

Cwm Taf Morgannwg University Health Board

Jul-21	Patients Waiting						
Specialty	**0-25 Weeks**	**26-35 Weeks**	**36-52 Weeks**	**53 to 76 Weeks**	**77 to 104 Weeks**	**Over 104 Weeks**	**Total Waiting**



100 - General Surgery	45	8	12	12	29	4	110
101 - Urology	16	1	0	4	2	1	24
104 - Colorectal Surgery	2	0	0	1	0	0	3
110 - Trauma & Orthopaedics	8	3	5	8	13	2	39
120 - Ent	6	1	2	1	1	1	12
130 - Ophthalmology	17	1	2	4	7	0	31
140 - Oral Surgery	19	2	9	7	17	2	56
141 - Restorative Dentistry	1	0	1	3	1	0	6
143 - Orthodontics	3	0	0	1	0	0	4
190 - Anaesthetics	1	0	0	0	2	0	3
300 - General Medicine	7	0	0	1	0	0	8
301 - Gastroenterology	8	2	0	0	0	0	10
303 - Clinical Haematology	1	0	0	0	0	0	1
320 - Cardiology	3	4	7	1	0	0	15
330 - Dermatology	4	1	1	0	2	0	8
340 - Thoracic / Respiratory Medicine	3	0	0	2	0	0	5
410 - Rheumatology	2	0	3	0	0	0	5
420 - Paediatrics	2	0	1	0	0	0	3
502 - Gynaecology	46	8	14	10	22	0	100
Total	**194**	**31**	**57**	**55**	**96**	**10**	**443**

Hywel Dda University Health Board

Jul-21	Patients Waiting						
Specialty	**0-25 Weeks**	**26-35 Weeks**	**36-52 Weeks**	**53 to 76 Weeks**	**77 to 104 Weeks**	**Over 104 Weeks**	**Total Waiting**

100 - General Surgery	82	18	44	18	14	2	178
101 - Urology	73	19	24	11	14	0	141
103 - Breast Surgery	24	9	3	0	0	0	36
104 - Colorectal Surgery	23	1	6	3	2	0	35
107 - Vascular Surgery	5	3	3	2	5	0	18
110 - Trauma & Orthopaedics	41	6	29	16	22	1	115
120 - Ent	10	4	4	7	17	1	43
130 - Ophthalmology	89	16	43	29	48	7	232
180 - Accident & Emergency	2	0	0	0	0	0	2
191 - Pain Management	1	1	1	6	2	0	11
300 - General Medicine	14	4	2	4	1	1	26
301 - Gastroenterology	68	13	12	11	4	0	108
302 - Endocrinology	5	0	0	0	0	0	5
303 - Clinical Haematology	3	0	1	0	0	0	4
307 - Diabetic Medicine	2	0	0	0	0	0	2
320 - Cardiology	159	6	4	1	0	0	170
328 - Stroke Medicine	5	0	0	0	0	0	5
329 - Transient Ischaemic Attack	2	0	0	0	0	0	2
330 - Dermatology	5	1	1	2	0	0	9
340 - Thoracic / Respiratory Medicine	28	0	1	0	3	0	32
361 - Nephrology	1	0	0	0	0	0	1
400 - Neurology	25	6	8	0	0	0	39
401 - Clinical Neurophysiology	9	0	2	0	0	0	11
410 - Rheumatology	4	0	1	0	0	0	5
420 - Paediatrics	24	0	0	0	0	0	24
430 - Geriatric Medicine	16	1	0	0	3	0	20
502 - Gynaecology	49	17	21	20	20	0	127
Total	**769**	**125**	**210**	**130**	**155**	**12**	**1401**

Swansea Bay University Health Board

Jul-21	Patients Waiting

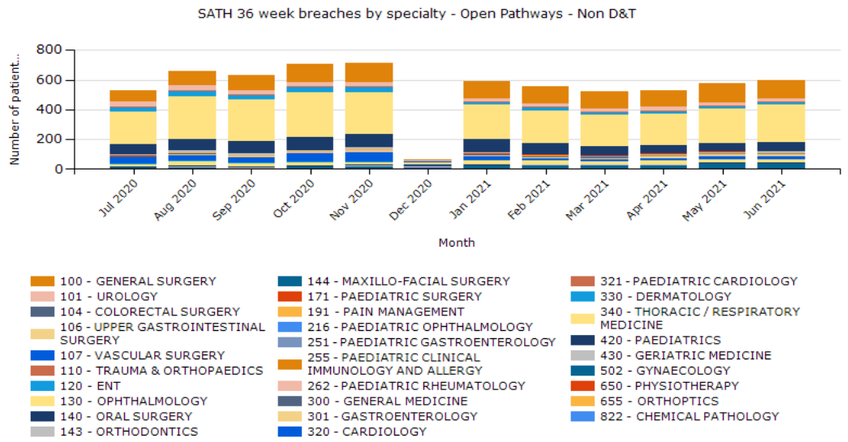
Specialty	0-25 Weeks	26-35 Weeks	36-52 Weeks	53 to 76 Weeks	77 to 104 Weeks	Over 104 Weeks	Total Waiting
100 - General Surgery	159	29	40	27	42	15	312
101 - Urology	48	9	9	8	13	4	91
110 - Trauma & Orthopaedics	87	25	49	32	108	44	345
120 - Ent	36	6	10	11	27	8	98
130 - Ophthalmology	89	18	33	24	43	21	228
140 - Oral Surgery	13	4	8	5	8	1	39
141 - Restorative Dentistry	1	0	0	1	0	0	2
143 - Orthodontics	3	1	0	3	2	0	9
160 - Plastic Surgery	34	11	10	9	10	6	80
170 - Cardiothoracic Surgery	5	0	0	0	0	0	5
300 - General Medicine	11	0	0	2	0	0	13
301 - Gastroenterology	53	12	10	18	11	0	104
302 - Endocrinology	5	0	0	0	0	0	5
303 - Clinical Haematology	6	1	0	0	0	0	7
314 - Rehabilitation	3	0	0	0	0	0	3
320 - Cardiology	45	5	12	5	2	0	69
330 - Dermatology	59	13	22	3	0	0	97
340 - Thoracic / Respiratory Medicine	12	4	4	2	2	0	24
400 - Neurology	27	4	0	1	0	0	32
410 - Rheumatology	3	0	2	0	0	0	5
420 - Paediatrics	24	2	0	0	0	0	26
421 - Paediatric Neurology	3	0	2	1	0	0	6
430 - Geriatric Medicine	2	0	0	0	0	0	2
502 - Gynaecology	49	19	23	13	29	2	135
Total	**777**	**163**	**234**	**165**	**297**	**101**	**1737**

Robert Jones and Agnes Hunt Orthopaedic & District Trust

Jun-21	Patients Waiting

Specialty	0-25 Weeks	26-35 Weeks	36-52 Weeks	53 to 76 Weeks	77 to 104 Weeks	Over 104 Weeks	Total Waiting
110 - Trauma & Orthopaedics	1131	250	234	168	95	6	1884
314 - Rehabilitation	10	0	0	0	0	0	10
400 - Neurology	60	3	1	5	0	0	69
410 - Rheumatology	373	12	6	0	0	0	391
420 - Paediatrics	2	1	0	0	0	0	3
430 - Geriatric Medicine	3	0	0	0	0	0	3
653 - Podiatry	1	0	0	0	0	0	1
Total	**1580**	**266**	**241**	**173**	**95**	**6**	**2361**

Jun-21	Patients Waiting						
Specialty	**0-25 Weeks**	**26-35 Weeks**	**36-52 Weeks**	**53 to 76 Weeks**	**77 to 104 Weeks**	**Over 104 Weeks**	**Total Waiting**
100 - General Surgery	311	72	52	30	35	0	500
101 - Urology	212	38	16	6	3	0	275
110 - Trauma & Orthopaedics	3	0	0	2	0	0	5
120 - Ent	135	24	8	4	4	0	175
130 - Ophthalmology	503	125	123	66	68	0	885
140 - Oral Surgery	86	26	27	19	12	0	170
143 - Orthodontics	10	0	0	0	2	0	12
170 - Cardiothoracic Surgery	2	0	0	0	0	0	2
171 - Paediatric Surgery	1	0	2	1	0	0	4
180 - Accident & Emergency	1	0	0	0	0	0	1
190 - Anaesthetics	2	0	0	0	0	0	2
191 - Pain Management	0	0	0	6	2	0	8
223 - Paediatric Epilepsy	1	0	0	0	0	0	1
251 - Paediatric Gastroenterology	5	0	1	0	0	0	6
252 - Paediatric Endocrinology	1	0	0	0	0	0	1
300 - General Medicine	63	11	1	1	0	0	76
301 - Gastroenterology	161	15	12	4	0	0	192
320 - Cardiology	208	40	20	1	0	0	269
330 - Dermatology	67	1	0	0	0	0	68
340 - Thoracic / Respiratory Medicine	52	21	19	1	0	0	93
420 - Paediatrics	57	3	3	0	0	0	63
430 - Geriatric Medicine	12	0	0	0	0	0	12
502 - Gynaecology	133	23	27	12	5	0	200
650 - Physiotherapy	2	0	0	0	0	0	2
655 - Orthoptics	1	1	0	0	0	0	2
800 - Clinical Oncology / Radiotherapy	2	0	0	0	0	0	2
822 - Chemical Pathology	12	0	0	0	0	0	12
Total	**2043**	**400**	**311**	**153**	**131**	**0**	**3038**



IFOR in Powys

"Source: NWIS"

Wye Valley Trust

Jun-21	Patients Waiting						
Specialty	**0-25 Weeks**	**26-35 Weeks**	**36-52 Weeks**	**53 to 76 Weeks**	**77 to 104 Weeks**	**Over 104 Weeks**	**Total Waiting**
100 - General Surgery	63	29	29	11	11	0	143

101 - Urology	185	28	24	16	6	0	259
103 - Breast Surgery	74	1	1	1	2	2	81
104 - Colorectal Surgery	102	12	7	5	3	0	129
106 - Upper Gastrointestinal Surgery	37	8	6	1	1	1	54
107 - Vascular Surgery	34	5	6	2	1	0	48
110 - Trauma & Orthopaedics	157	35	63	49	44	0	348
120 - Ent	87	10	16	3	4	0	120
130 - Ophthalmology	275	50	47	10	4	2	388
140 - Oral Surgery	9	1	1	0	1	0	12
143 - Orthodontics	3	0	0	0	0	0	3
144 - Maxillo-Facial Surgery	3	0	1	1	2	0	7
160 - Plastic Surgery	9	1	1	1	1	0	13
173 - Thoracic Surgery	7	0	0	0	0	0	7
190 - Anaesthetics	12	0	0	0	0	0	12
255 - Paediatric Clinical Immunology And Allergy	7	0	0	0	0	0	7
258 - Paediatric Respiratory Medicine	2	0	0	0	0	0	2
290 - Community Paediatrics	1	0	0	0	0	0	1
300 - General Medicine	5	0	1	1	0	0	7
301 - Gastroenterology	182	49	29	6	1	0	267
302 - Endocrinology	20	0	1	0	0	0	21
307 - Diabetic Medicine	4	0	0	0	0	0	4
320 - Cardiology	181	26	29	4	0	0	240
321 - Paediatric Cardiology	5	0	0	0	0	0	5
330 - Dermatology	171	12	4	1	0	0	188
340 - Thoracic / Respiratory Medicine	96	17	8	29	17	0	167
341 - Respiratory Physiology	2	0	0	0	0	0	2
361 - Nephrology	3	0	0	0	0	0	3
400 - Neurology	66	10	7	0	0	0	83
401 - Clinical Neurophysiology	31	0	1	2	0	0	34
410 - Rheumatology	46	2	1	0	0	0	49
420 - Paediatrics	15	0	0	0	0	0	15
430 - Geriatric Medicine	8	1	0	0	0	0	9
502 - Gynaecology	99	10	17	9	4	0	139
800 - Clinical Oncology / Radiotherapy	1	0	0	0	0	0	1
Total	**2002**	**307**	**300**	**152**	**102**	**5**	**2868**

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.2

Delivery and Performance Committee	**Date of Meeting: 2 September 2021**
Subject:	**Elective Care Performance Update**
Approved by:	Jamie Marchant, Executive Director of Primary, Community and Mental Health Services
Presented by:	Jason Crowl, Assistant Director Community Services Group
Prepared by:	Victoria Deakins, Head of Therapies Nicola Kelly, Senior Manager Planned Care
Other Committees and meetings considered at:	

PURPOSE:

This paper aims to provide the Committee with a high-level report summarising operational performance across a range of measures and national programme requirements relating to elective care which includes Diagnostics, Therapies, Healthcare Sciences and Planned Care.

RECOMMENDATION(S):

The Committee is asked to:

- DISCUSS and NOTE the update and the operational actions, risks and corporate support requirements outlined to manage the delivery of associated targets

Approval/Ratification/Decision	**Discussion**	**Information**
	✓	✓

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

EXECUTIVE SUMMARY:

The purpose of this report is to provide the Committee with a summary of current operational performance across a range of measures, and national programme requirements relating to Elective Care, including areas where the Community Service Group has made significant improvements or has particular challenges. This paper provides an update of Powys provided services.

Actions are listed where performance is not compliant with national or local Powys Teaching Healthboard (PTHB) annual plan targets as well as highlighting both short- and long-term risks to delivery.

PTHB has received funding from WG for the renewal priorities and non-recurring monies have been allocated for the workstream of Diagnostics, Ambulatory and Planned Care. This paper is not an update on that specific programme but does refer to specific actions relating to outpatients and theatres as part of the work to deliver improved waiting times

DETAILED BACKGROUND AND ASSESSMENT:

<u>Therapies and Health Science Services</u>

The waiting time target for therapies (and audiology) is 14 weeks from referral whilst the target for diagnostics is 8 weeks. At the end of July 2021, there were 3,397 patients waiting for these specialties but 162 were breaching the associated waiting time.

Service	End of July 2021 Breaches	Longest Wait (weeks)	Total number on Waiting List at end of July 2021	Comments
Audiology	0	13	114	
Dietetics	4	15	336	The service is currently working to 12-13 weeks and therefore absence at short notice increases the risk of breaching. September 2021, have new recruits joining the service which will stabilise the service.
Occupational Therapy	2	14	220	The service is currently working to 12-13 weeks and therefore absence at short notice increases the risk of breaching. September 2021, have new recruits joining the service which will stabilise the service.
Physiotherapy (*including Clinical Musculoskeletal Assessment and Treatment Service (CMATS) for Physiotherapy and Podiatry*)	10	19	1715	The 10 breaches are Podiatry CMATS which are due to the COVID backlog of patients. These patients have now been allocated appointments during September.
Podiatry	1	14	462	The initial backlog in October 2020 was significant with 349 patients waiting over 14 weeks.

Radiography	145	37	550	The situation has deteriorated due to long-term sickness of the Powys-wide Sonographer from April 2021. Detailed position provided below.
Speech and Language Therapy	0	6	28	

Services are adapting to new ways of working and are starting to recover from the pandemic. The demand is now resuming to pre-pandemic numbers for Therapy and Health Science services. We have staff vacancies in some areas, which is resulting in challenges and potential longer waits. All services are looking at the opportunities learnt during the pandemic to maintain the virtual offer where clinically appropriate and the development of new clinical templates will reflect this. We are aware of the recruitment and workforce challenges and all Head of Services are reviewing workforce planning and creative ways of recruitment

The Non-Obstetric Ultrasound service provided under the SLAs for specialist MSK lumps and bumps are currently facing challenges due to the capacity of the visiting Radiologists from Betsi Cadwaladr University Health Board and Swansea Bay Health Board. These patients have been triaged as routine and are currently waiting over 8 weeks. The Head of Service is working actively with these organisations to establish a plan for these patients and confirm ongoing service levels.

Podiatry have been working through a back-log of patients as routines were temporarily stopped through the pandemic. This service has recovered to this position working within the new COVID restrictions within clinic environments and development of new ways of working as outlined in the redesign paper. The Head of Service has presented an update on the progress within the Podiatry service to PTHB Board and the local Community Health Council. A renewal plan is in place with a forecast of providing a service back to the target 14 weeks wait by the beginning of September 2021.

During the COVID outbreak therapy services have adapted to new ways of delivering a service virtually. Dietetics and Physiotherapy Musculoskeletal (MSK) have embraced the opportunity of digital consultations.

A Physiotherapy patient recently commented

"I had over a period of many years experienced major discomfort in my neck and shoulder but had largely ignored it or learnt to compensate by changing my posture. The doctor suggested physiotherapy and I jumped at the opportunity although disappointed to learn it would be via the phone. I am delighted to say however, that I was wrong and have been more than happy with the outcome. I undertook a series of exercises that have virtually eliminated the problem. I did not anticipate the treatment being this successful and I'm extremely grateful for the time and help I have been given."

As well as one to one appointment, groups have been held online. Dietetics have introduced a weight management programme called "Foodwise For Life". It is a nine-week course run virtually over TEAMS. A recent participant reported:

"*I was fortunate enough to be a part of the first Foodwise for Life course held online. It's a group session and we all got on well with each other, sharing tips and ideas and we really supported each other whilst acknowledging our accountability. It has been absolutely fantastic. The dietetic support workers were extremely resourceful. I'd recommend it to anyone who wants some help to lose weight and gain dietary knowledge."*

The Virtual Pulmonary Rehabilitation Programme is scheduled to re-commence again in September 2021 with six programmes planned to run through to December 2021. There was a backlog of patients following the temporary shutdown of the service due to the COVID-19 pandemic. Feedback from a patient who attended in September 2020.

"Two days a week for six weeks, we had 45 minutes of group exercise followed by expert advice on a different topic," she says. "It was so incredibly professional and the staff were so thorough. I cannot sing their praises enough. They adapted exercises for individuals, depending on what we could and couldn't do. And then we would have a session about nutrition or how to conserve energy or the physiology of how the lung worked.

"It means I now have tools in my pocket to help my lung function. The team were very careful to build up gently and gradually and I'm now much more energetic. It has been hugely helpful. It has helped with practical tips too for when I am gasping for breath.

"Being able to receive the support online was wonderful. As someone with respiratory problems, I have been very careful throughout the pandemic. For over a year, no-one had stepped into my house so to do this from the safety of my own home was fantastic."

Referral to Treatment Times (RTT):

The latest reported position (July 2021) for patients waiting over 36 weeks is 463 which includes 248 waiting over 52 weeks, 80.7% of patients (3006 out of total waiting list 3724 patients waiting) waiting less than 26 weeks. The following table shows the current RTT position progress.

Powys Provider RTT (All patients inc non residents)	Apr 2021	May 2021	Jun 2021	Jul 2021
% of patients waiting < 26 weeks for treatment	74.3%	75.9%	78.6%	80.7%
Number of patients waiting < 26 weeks for treatment	2581	2718	2895	3006
% of patients waiting 26 - 35 weeks	8.2%	8.7%	7.7%	7.1%
Number of patients waiting 26 - 35 weeks	285	311	284	265
% of patients waiting 36 - 51 weeks	4.7%	5.1%	5.8%	5.8%
Number of patients waiting 36 - 51 weeks	165	184	212	216
% of patients waiting 52 weeks and over	12.8%	10.3%	7.9%	6.4%
Number of patients waiting 52 weeks and over	443	370	292	237
Total Patients waiting 36 weeks and over	608	554	504	453
Total Patients waiting	3474	3583	3683	3724

Powys Provider RTT (All Patients ex Diagnostic & Therapies) – Source Ifor

The table below illustrates waits by speciality.

Sou**rce: Ifor R**TT waits by Speciality July 2021

Source: NWIS RTT	Weeks Wait Bands				
RTT Specialty	Under 26 Weeks	26 to 35 Weeks	36 to 51 Weeks	52 Weeks and Over	Total
100 - GENERAL SURGERY	420	30	22	24	496
101 - UROLOGY	129	14	25	3	171
110 - TRAUMA & ORTHOPAEDICS	487	51	59	94	691
120 - ENT	398	24	12	1	435
130 - OPHTHALMOLOGY	718	75	39	6	838
140 - ORAL SURGERY	156	40	49	107	352
143 - ORTHODONTICS	10		1		11
191 - PAIN MANAGEMENT	46				46
300 - GENERAL MEDICINE	49	6			55
320 - CARDIOLOGY	103	7	1		111
330 - DERMATOLOGY	27				27
410 - RHEUMATOLOGY	107	11	7	1	126
420 - PAEDIATRICS	34				34
430 - GERIATRIC MEDICINE	18				18
502 - GYNAECOLOGY	304	7	1	1	313
Total	**3006**	**265**	**216**	**237**	**3724**

The Community Services Group has made huge progress in managing the backlog of long waiting patients (from 1478 Nov 2020 to 463 patients waiting over 36 weeks in July 2021) however there are significant challenges to achievement of RTT moving forward these include:

- The scale of the urgent and urgent suspected cancer demand due to patients not presenting in primary care through C19 is unknown across all specialities;

This demand will impact on the organisations ability to tackle long waiting routine patients;

- The underlying historical fragility of in reach providers (Health Boards & NHS Trusts). The ability of these organisations to support additional sessions and waiting lists in Powys whilst managing their own Recovery Plan;
- Theatre/Endoscopy staff unable to work clinically due to health issues including former shielders. As a result of these staffing shortfalls elective surgery which re-started in December 2020 has only been able to run an hoc basis to date;
- The ability to recruit staff when all NHS organisations will be actively recruiting to support Recovery Plans. The availability of skilled staff e.g. there is a national shortage of colonoscopists and theatre scrub nurses;
- Covid 19 operating protocols, social distancing, Royal College Guidance and impact on capacity, flow, templates;
- Availability of private sector capacity;
- Estate limitations for example number of clinic rooms, airflow in clinic/endoscopy rooms;
- Delays in diagnostic pathways in District General Hospitals (DGH) external providers will impact on pathways within PTHB;
- Lack of infrastructure and specific Planned Care Medical Leadership;
- Seasonal pressures flu, covid 19, booster vaccination resource requirements.

Challenges to Achievement	**Actions & Timescales**
Fragility of in reach providers. Service level agreements (SLAs) with in reach providers underperformed in 2020/21 due to DGH covid response, this underperformance has continued into Q1/Q2 2021/22. Challenges with succession planning for retiring clinicians, recruitment to substantive posts, securing locums, managing DGH recovery/renewal, annual leave carried forward due to C19 workload, long & short term sickness absences.	SLAs are formally discussed via regular provider meetings as part of the Commissioning Assurance Framework. Developing plans for PTHB multi-disciplinary teams (MDT) to manage demand away from consultants to PTHB based clinicians e.g. eye care – MDT specialist nurses, optometrists, ophthalmic healthcare scientist – on-going. Similar plans under development for ENT, Orthopaedics. The Senior Nurse Manager for Outpatient Development is progressing a scheme for nurse-led gynaecology clinics in North Powys which will commence in Sept 21. The Welsh Government National Planned Care Programme recognises clinical sustainability as a key area of challenge across all health boards and is working with health boards to develop regional solutions – on-going with National Clinical Summit in Oct 21.
Shortfall in Theatre/Endoscopy staff. Blended nursing roles covering range of surgical/endoscopy and competitive jobs market.	Extensive work undertaken by WOD/Senior Nurse Theatres/Endoscopy with staff formerly

	shielding/long term absence from clinical service. New job descriptions for each separate service (Theatre & Endoscopy) developed & are currently out to advert. Band 5 appointments have been successfully made following recruitment campaign in July/Aug 21 but further posts are required to support recovery/renewal so rolling advertisement on-going.
Staff recruitment in highly competitive market	Reviewing job descriptions speciality recruitment rather than blended roles to enhance recruitment – completed Q1. Working with Workforce & Communications team to market roles to broader audience – on-going. Supporting Workforce with review of bank rates for hard to fill posts – ongoing.
Covid 19 operating protocols & impact on capacity flow templates	Since March 2020 clinical teams have been working with in reach providers and PTHB infection control to ensure that standard operating protocols are updated regularly in line with changes in WG C19 policy and Royal College Guidance. As part of this process theatre and outpatient templates / capacity is regularly reviewed and updated.
Availability of shared services procurement support/private sector capacity. Delays in DGH diagnostic pathways.	Private sector capacity will be required across a broad range of specialities to manage the backlog and support the current in reach service to recovery. As part of the Renewal Programme working with lead officer Assistant Director of Transformation & Value to determine level of private sector capacity required and service specifications. Renewal Programme has secured specialist Procurement Support from Shared Services to support PTHB with private sector contracts. Diagnostics will also require private sector capacity but in house schemes are under development e.g. doppler scanning pilot with PTHB

	ultrasongrapher to support vascular surgery in North Powys. Patients are scanned in clinic without requirement for referral to DGH.
Estate limitations including outpatient clinic rooms, medical equipment	Outpatient Departments in North Powys were updated as part of C19 response to free up and maximise clinical space. Successful capital bids for new medical equipment to Welsh Government Eye Care Transformation Fund, North Powys Wellbeing Programme, WG Renewal Fund. Between 30% - 40% of all activity in an outpatient setting is now undertaken virtually. Virtual appointments are more suited to therapies and medicine as opposed to surgery.
Planned Care clinical leadership and infrastructure	Executive Lead working with Medical Director to review clinical leadership model for Planned Care with Clinical Director type roles. New transformational pan Powys nurse leadership roles have been developed and recruited to for Planned Care including a Senior Nurse Manager for Outpatient Development and Senior Nurse Manager Theatres. Senior Nurse Manager Endoscopy post out to advert Aug 21, pilot fixed term 12 months. A Planned Care Manager has been successfully recruited to support operational management and PTHB delivery of the National Planned Care workstreams – commencing in post Sept 21.
Referral demand, urgent suspected cancer (USC), urgent referral. Referral demand increased during Q4 2020/21 and continues to increase. The quality of referrals in some areas of service is an issue as they have not been physically seen in primary care.	To support operational teams going forward the Executive Director has requested assistance from the Delivery Unit to facilitate the development of robust demand and capacity modelling tool. Levels of USC, urgent demand however remains difficult to predict as many patients did not present to primary care during the pandemic. Referral rates are anticipated to increase and exceed pre covid levels, this will require a sustained period of recovery and additional capacity which is being factored into Renewal Plans.

Improvement work to manage waiting lists in line with the National Planned Care Programme Outpatient Transformation and Speciality Boards continues with activity levels closely monitored locally via the daily review of patient lists and weekly RTT meetings.

Waiting lists are clinically validated and risk stratified in addition to administrative waiting list validation. Theatre lists are clinically prioritised utilising the Federation of Surgical Speciality Association C19 prioritisation tool with the vast majority of patients categorised as priority 4 (low risk), however all long waiters are regularly, clinically reviewed to ensure their condition is not changing and in need of re-prioritising. Any patients requiring urgent treatment are transferred to DGH urgent pathways if immediate lists are not available in PTHB.

The WG 52-week risk stratification exercise commenced in Q1 2021/21 with letters sent to patients waiting over 52 weeks in orthopaedics. This initiative was clinically supported by PTHB musculoskeletal physiotherapist who was also able to contact and review orthopaedic patients waiting 36-51 weeks and 100% overdue follow up patients. Throughout 2020/21 and 2021/22 the Assistant Clinical Director for Community Dental Services has undertaken a similar clinical review exercise for long waiting dental/oral surgery patients.

Staff are key to recovery/staff and are being supported and fully engaged in defining and embedding new ways of working. Staff well being is managed very closely within the Directorate and staff are encouraged to take their full annual leave and additional hours are monitored to ensure avoid burn out.

Diagnostics:

Endoscopy

The latest (July 2021) reported position for patients waiting over 8 weeks is 169 (60 colonoscopy, 73 gastroscopy, 36 sigmoidoscopy). This is a deteriorating position June 2021 131 patients waiting over 8 weeks, May 2021 111 patients waiting over 8 weeks, April 2021 107 patients waiting over 8 weeks.

Specialty	Sub Spec	Total patients	Patients waiting 8 weeks or longer	% Over 8 week target
Diagnostic Endoscopy	Colonoscopy	79	60	75.9%
	Flexible Sigmoidoscopy	48	36	75.0%
	Gastroscopy	118	73	61.9%

July 21 position – source Ifor

The endoscopy service re-started in late July 2020 with a focus on urgent suspected cancers, urgents and overdue surveillance patients. This backlog of patients was successfully cleared during Q4 2020/21 with excellent progress maintained during April/May 2021 (despite reduced list sizes due to C19 clinical guidance) utilising additional lists provided by PTHB clinical endoscopists. Unfortunately, during June

21 sessions reduced due to clinical absence, in June/July this had a significant impact on capacity (reducing to 5% capacity lowers, 20% total capacity). The longest routine wait is currently (July 21) 45wks (colon), 36 wks (gastro), 29wks (sigi). However, patient satisfaction surveys still report excellent levels of care.

As part of the RTT management detailed previously, improvement work to manage endoscopy waiting lists continues with activity levels closely monitored via weekly RTT meetings, daily reviews of lists and fortnightly endoscopy scheduling meetings. Session availability has improved during August 21 but still remains severely reduced with annual leave now compounding the situation (only 44% of total capacity). The on-going capacity shortfall has now begun to impact on the management of USC patients with a small number of urgent suspected cancers (USC) breaches in month. Some locum cover has been provided by the in reach provider Cwm Taf Morgannwg University Health Board (CTMUHB) but this has only been on an ad hoc basis due to District General Hospital (DGH) USC pressures. In line with National and College guidance the C19 Endoscopy Operating Protocol was updated in July 21 and endoscopy templates increased from 3 to 5 patients on a list but the waiting list position will to continue to deteriorate into Q3.

All welsh health boards have significant backlogs in USC, urgent and routine endoscopy patients, the national shortfalls in capacity are reported to WG via monthly National Endoscopy Programme (NEP) health board level demand and capacity modelling which is refreshed on a monthly basis. Pre-covid the modelling exercise illustrated a national shortfall in capacity particularly in colonoscopy and this was also evident in the PTHB level model.

As a result of the C19 backlog, underlying capacity gap, increasing demands, theatre staffing challenges, reliance on ad hoc waiting list initiatives and the fragility of in reach services (CTMUHB), the achievement of the access targets including RTT and Joint Advisory Group (JAG) future re-accreditations are at significant risk.

Service transformation plans aligned to the National Endoscopy Plan in place pre covid have continued to progress and further developed to modernise the service and increase PTHB capacity as summarised below:

- 1st trainee nurse endoscopist post for PTHB commenced training – May 21
- To pilot Senior Nurse Manager Endoscopy Post 12 months fixed term – Autumn 21
- Dedicated Endoscopy Nursing Team. Further skill mix with band 4 roles – On-going
- Continue plans for PTHB to become a JAG Training Site, Recruit Trainee Endoscopists in line with National Endoscopy Programme Training Plan – On-going
- Increased efficiency with new equipment endoscopy washer/scopes replacement supported by WG Renewal fund – Q3/Q4
- Opening of unit in Llandrindod, plan for JAG accreditation, regional capacity option – Q3/Q4

- Potential Cytosponge Pilot opportunities to enhance patient experience, increase capacity, support demand management – Q2/Q3
- New endoscopy IT system when fully operational will improve service delivery, image quality & audit reporting – On-going
- Support Regional working, National Endoscopy Programme (NEP) Regional Plans for all Wales service sustainability. Support PHW with Regional working for Bowel Screening – On-going
- Increase GP education & communications regarding referrals and pathways – May 21 on-going
- Exploring outsourcing options via NHS shared services, CTMUHB South East Wales short term mobile unit capacity not supported by NEP. Renewal bid provision for £90K.
- Additional locum medical endoscopist capacity has been identified and a contract of employment is being progressed by Workforce – on-going

Further to the non-recurring renewal funding from WG work is ongoing to scope all options for additional capacity in terms of additional workforce, additional sessional work as well as potential for outsourcing.

Public Health Wales (PHW) PTHB hosted Bowel Screening Wales (BSW) Service

In addition to fragilities within the PTHB core endoscopy service there are also concerns around the sustainability of the PTHB Bowel Screening Service. The current BSW Endoscopy Service is provided by a consultant from Hywel Dda University Health Board in reach and a PTHB specialist nurse (0.4wte). Service cover for the specialist nurse post is currently being provided by Bowel Screening Wales, there is currently no service cover for the consultant post.

In July 21 BSW undertook an options appraisal for PTHB service nursing sustainability, PHW preferred option was a shared nurse post PTHB/CTMUHB. PTHB preferred option centrally managed post as part of wider team BSW team. PHW are currently agreeing the shared post option with CTMUHB. The Directorate have also asked PHW BSW to consider sustainability options for the consultant post, this request has been noted by BSW.

There is currently no backlog of BSW patients in PTHB but this position is likely to deteriorate in Q3 with an anticipated increase in referrals due to changes in screening pathways.

Cystoscopy

The backlog of cystoscopy patients was seen during Q1 2021/22 and all waiting lists are up to date with no breaches reported (July 21).

Cardiology

Excellent progress was made during Q1 in terms of reducing the backlog but unfortunately due to equipment failure (with full service contract in place) in June 21 and annual leave in July/Aug 21 this progress slowed. As at July 21 there are 22 patients waiting over 8 weeks (longest wait 11 weeks). With equipment repaired and staff returning from annual leave it is anticipated that the service will clear the backlog of breaches by the end of Q3 2021/22.

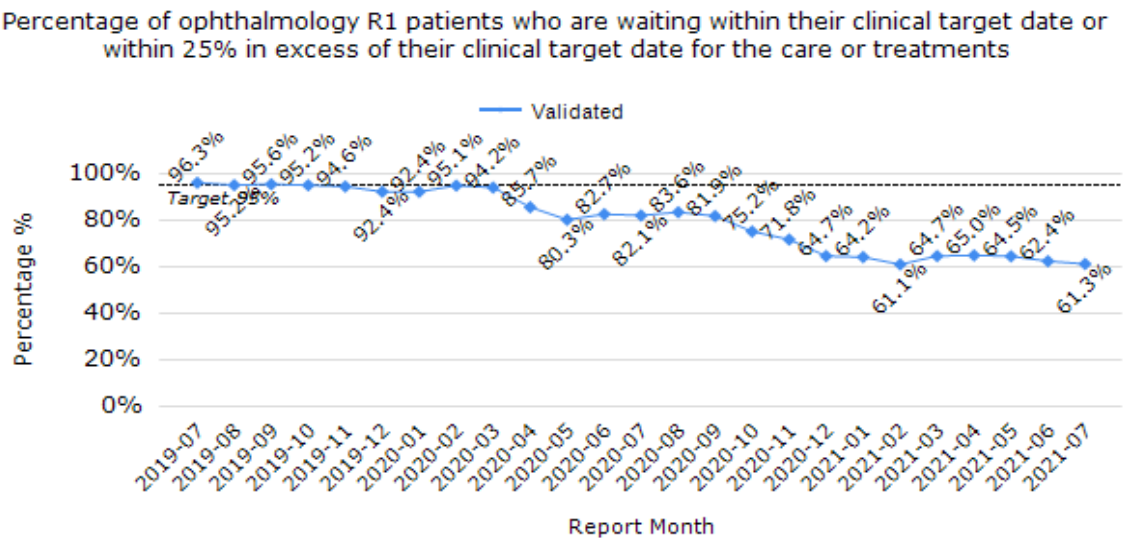
Follow Ups

As at July 2021 there were 6579 patients in total waiting for follow up appointments (a reduction from the June 2021 position 6671 patients) of those 508 were 100% overdue follow up.

The priority specialities in Planned Care for follow up improvement are General Medicine (Respiratory) and General Surgery. The priority specialities for total number of patients on the follow up list are Ophthalmology, General Medicine (Respiratory), Rheumatology and Gynaecology.

Eye Care Measure & Eye Care

The latest (July 2021) reported position is 61.3% (140 patients waited 25% beyond) risk factor 1 (R1) graded within their clinical target date. The Health Risk Factor Target was achieved again in July 21 with 99.5% against 98.0% target. There are significant challenges to achievement due to the fragility of services of Wye Valley NHS Trust (WVT)in reach Ophthalmology service, follow up backlogs and increasing referral demand.



** Unvalidatated data only avaliable between the 1st and the 13th of the latest reporting month*

Source: WPAS

Cataract Surgery and Ocularplasty
The PTHB cataract service restarted in August 20, with core service and waiting list initiatives PTHB achieved no cataract waits over 36 weeks at 31 March 2021 successfully clearing the C19 waiting list backlog. This position was maintained during April/May 21 with PTHB the only health board without cataract breaches. Due to capacity shortfall/demand pressures the service has seen waiting lists increase with 21 patients waiting 36 – 51 weeks in July 21 for cataract surgery and 6 patients waiting 36 – 51 weeks for cataract outpatient appointment.

In ocularplasty there is a significant backlog in other eye care treatments due to lack of theatre staffing and need to prioritise cataracts with patients currently waiting over 52 weeks.

Eye Care Service Fragility
The in reach services (across all areas of eye care) provided by Wye Valley NHS and Shrewsbury and Telford NHS Trust (SaTH) remains fragile with consultant/clinical fellow vacancies, sickness absence and leave carry over due to C19, in addition to increasing referral demand which has meant late conversion from outpatient to treatment. The fragility of in reach services has an on-going impact in capacity to deliver access targets.

WVT have successfully recruited a replacement clinical fellow who will commence in PTHB in September 21 and levels of sickness absence, annual leave will reduce in Q3. It is anticipated that the waiting list position will deteriorate in Q3 due to referral demand and follow up backlog across eye care (including cataracts, glaucoma & general ophthalmology). SaTH have advised across all specialities that they will continue to struggle to meet current SLA contracted levels of service due to DGH pressures. The eye care service provided into North West Powys is also very fragile with a single handed long term locum currently providing outpatient services in Llanidloes and Machynlleth.

A multi disciplinary team (MDT) approach is being further developed in eye care which will provide additional capacity with clinicians such as the Ophthalmic Healthcare Scientist (funded via the North Powys Transformation Fund) following a period of training able to run standalone glaucoma and ocularplasty follow up clinics and support with Wet AMD injecting. The Directorate is also in the process of recruiting to other MDT posts for North Powys including optometry and eye care specialist nurse. It should be noted that as in other areas of Planned Care all health boards/NHS Trusts are recruiting eye care staff so the recruitment is challenging and the market highly competitive.

Wet Age Related Macular Degeneration (AMD)
The PTHB wet AMD service in Brecon has been maintained throughout the C19 period with additional capacity provided by hospital optometry and PTHB first Eye Care Specialist Nurse/Nurse Injector who commenced in post in Q3 2020/21. In April 2021 the service was also able to commence clinics in a second location within Powys in Llandrindod Wells enabling care closer to home for patients/families in mid Powys (previously travelled to Brecon). With further MDT recruitment the

Directorate is developing plans to increase service provision in PTHB with the extension of the WeT AMD service into North Powys as part of the North Powys Wellbeing Programme. In addition to MDT resource this will also require additional consultant in reach which may prove challenging to secure in the current environment.

WG Eye Care Review

Due to significant capacity and sustainability issues across eye care within Wales WG has commissioned the Royal College of Ophthalmologists to undertake a review of welsh eye care. The findings from the review will be shared by WG in Q3 2021/22.

Eye Care – Electronic Patient Record & Electronic Patient Referral

The Eye Care Electronic Patient Record (EPR) is the largest national digital Programme in Wales it is being introduced to support delivery of the New Eye Care Measures. Each Health Board has given a commitment to support the Programme and the Outline Business Case (OBC) has been approved by WG and the Minister for Health. PTHB has established a project team and weekly Project Board Meetings to progress this key development. With successful funding bids to WG National Eye Care Programme PTHB has been able to purchase additional equipment for Eye Care to further support service development. Funding for a range of posts for each health board and regional digital eye care support were agreed by the National Programme but changes to the WG financial provision in 2021/22 have been that there are now health board posts and regional posts which will require additional health board resources for PTHB the posts are Band 4 PTHB and Band 6 PTHB regional post. There are IT challenges and issues at a National level in terms of full roll out of the Digital Eye Care Programme but within the resource available PTHB is making good progress with the project, Ystradgynlais hospital has been identified as pilot site and work will commence on roll out during Q3 2021/22.

<u>National Programmes</u>

Wales National Endoscopy Programme (NEP)

- The Directorate is fully engaged in the Welsh National Endoscopy Programme, with Dr Phedra Dodds, PTHB Consultant Nurse appointed to the National Clinical Lead post for Demand and Capacity work stream in 2019. There are however four separate workstreams covering clinical pathways, workforce, demand and capacity and infrastructure in addition to Directorate Manager, Unit Manager, Regional meetings and a National Endoscopy Board, the volume of meetings and subsequent information requests/deadlines is often a challenge to manage within the small PTHB Planned Care staff resource.
- The NEP have developed a Regional Plan proposal for regional endoscopy centres in South East Wales, South West Wales and North Wales these are currently with WG for consideration. Regional Plans will need to be considered

under Renewal/Transformation and in terms of future developments in North Powys.

National Planned Care Programme

- The Directorate continues to support/implement the National Planned Care Programme across Outpatient Transformation, Orthopaedics, Eye Care, ENT, Dermatology and Urology. There are a large number of Boards, Sub Groups, Task and Finish Groups and daily requests for updates, presentations, data that is challenging to manage with a small PTHB Planned Care resource. These meetings also require secondary care clinical and primary care clinical attendance which PTHB is currently unable to field. A Welsh Government produced update on the National Planned Care Programme (Appendix 1) illustrates the range of groups/workstreams and broad ranging, detailed work plan.

NEXT STEPS:

The Committee is asked to:

- DISCUSS and NOTE the update and the operational actions, risks and corporate support requirements outlined to ensure the achievement of targets.

Appendix 1 - National Planned Care Programme Update March 2021

After more than 20 years of service in the NHS, Chris White will be retiring from Swansea Bay University Health Board in April 2021, and is stepping down as the Senior Responsible Owner of the Planned Care Programme in Wales.

Chris has been dedicated to the programme and has been pivotal to its achievements. On behalf of the programme board and stakeholders we would like to express our good wishes to Chris on a long and wonderful retirement. Simon Dean will continue to chair the Board.

Project updates:

Individual Pathway Targets (IPT) Reporting directly to the National Planned Care Programme, this group led by Nick Lyons, Medical Director from CTM is developing proposals to introduce patient focused waiting times based on clinical conditions and risk of harm should that waiting time be missed as an alternative to RTT. The five work streams continue to progress, NHS Chief Executive Officers received a progress update in their February meeting. Robust engagement with stakeholders is key to the development of this project. A communication strategy is under development, and an independent Scrutiny Panel is being commissioned to provide stakeholder oversight.

Work stream 1: Principles and Ethics Led by the NHS Delivery Unit, five principles have bene identified to underpin the development of the new model. The document Moving to risk stratified waiting lists – the principles is being shared for feedback and comments.

Work stream 2: Developing the model The clinically led process will work to create a standard set of metrics to support the proposed patient-centred risk stratification and prioritisation of the outpatient waiting list. This will be based on risk of harm to patients if delivery of care is delayed.

Development is focusing on a small number of medical and single surgical specialties utilising rapid improvement cycle methodologies to test

assumptions and unexpected impacts of transformation. Initial focus is on clinical matriculation of specific conditions within general surgery, gastroenterology and urology.

Work stream 3: Cardiac and cardiology The Welsh Cardiac Network have proposed a new pathway comprised of enhanced referral management, referral risk stratification and prioritisation, and pathway milestones. This now needs to be tested.

Work stream 4: Paediatrics Membership of the group has been identified and planning is underway to carry out stakeholder engagement in primary, community and secondary health care sectors.

Work stream 5: Reviewing stage 4 patients IT functionality within health board patient administrations systems have been updated to capture the RCS prioritisation of waiting lists approach. This is the first step in supporting robust recovery planning and will form the starting point of applying the patient centred risk stratification and prioritisation model similar to that proposed for outpatients to support "time-to-treatment." Outcomes measures are currently being developed and a working group is to be set up to identify the data required and define data standards for WISB.

Outpatient Transformation The Outpatient Steering Group (OSG) provides a forum for sharing of challenges and local innovations while also providing subject specific workshops for more complex issues in the delivery of the outcomes identified within the Outpatients Transformation Strategy, utilising standardised, once-for-Wales approaches where appropriate.

Stage 1 waiting lists At the end of January there are over 50,000 patients waiting over 52 weeks for a first appointment. Estimates indicate that this will increase to just under 100,000 by the end of March 2021. Agreement has been made that NHS Wales will approach the review of these patients in a consistent and co-ordinated manner. A standard letter and patient reported questionnaire is being developed and health boards will start to send this out to patients in April. All patients who need to stay on the list will be offered a clinical assessment: this may be advice, clinical triage or virtual or face to face review as appropriate. Clear SOPs have been developed and agreed involving a three stage process of administrative and clinical validation followed by clinical review and prioritisation.

Follow-up Waiting Lists The increase in the number of patients (just over 200,000) who are waiting past 100% of their target review is concerning. Implementation of the new ways of working such as see on symptoms and patient initiated follow ups need to be extended at pace to support these patients.

Advice, Guidance and Referral Management Work is taking place with NWIS / WPAS colleagues to introduce an advice only option for primary care to utilise rather than having to make a formal referral. The advice only option will start the RTT and be subject to agreed timescales for responses and will record all correspondence within the patient notes. The next phase of work is the development of referral management guidelines for common conditions.

Virtual Group Consultations/Video Group Clinics (VGC) We are working with 30 early adaptors to develop the model for VGCs across a range of specialities and primary and community care (including rheumatology, dermatology, orthopaedics, endocrinology, cardiology, pain management, gynaecology and cancer services.) Velindre has undertaken the first VGC using this model in Wales focusing upon multi-disciplinary support in neuro-oncology. A webinar on COVID-19 vaccinations was held in Swansea Bay UHB, run by a rheumatology consultant and it successfully supported 175 patients.

Further information and booking of on training can be accessed via the link below. https://digitalhealth.wales/tec-cymru/vc-service/i-am-clinician/training/virtual-groups

Clinical Boards update

The five speciality programme boards are focused on understanding speciality specific challenges and variation across the health boards. To support the restarting of outpatient and elective services.

Refresh of the strategy plans / implementation plans The National Planned Care Programme Board have recommended a review to ensure that the work of each of the clinical boards support the overarching NHS Wales recovery programme and is reflective of the changed health landscape.

Dermatology The national review of dermatology the final stages of development and will be published in May 2021. This document will identify the national priorities for the provision of dermatology in Wales over the next two years.

ENT The ENT board is sharing local innovations developed during COVID-19 and evaluate the learning from these to support service transformation, and include the use of the ENT-UK triage tool for cancer referrals, virtual activity and the introduction of SOS pathways.

Ophthalmology The board has been progressing work through a series of task and finish groups. The groups looking at cataract end-to-end pathways, unscheduled eye care delivery and wet-AMD have finalised their recommendations, which will be presented at the Welsh Ophthalmic Planned Care Board on the 31 March 2021 for approval. Work within glaucoma continues with progress being made on the agreement of care pathways.

Work is ongoing to develop a robust regional solution to address the backlog in cataract treatments. Clinical teams are engaged in developing sustainable models of care.

Diabetic referral refinement scheme (DRRS) SBUHB have been piloting a DRRS to ensure that patients at risk of sight loss are seen within an appropriate timeframe. Early indications suggests that this could be successfully be rolled out across Wales.

Orthopaedics The group has expressed concerns over the ability to access treatment facilities for those patients with a high RCS priority group while linking in locally with restart plans.

Analysis to understand sub-speciality pressures in each health board has been undertaken. Local innovations have been shared with the national group to promote new ways of working and consistent roll out of clinically appropriate service transformation.

The work streams have been established to support patients in both the short and long term: i. Support systems / health optimisation and processes for patients awaiting surgery ii. National long term plan for orthopaedic recovery. iii. Management of ambulatory trauma within fracture clinics.

Urology Discussions are taking place about the implementation of a national self-management portal for patients with stable PSA levels post prostate cancer diagnosis. The Welsh Urology Board are agreeing a number of referral criteria for high volume benign conditions. The aim is to support primary care to manage patients locally with certain symptoms without the need for a hospital consultation, preventing waits for a secondary care review.

A working group is being established to look at the potential for using Specialist Telephone Advice and Guidance consistently across health boards. This work stream will look to examine how advice and guidance can be provided, what can be undertaken locally and nationally and what conditions could be prioritised

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.3

Delivery & Performance Committee	**Date of Meeting: 2nd September 2021**
Subject	**Neurodevelopmental (ND) Service Performance Update**
Approved by:	Jamie Marchant – Executive Director of Primary, Community & Mental Health (DPCCMH) Services.
Prepared and Presented by:	Louise Turner – Assistant Director of Womens and Childrens Services.
Other Committees and meetings considered at:	None at the time of reporting

PURPOSE:

This paper presents progress on the implementation of a redesigned ND service that underpins the delivery of provision based on a multi-disciplinary workforce model.

The Powys Teaching Health Board (PTHB) ND service has experienced an increase in demand since its inception in 2018 that has been compounded by the COVID-19 pandemic. Consequently, the service is significantly breaching the Welsh Government (WG) 26 week referral to treatment time (RTT) waiting time target. Furthermore, insufficient capacity to meet this referral demand, coupled with a deficient professional skill mix has resulted in non-compliance with respective evidence-based Autism Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD) recommendations from the National Institute for Health and Care Excellence (NICE) guidelines.

The paper highlights the current fragility of the service and outlies the renewal investment to support a remodel of the ND service.
In summary, the paper aims to:

- Explore the key drivers for change
- Outline the breach of the Welsh Government (WG) 26 week RTT waiting time target.
- Highlight the challenges experienced by the ND service due to a mismatch in demand and capacity.
- Outlines solution to address the backlog, maintain the ND service and effectively respond to post diagnostic support for families.

- Outline a new ND service model and the objectives and benefits the proposal will deliver for the organisation and the local child and young person's population of Powys.

RECOMMENDATION(S):

The Committee is asked to note and discuss the contents of the paper and the specific work to improve the waiting times of the service utilising additional monies from WG.

Approval/Ratification/Decision	Discussion	Information
✖	✓	✓

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

EXECUTIVE SUMMARY:

PTHB ANNUAL PLAN RENEWAL INVESTMENT

The ND service redesign is a renewal priority for PTHB's Annual Plan emerging from a full appraisal of the impact of the COVID pandemic and sits under Priority 5 Children, Young People and Families (CYPF). The focus of this priority is informed by the emerging evidence base related to the effects on CYPF of the COVID-19 pandemic, aspects which will matter most to the wellbeing of the population of Powys, and interventions which will work best to address the need identified. The implementation of a new ND workforce model will recognise the need to enable recovery in the short term and realise renewal and transformation long term.

Through Welsh Government monies, an investment of 299k has been allocated on a non-recurrent basis to address the waiting list backlog.

DETAILED BACKGROUND AND ASSESSMENT:

BACKGROUND

Children with a potential ASD or ADHD diagnosis can be complex and their history multifaceted. Therefore, diagnostic assessment and support requires a multi-disciplinary, multi-agency approach in accordance with the *Guidance on the Delivery of Neurodevelopmental Services in Wales standards* (Public Health Wales, 2018) Appendix 1; the National Institute of Health and Care Excellence (NICE) the Clinical Guidelines CG128 ASD in under 19s: recognition, referral and diagnosis (2011); ASD in Under 19s: support and management CG170 (2013) and ADHD: diagnosis and management NG87 (2018).

Welsh Government (WG) has provided a framework about how ND services are to be delivered in Wales thanks to the publication of their guidance documentation at Appendix 1. The guidance will support ND teams to demonstrate the quality of services and better understand the demand for diagnostic assessment and intervention. In June 2021, the Together for Children and Young People (2) Programme's ND Work Stream presented the current position in terms of embedding these national standards and proposals for the future, recognising the challenge of demand and capacity pre and post COVID. See Appendix 2.

The PTHB's children's ND service was established in February 2018 and offers diagnostic assessment for ADHD and ASD. The service superseded the former Social Communication Assessment Team (SCAT) and consequently inherited a large number of incomplete assessments at its inception. The ND service comprises a small core team and virtual wider work force colleagues. This virtual resource is not ring fenced nor protected, and is difficult to consistently secure due to the commitments and demands within their core services.

The assessment of children with possible ND conditions is a complex process as there are many stages that require multi-disciplinary, multi-agency involvement and meetings, and detailed report writing, all of which are resource intensive.

Prior to the pandemic, the ND team were compliant with the 26 week RTT target but this was achieved by frontloading the initial assessment, often by a ND nurse undertaking a school observation. This approach appears to be standard across NHS Wales and thus allowed more time for the detailed assessments to be undertaken according to the presentation and needs of the child. This does however mean that there is a large number of children waiting conclusion of assessment. Furthermore, the impact of COVID on service levels has meant that the ND 'backlog' of children that need to be reviewed and assessed has further increased.

The ND service demand and capacity disparity has been exacerbated by COVID and the suspension of the service between March and September 2020. Consequently, the recovery of this service is challenging due to workforce capacity issues and there are currently a large number of children with lengthy 'referral to treatment times'. PTHB must therefore remodel the service to ensure capacity satisfies the increases ongoing demand whilst complying with statutory targets imposed by WG.

PROJECT OUTLINE

(Extract from the Immediate Recovery Proposal – Phase 1)

"The assessment of children with possible neurodevelopmental conditions is a complex and resource intensive process. Timeliness is absolutely key, the earlier a child is diagnosed then the more likely he or she is to receive the support and intervention required to optimise their development and thrive. Additionally, families who are well supported are less likely to face issues that undermine the family unit. Delayed assessment of children and young people with possible neurodevelopmental conditions has the potential to increase harm.

The demand on this service is threefold; the requirement for 26-week Referral to Treatment; the requirement to complete the assessment in 12 weeks and the provision of post-diagnostic support, intervention and review.

This project will enhance existing provision, enabling a move to a more sustainable, Multi Disciplinary Team model to ensure that children and young people are seen, assessed and provided with holistic, safe, timely, high quality treatment and support to address their needs.

The proposal is to ensure dedicated input and support is available through the creation of a Powys Neurodevelopment MDT which will include:
• advanced clinical practitioner • dedicated consultant community paediatrician support • dedicated consultant psychiatrist • dedicated paediatric therapy • additional learning disabilities nursing support • dedicated educational psychological support • additional administration to ensure clinical staff can focus on clinical duties."

HISTORICAL REFFERAL DEMAND (excluding C.19 period)

PTHB ND Service Referrals Accepted 2019/20 ***Source: WPAS/IFOR*** *NB 2019/20 selected to offer more reflective referral rate pre COVID*					
Month/Year	No of Referrals	No of hrs per assessment (15 hrs)	Month/Year	No of Referrals	No of hrs per assessment (15 hrs)
April 2019	15	75	October 2019	20	300
May 2019	20	300	November 2019	19	285
June 2019	13	195	December 2019	25	375
July 2019	20	300	January 2020	26	390
August 2019	17	255	February 2020	26	390
September 2019	20	300	March 2020	20	300
Total no. referrals received 2019/20 = **333**			Total no referrals accepted 2019/20=**241** (as above figures)		
Average no. of referrals received p/m=**28**			Average no. of referrals accepted p/m=**20**		

CURRENT POSITION

PTHB ND Service Referrals Accepted 2021/22 ***Source: WPAS/IFOR***	
Month/Year	No of Referrals
April 2021	14
May 2021	11
June 2021	18
July 2021	20
Total no. referrals received	**67**
Total no. referrals accepted	**64**

During 2021/22 the ND service has an average referral rate of 16 per month but it is anticipated that the volume of referrals will increase due to the COVID legacy.

WAITING LIST POSITION	**NUMBER OF CYP**
Current Referral To Treatment (RTT) waiting list (including 2021/22 referrals received and accepted to date = 64)	189 *as at end July 21*
Conclude assessments in progress	294
TOTAL	**482**

RTT Waiting List 2021/22	**Total Number of CYP waiting for first appt**	**No of CYP Waiting Over 26 Weeks**	**% of Total Waiting Over 26 Weeks**
April 2021	188	76	41%
May 2021	196	94	48%
June 2021	189	98	52%
July 2021	189	96	51%

NEXT STEPS:

- **Project Board (PB) -** The ND work stream has established a formal project board ultimately reporting to the CYPF Renewal Programme Board. A Project Initiation Document (PID)will be developed is being developed to steer delivery subsequent to the business case. A fully fledged project plan is being implemented and monitored weekly with governance to the Children, Young People and Families (CYPF) Renewal Programme Board and ultimately the PTHB Renewal Portfolio Board. This has been initiated by the review of the current pathway and service processes.

  Investment in additional capacity – A non-recurrent funding allocation of £299k thanks to Renewal group monies has enabled the project to introduce additional workforce to increase capacity according to demand and capacity work undertaken. Recruitment of priority non-recurrent posts has commenced and job descriptions are being prepared for all positions.

- **Addressing the Backlog -** Work has commenced to address the waiting list backlog (294 diagnostic assessments). Work to complete the full backlog is time consuming underpinned by the current lack of Paediatrician. However, locum doctors have been recruited as interim solution.

- **Service remodel –** the ND service will be subject to a redesign to ensure robust delivery of provision. This will include a pathway review to ensure compliance with statutory obligations, national standards and NICE guidance.

- **Data Collection and Reporting –** Systems software development will be integral to the project to ensure data capture on the Welsh Community Care Information System (WCCIS) and Welsh Patient Administration System (WPAS) systems can satisfy local and statutory reporting requirements.

- **Engagement and Consultation –** a key CYPF renewal programme cross cutting theme in relation to professional and service user consultation and engagement has commenced. This will include co-production to include families in the ongoing design and delivery of the ND service.

GUIDANCE ON THE DELIVERY OF NEURODEVELOPMENTAL SERVICES IN WALES

Written by the Neurodevelopmental Services National Steering Group, supported by 1000 Lives Improvement Team, Public Health Wales. June 2018

Introduction

This document provides guidance on the functions of Neurodevelopmental (ND) Services in Wales (currently provided for those with Autism Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD)). The services are inclusive of children who may also have learning disabilities and additional learning needs.

It has been developed in conjunction with key stakeholders, including those with lived experience and the third sector. All professional groups have been represented. The most up to date research and evidence have informed its content[1]. It also sits firmly in the context of the Parliamentary Review of Health and Social Care in Wales[2] and specifically the quadruple aim to:

- Improve population health and wellbeing through a focus on prevention
- Improve the experience and quality of care for individuals and families
- Enrich the wellbeing, capability and engagement of the health and social care workforce
- Increase the value achieved from funding of health and care through improvement, innovation, use of best practice and eliminating waste.

Purpose

Whilst this document provides a framework for the delivery of services, it does not supersede clinical judgement or new and emerging evidence. Though the pathway described is linear, the needs of the child should determine the actions to be taken.

[1] https://www.nice.org.uk/guidance/ng87 and https://www.nice.org.uk/guidance/cg128
[2] http://gov.wales/docs/dhss/publications/180116reviewen.pdf

This guidance is also intended to support ND teams to demonstrate the quality of their services and increase the understanding of demand for assessment and interventions.

The assumption made throughout is that families, and as appropriate children, will be equal partners in the assessment and, if needed, the delivery of interventions that will help and support the child and family in the most effective and prudent way possible.

In this document the terms child/children also refers to those commonly described as young people or adolescents.

Equity and diversity

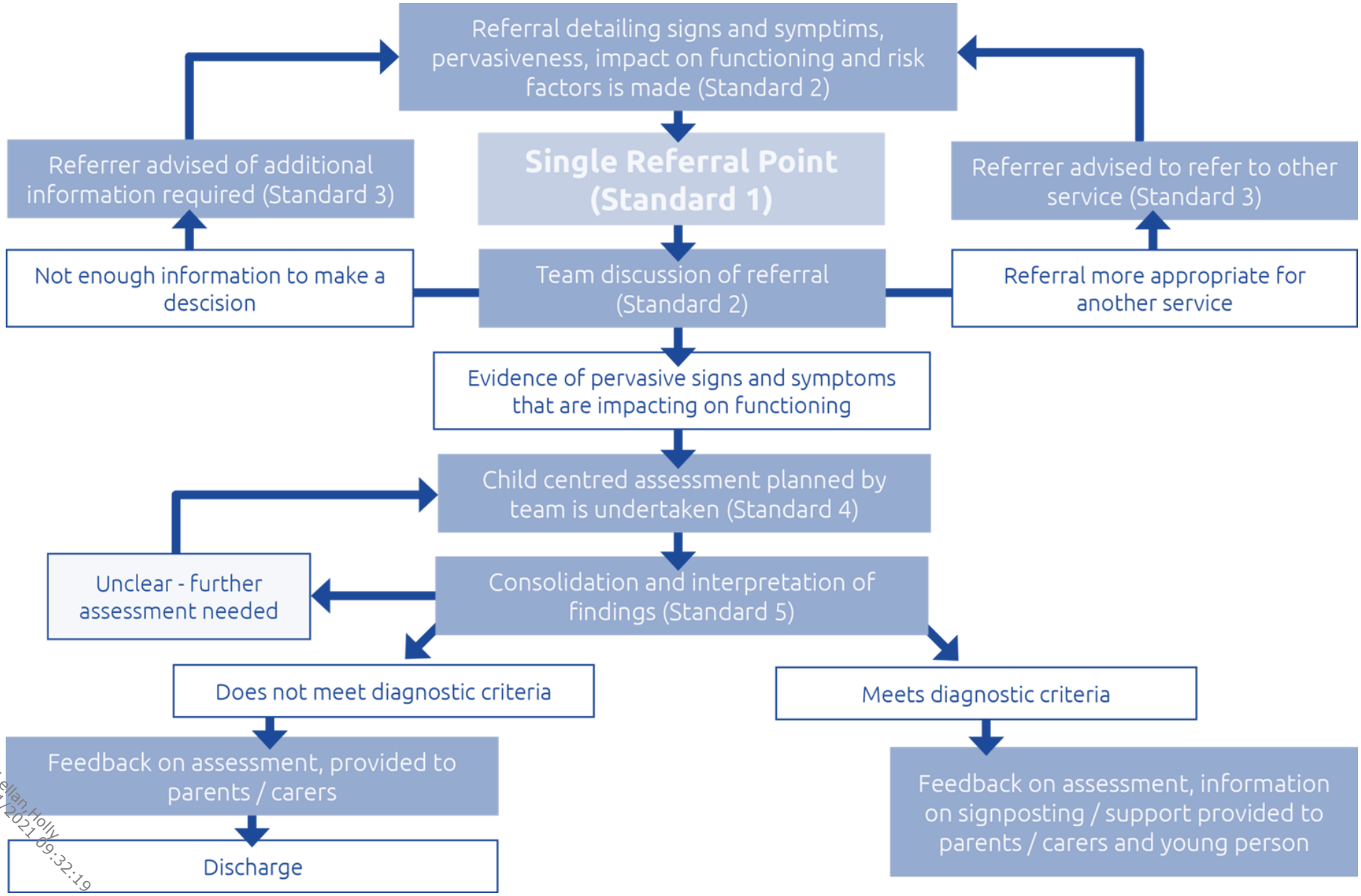
The Welsh Language Act (1993)[3] and the Welsh Language (Wales) Measure (2011)[4] set standards for public bodies regarding the provision of services in the Welsh language. Wales has a diverse range of people and cultures. In the creation of services that are designed to meet the needs of the whole population, health board planners are required to adhere to the Equality Act 2010[5] which specifies the *protected* characteristics; age, race, gender reassignment, disability, marriage and civil partnership, pregnancy and maternity, religion and belief, sex and sexual orientation.

The Equality Act also places a duty on public bodies to make reasonable adjustments for people with impairment, including mental impairment that constitutes a disability under the Equality Act. The reasonable adjustments that a person may need should be considered throughout a person's contact with services.

[3] http://www.legislation.gov.uk/ukpga/1993/38/pdfs/ukpga_19930038_en.pdf

[4] http://www.comisiynyddygymraeg.cymru/English/Commissioner/Law/The%20Welsh%20Language%20(Wales)%20Measure%202011/Pages/The-Welsh-Language-(Wales)-Measure-

[5] http://www.legislation.gov.uk/ukpga/2010/15/contents



Standards

The nationally agreed diagnostic assessment pathway and standards[6] published in 2016 have informed the development of this guidance. The standards were developed by clinicians to support equitable access to and provision of ND services in Wales. This guidance builds on those standards and suggests information to be collected by health boards to provide a clear picture of service demand, uptake and delivery. In addition to the referral to assessment waiting time targets required by Welsh Government, it is expected that additional quantitative and qualitative information will become available as services develop and mature. Auditing this information should enable health boards to make evidence-based decisions about the future provision of their ND services.

Tools and data dictionary decisions to support the collection of auditable information will be provided in a separate document.

Standard 1

There is a single point of access for diagnostic assessment of all neurodevelopmental disorders.

Referrers should be provided with guidance on the information they should send to the single point of access. To ensure equity of access to assessment the referral information required should be based on that described in the ASD[7] and ADHD[8] toolkits.

[6] http://www.goodpractice.wales/SharedFiles/Download.aspx?pageid=185&mid=3 26&fileid=653
[7] http://www.asdinfowales.co.uk/clinicians-toolkit-children
[8] http://www.1000livesplus.wales.nhs.uk/clinicians-toolkit-adhd-assessment

Standard 2

> The decision as to whether to accept a referral or not is made on the quality of information provided (as outlined in National Institute for Care and Health Excellence (NICE) guidelines). Where there is adequate information to support concern, access should not be subject to permitted referrers, the use of screening questionnaires or other specifications.

Referrals should detail signs and symptoms, pervasiveness, impact on functioning and risk factors, as described in NICE guidelines[9]. There should be a ND team discussion of the referral and a decision made as to whether to proceed or whether further information is required. To ensure equity of access, all efforts should be made to facilitate a diagnostic assessment if appropriate, even if some information is not available initially.

Standard 3

> When referrals are not accepted, the referrer is provided with rationale for this, alongside advice on how to improve the referral

When referrals are not accepted the referrer should be provided with a rationale for this, alongside advice about what additional information is needed to progress the referral and/or other service to refer to. It is expected a local protocol will be developed to ensure this information will be shared with the child and family.

Standard 4

Assessments are planned in a child centred way ensuring sufficient information to create a profile of the child's need is gathered (as outlined in NICE guidelines), whilst ensuring a prudent, flexible approach to the use of resources.

Children referred to a ND team for an assessment should have the assessment started within 26 weeks of the referral being received by the ND service[10]. Some children may need to be seen more quickly and teams should develop prudent ways to identify those that are in need of an expedited assessment. Assessments should be planned by the multidisciplinary ND team in a child centred way, ensuring sufficient information to create a profile of the child's needs is gathered, whilst ensuring a prudent, flexible approach to the use of resources. Children having an assessment should also be assessed for any related physical and mental health needs[11]. Assessing staff will need to be alert to the impact of adverse childhood experiences and/or any safeguarding considerations. Evidence that an assessment has been planned in a multidisciplinary, child centred way includes parents and/or children being provided with information about how the assessment will be conducted[12].

The assessment process should use evidence-based assessment tools, as described in the ASD and ADHD toolkits and NICE guidance. Tools however should not supersede clinical judgement. Assessing staff should be aware of new and emerging evidence to promote effective and prudent service delivery.

[9] http://asdinfowales.co.uk/managing-referrals/
[10] Welsh Government target
[11] NICE quality statement 2. https://www.nice.org.uk/guidance/qs51/chapter/Quality-statement-2-Assessment-and-diagnosis
[12] http://www.asdinfowales.co.uk/clinicians-toolkit-children and http://www.1000livesplus.wales.nhs.uk/clinicians-toolkit-adhd-assessment

Standard 5

There is a timely multi-disciplinary discussion with all those involved in the assessment process which leads to a decision about the outcome of the assessment, a profile of the child's strengths and difficulties and agreement on future. The implementation of this process can be locally determined.

To consolidate and interpret the findings from the assessment, there should be a timely multi-disciplinary discussion with all those involved. The implementation of this process can be locally determined. Consideration should be given to diagnostic criteria and guidelines ICD 10/11 and DSM 5 as well as clinical judgement. This will normally result in a report (or other document) which clearly details the supporting evidence for the outcome of the assessment.

Standard 6

A professional who has been involved in the assessment process will communicate the outcome of the assessment with the family (and where appropriate the child). This is followed up in writing, and where consent is given, should be shared with other professionals who support the child. For children who have received a diagnosis, advice about how best to meet the child's needs.

Professionals (or a professional) who have been involved in the assessment process will normally communicate face to face the outcome of the assessment to the family and where appropriate the child.

When this does not occur, clear reasons should be given. This will be followed up in writing and where consent is given, will be shared with other professionals who support the child.

To support a continued person centred approach, a profile of the child's strengths and difficulties should be produced; any advice and or recommendations will be included.

For children with a diagnosis of ASD and/or ADHD, a follow-up appointment with an appropriate member of the team should be offered if clinically indicated.

The following standards have been developed by clinicians since the original standards were published in 2016.

Standard 7

After assessment, next steps should be discussed with the family and as appropriate, child.

Post assessment consideration should be given to the following:

- The assessment and profile may identify the need for some specific interventions. Those interventions should be proportionate to identified need, evidence-based to achieve identifiable outcomes in a stated timescale and not solely driven by diagnosis.

- Information and education should be provided on the core features of the child's diagnosis. This may include written information, one to one sessions or workshops. If no ND diagnosis is given, other relevant information should be given. Information on seeking a second opinion should be provided if required[13].

- Signposting to relevant support and other information may also be provided. This could include any additional learning needs identified.

Standard 8

Interventions advised and offered by neurodevelopmental services should be based upon the best possible evidence.

Data collection

An all Wales data set has been developed following referral for a ND diagnostic assessment. Data collection methods for the other measures identified in the document will need development and dissemination. Suggested data collection items and audit questions can be found at the mental health and learning disabilities 1000 Lives web page.

[13] National Steering Group protocol for second opinion http://www.1000livesplus.wales.nhs.uk/sitesplus/documents/1011/2018-03-13%20Protocol%20for%20second%20opinion-re-%20assessment.pdf

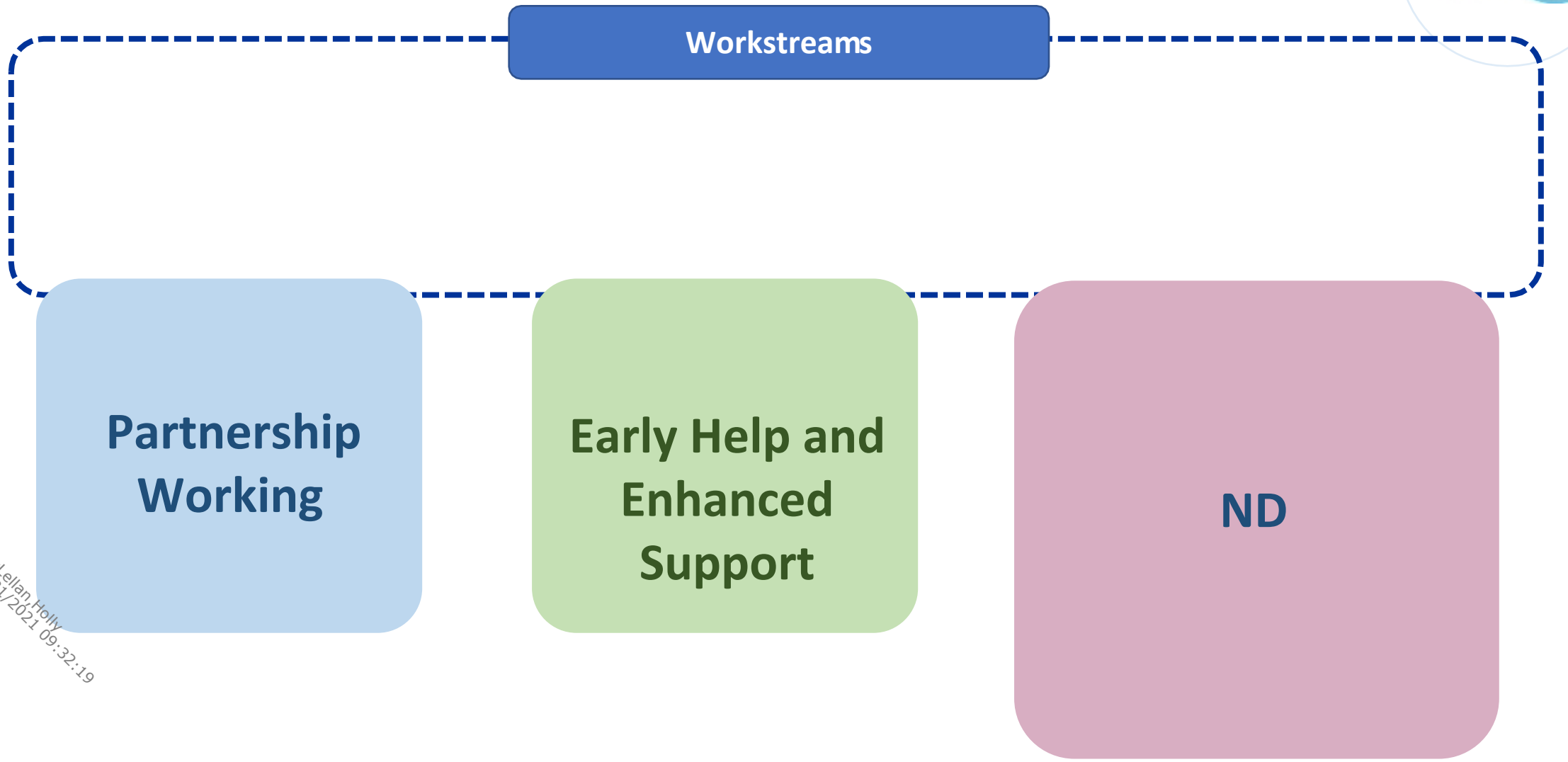
Together for Children and Young People (2) Programme
Neurodevelopmental Work Stream

Vice Chairs Peer Group 9 June 2021

Dr Cath Norton

National Clinical Lead for Neurodevelopmental Services

T4CYP (2)



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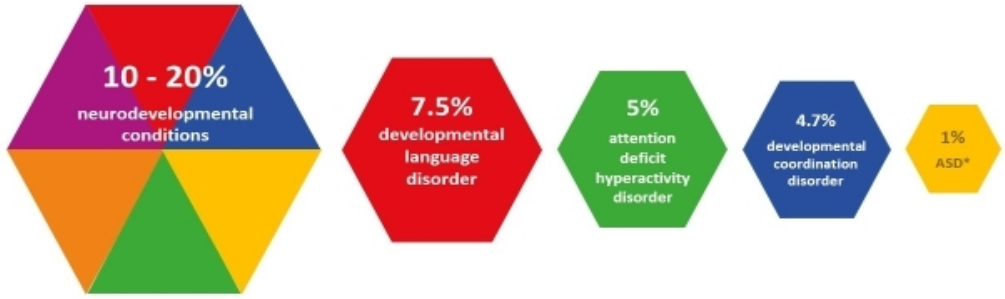
Context Setting

- **Embedding National Standards**
  - **Challenge of demand and capacity pre and post Covid**
  - Understanding historical rationale to investment in ND services
  - Understanding demand, experience and research to shape long term vision ?
  - Alignment regarding training ,workforce , resources, Professional Learning and process(IT)

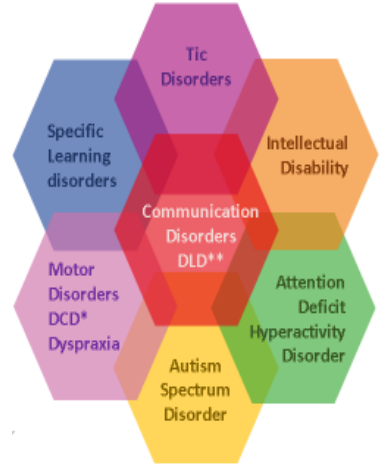
- **Bigger Picture**
  - Neurodiversity- language ,culture and values
  - Co Production, Early support, CYP focussed
  - Welsh Model - a fusion

- **Concrete Actions**
  - **Digital Profiler Tool**
  - Centre of excellence

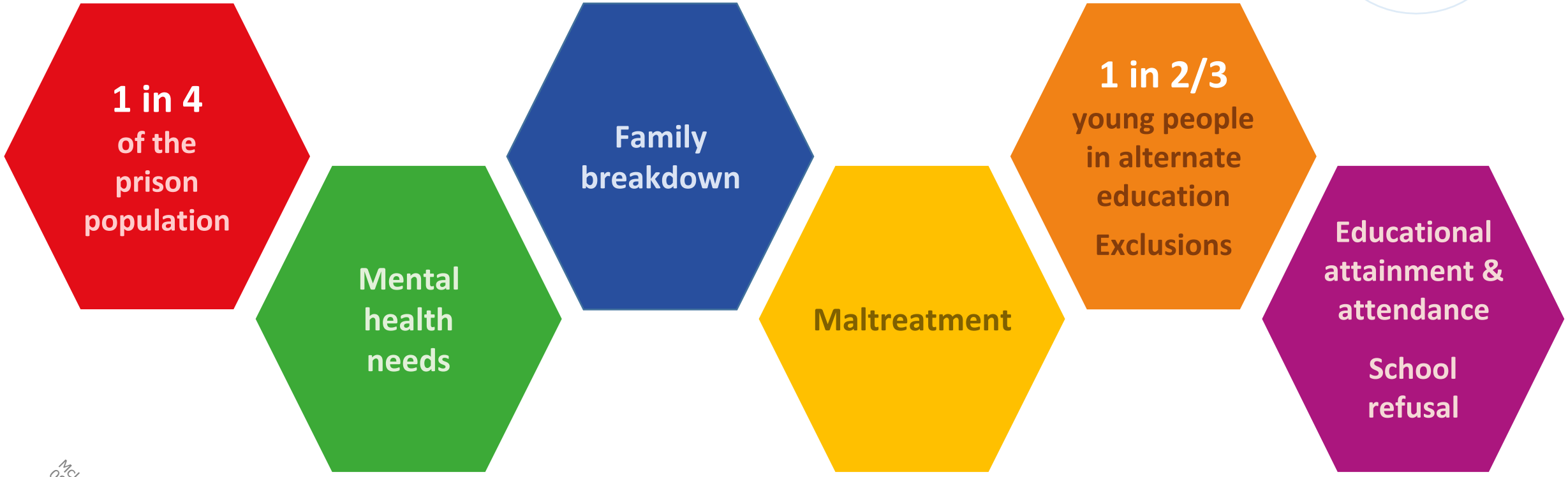
A Neurodiverse approach



- What experience & academics tell us
- Neurodiversity is common
- Co Morbidity is common
- Co Occurrence of symptoms can make diagnosis challenging
- They are Trait disorders with no clear cut off
- There are genetic factors yet siblings present differently
- Environment has an impact



Lifetime Impact

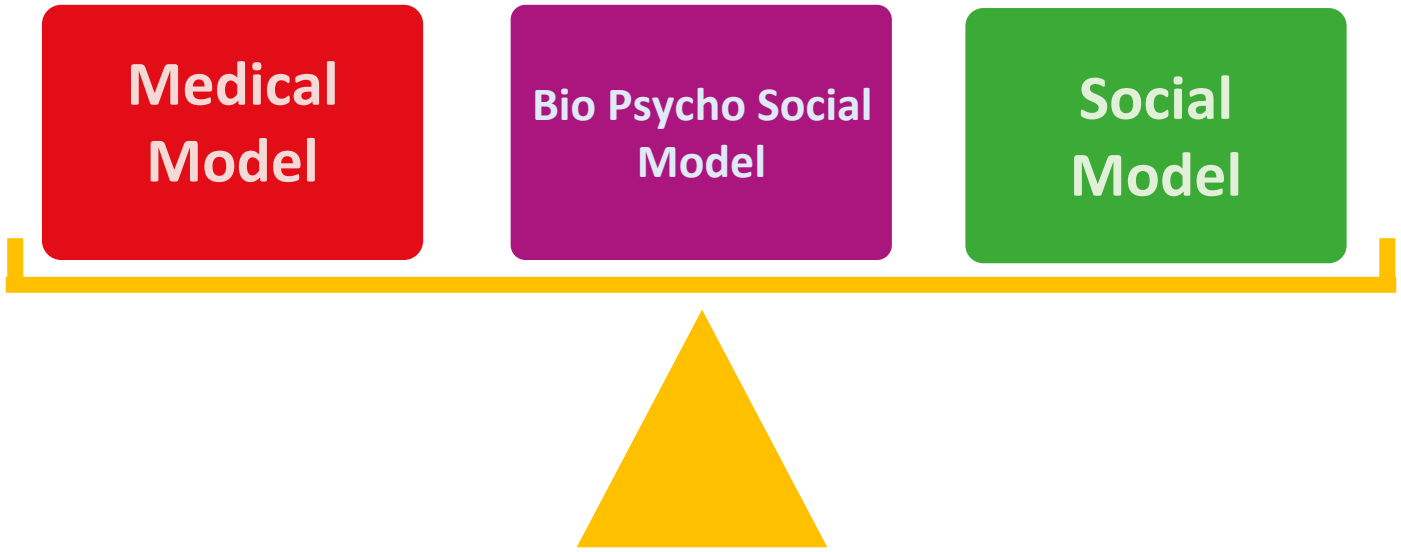


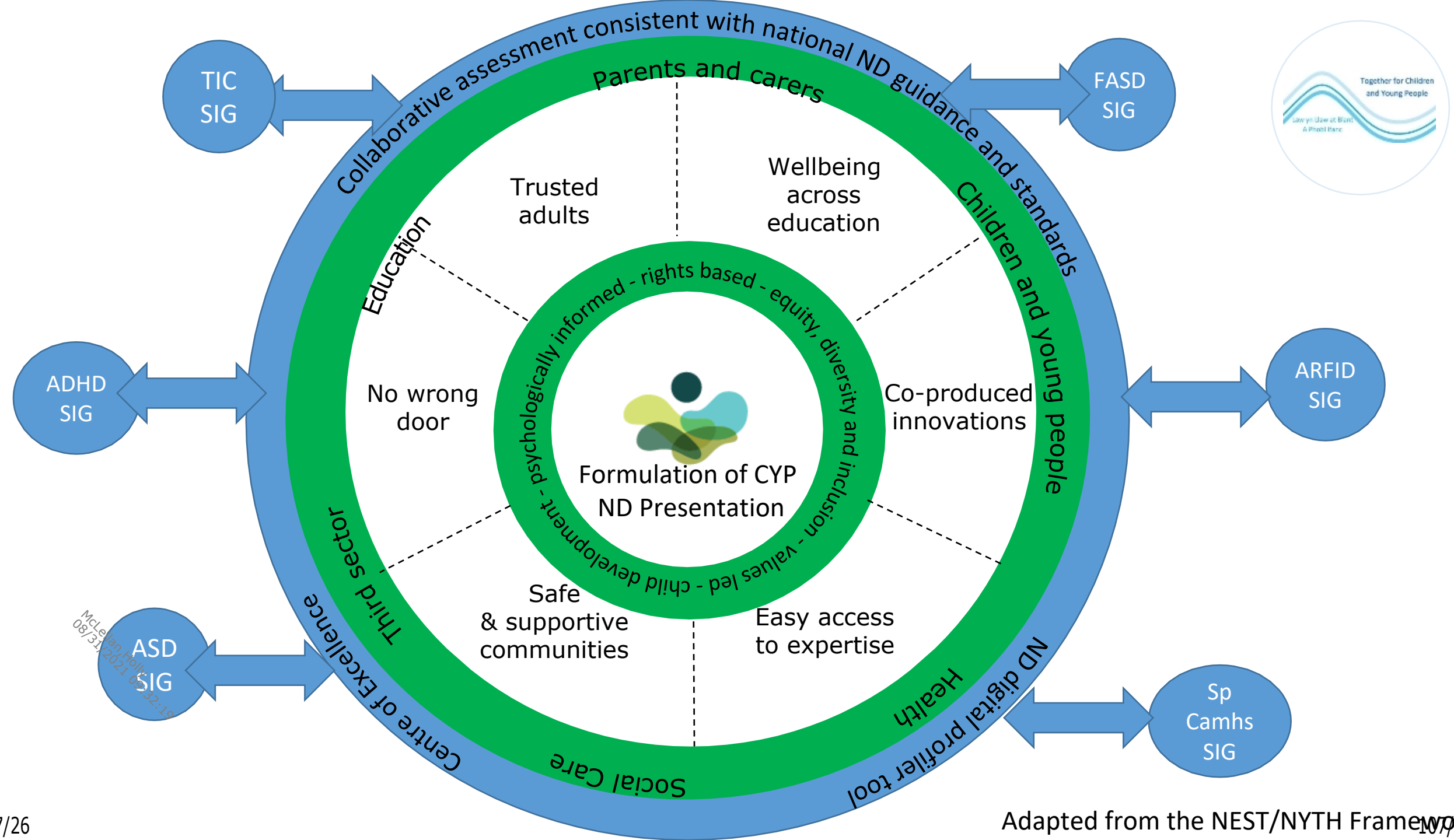
The cost of ADHD and ASD alone in children and adults in the UK, is more than £40 billion per year in treatment, education, lost earnings, care & support.

(Based on figures from the UK and Australia.)

Difference not Disorder

Shifting The Balance





Adapted from the NEST/NYTH Framework

NEST holistic formulation

"held"

Specialist Guidance

"supportive"

NEST holistic formulation

"held"

Specialist Guidance

"supportive"

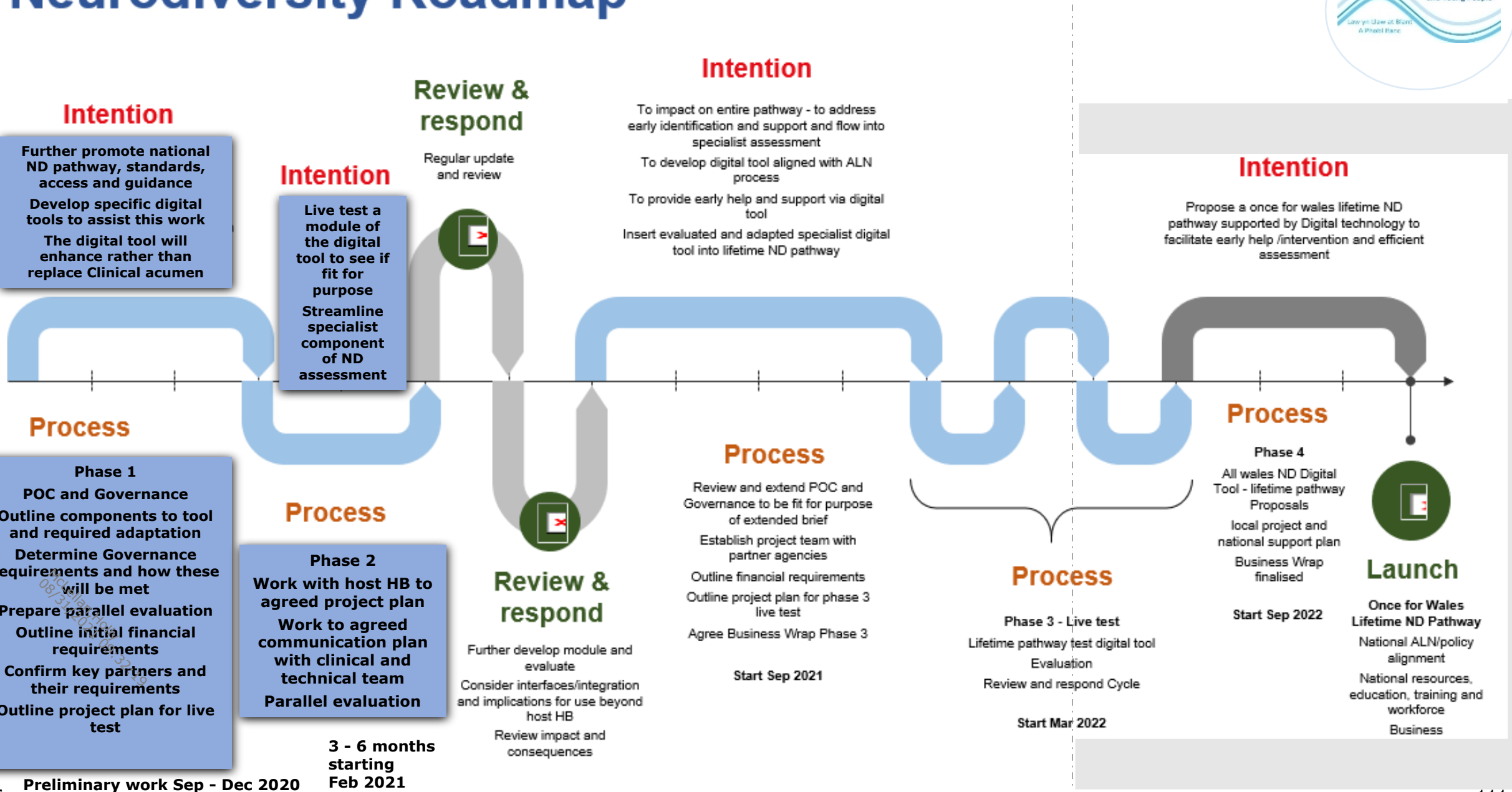
Moving Beyond Concept into Concrete Actions

- Facilitate holistic assessment to streamline and enhance the process
- Digital technology:
  - Collation and organisation of reported information
  - National guidance on use of telemedicine

Platform

  - Customisation and further unique development of existing Do It software- developing the diagnostic ND patient management aspects
  - USP: CYP centred, holistic, function, early advice & support, improve efficiency, Facilitate clinical assessment and diagnosis, support Implementation of the National ND Standards
  - Evaluation from the start – outcomes and experience

Neurodiversity Roadmap



Home

Parent/Guardian 0 / 1

ND initial screen 0 / 1

Additional Modules 0 / 1

Your reports

You will be able to view your report once you have completed a module.

Welcome to Do-IT Profiler

Welcome to Do-IT Profiler. There are a series of modules to be completed in the folders on the left, which will help to highlight strengths and challenges.

You may like to watch the video below to learn how to use the Profiler.

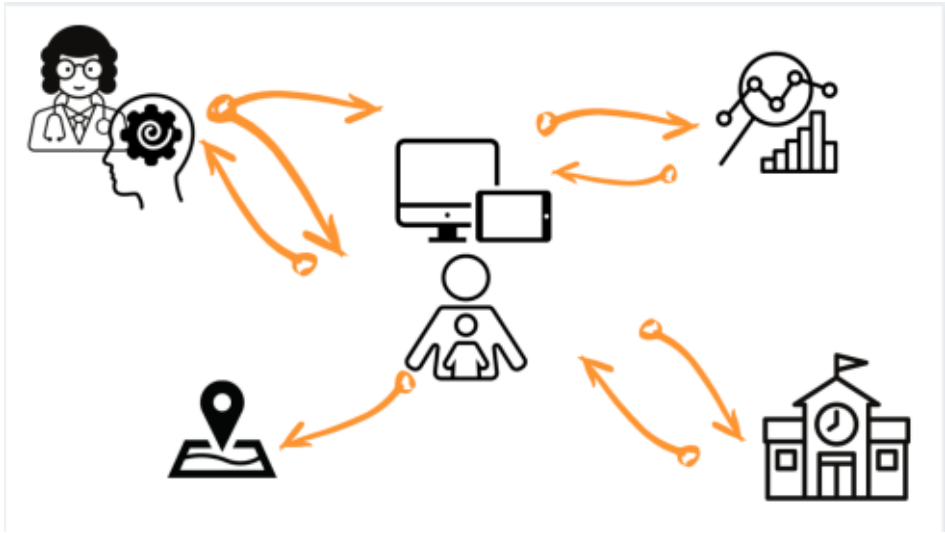
Any video can be inserted to welcome parents

When you are ready click 'Start'.

Reports

Start

- **Parent** – inputs information, produces an editable record and receives practical guidance, and monitoring tools.
- **Clinician**- access to formatted information, reducing admin and clinical time to triage and provide quicker guidance and manage clinical ’load’ effectively.
- **Education** – input information- to be developed



www.doitprofiler.com

Parent/Carer

Parent completes information in own time

Further information added where necessary

Record they can use to empower parents with practical personalized resources

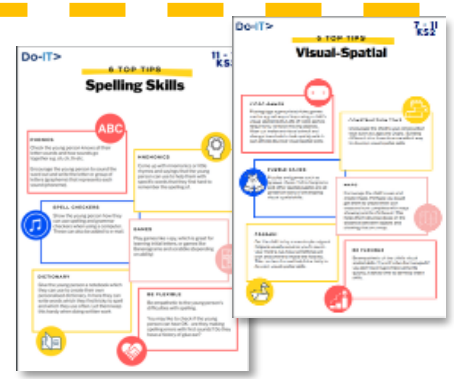
Clinical services

Clinical input

Person-centred ..leading to next steps

Educational and other services

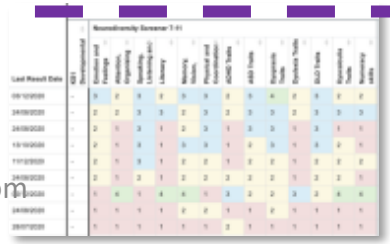
Email **alerts** service of completion



Practical resources

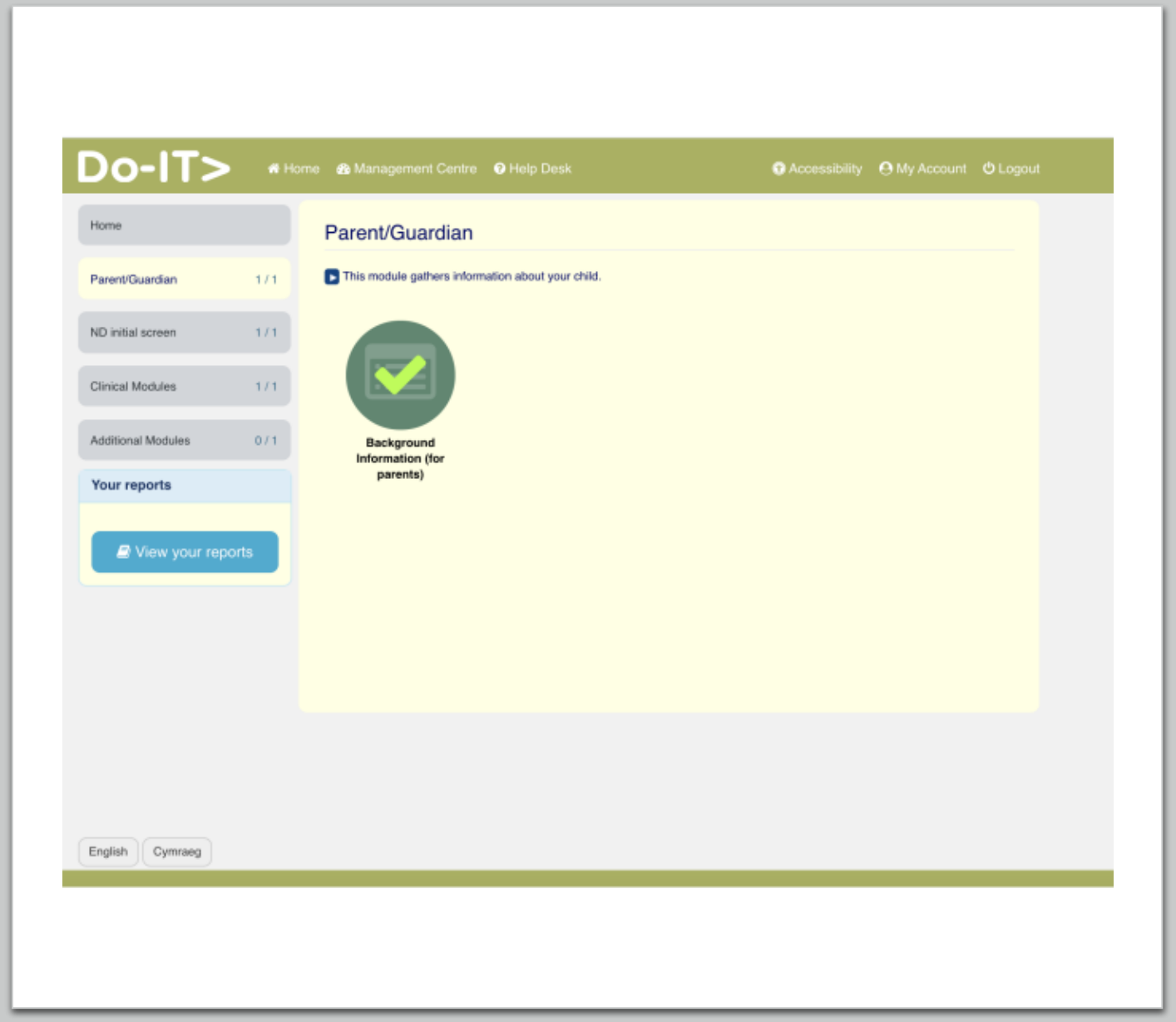
Data and admin

Macro data all collated instantly



Actions

- Parent module completed and ready to test
- Clinical module completed and ready to test
- Resource library being collated



www.doitprofiler.com

Automatically generated reports

Download Report Section (PDF)

Parent/Guardian

Parent/Guardian Concerns

Background Information (for parents)

Main Concerns

Main concerns: Why does this information disappear when I enter it

When did first concerns occur: I can enter information about my child so I don't need to type it this is really useful if I have difficulty in using the keyboard

Diagnosis: ADHD, Epilepsy

Currently or recently seen professionals: Occupational Therapist, Speech and Language Therapist

Birth and Early Developmental History

Planned pregnancy: Planned

Were you well during your pregnancy?: No

If no please describe: Asa

Medication during pregnancy:

Alcohol consumed during pregnancy:

When was child born:

What was labour like:

Special Baby Care Unit (SCBU) after birth:

Feeding until 4 weeks of age: Bottle fed

How did child feed: OK

Main carer - up to 6 months: Prefer not to say

Describe your child during first 6 months: Prefer not to say

How was main carer during this time: Felt low

Developmental History

Age first word spoken: Prefer not to say

Talking full sentences by 3 years of age: Prefer not to say

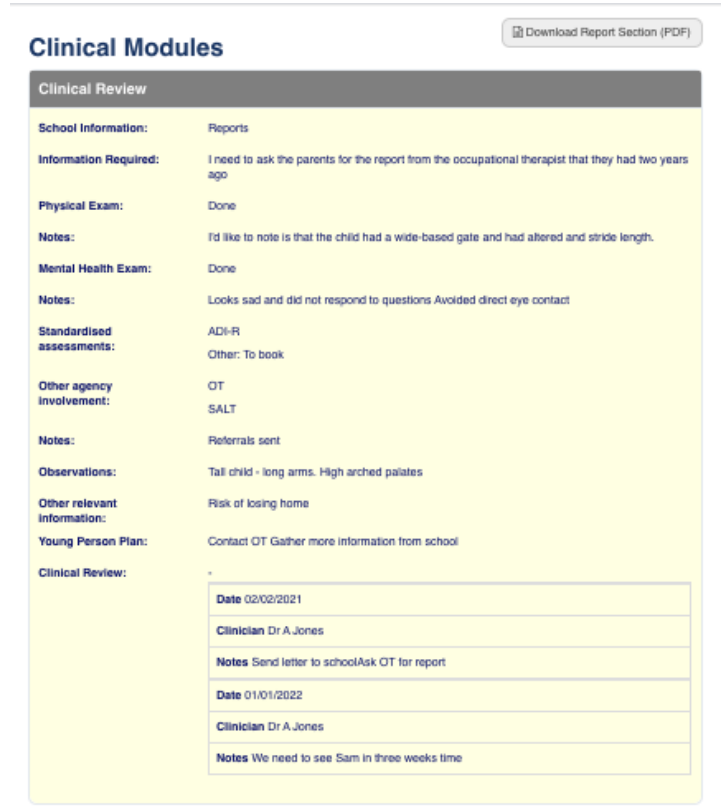
Understand child's speech by age 3-4 years: Can't remember

See the responses to this Background Information Module. Red dots next to responses indicate possible areas where further investigation may be needed.

The information from this module should be looked at with the results from the Neurodiversity Children's Profiler to gain a picture of the the 'whole child'.

You can find the child's Neurodiversity Children's Profiler Report in the left hand column at the bottom, as a separate report.

When we report traits in the Neurodiversity Children's Profiler associated with specific conditions this is an indicator only and **NOT** a diagnosis. We recognise that this information can help to stimulate further discussion or exploration with suitably trained professionals. When looking at the 'whole child' we need to consider the background information.



Download Report Section (PDF)

Clinical Modules

Clinical Review

School Information: Reports

Information Required: I need to ask the parents for the report from the occupational therapist that they had two years ago

Physical Exam: Done

Notes: I'd like to note is that the child had a wide-based gate and had altered and stride length.

Mental Health Exam: Done

Notes: Looks sad and did not respond to questions Avoided direct eye contact

Standardised assessments: ADI-R
Other: To book

Other agency involvement: OT
SALT

Notes: Referrals sent

Observations: Tall child - long arms. High arched palates

Other relevant information: Risk of losing home

Young Person Plan: Contact OT Gather more information from school

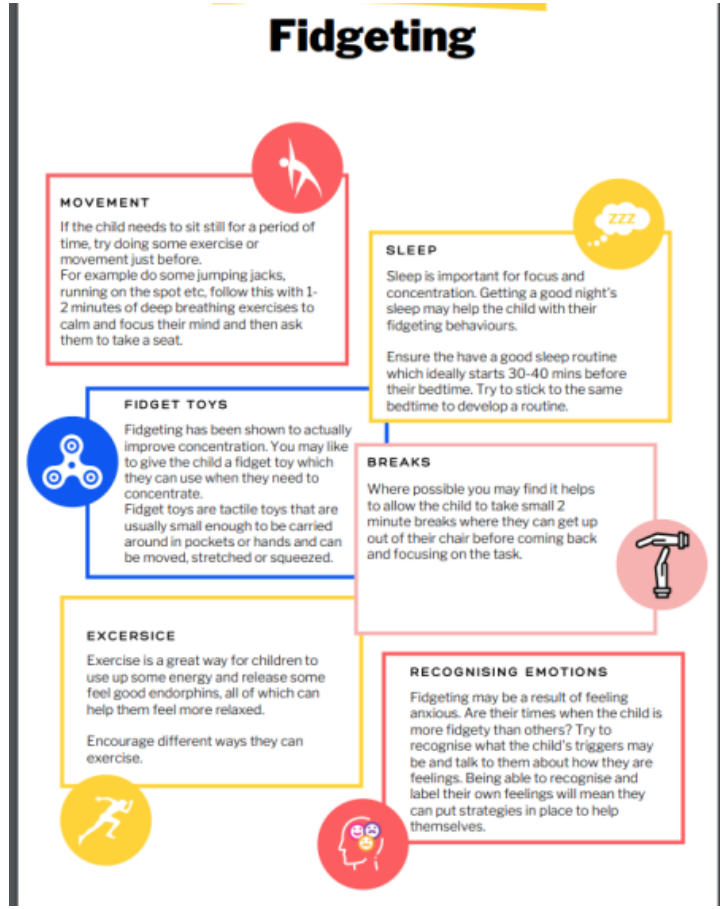
Clinical Review:

Date 02/02/2021
Clinician Dr A Jones
Notes Send letter to schoolAsk OT for report
Date 01/01/2022
Clinician Dr A Jones
Notes We need to see Sam in three weeks time

Age related personalised resources

-

Collated and contextualised



Progress during the period of March – May 2021

- Proof of Concept and Engagement sessions – "Do you feel that the ND Profiler would work from your expert viewpoint?"
  - Met with Clinical Representatives from all Health Boards.
  - National Lived Experience, Parental, and support Groups
  - Very high engagement and interest from all
  - Key recommendations for business process design; e.g. school and education will not always be a positive experience for parents ;
  - Future benefits and research for all stakeholders.

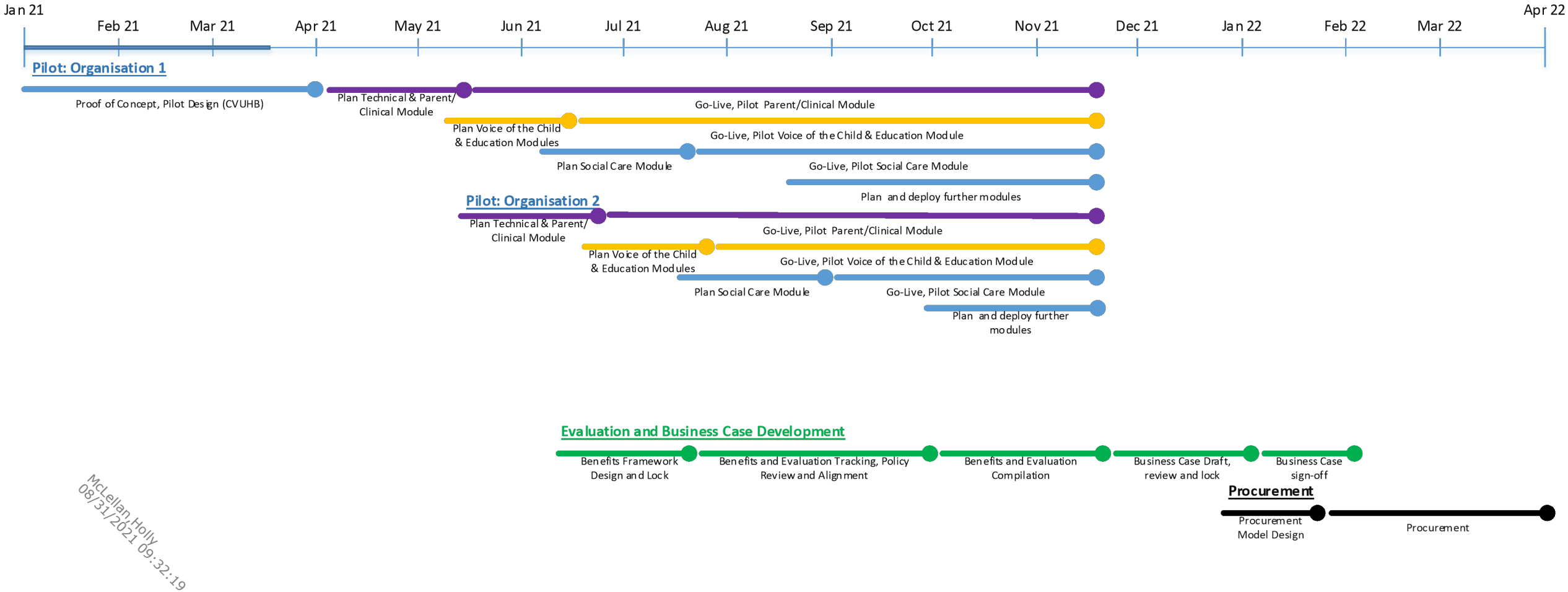
- Design of pilot proposal for Ministerial Group – from one to all RPBs.

- Design of key functional aspects of tool; i.e. consent, technical links.

Next Steps: May – July 2021

- 'Lock-off' the design and ambition for pilot and component modules.
  - Family and Specialist Services;
  - Scoping and planning for Education, 'Voice of the Child', and Social Care.
- Finalising pilots 1 and 2 – reviews with stakeholders as required.
- Implementation of localised project plans.
  - Families and parent communications and support
  - Services' business processes and ensuring full support;
  - Technical links and information flows;
  - Governance, safety, and security aspects as required for all e-health projects.
- Support to the evaluation model to ensure local and national ambitions reflect one another.

Pilot Design Option 4 –
Develop and deploy other modules, e.g. Monitoring Tools, Probation



Design of the Model:

Pilot: This is how up to four organisations can be brought on-board to pilot the solution with Parental, Clinical, Education, and Social Care modules by December 2021.

Evaluation and Business Case Development: Running parallel to the pilot, the evaluation (benefits, academic, experience) will be undertaken to deliver a business case from November and signed off by January 2022.

Procurement: From December 2021 the procurement work should begin so that when the business case is accepted and approved it will allow the award of contracts by April 2022 to happen.

Delivering Value Through Pathways

T4cyp (2) – Pathway Framework

PHASES AND STAGES WITHIN THE FRAMEWORK

OBJECTIVE	Why	Agree mandate - collaborative digital assessment and patient management Identify SRO Will this change over time? LHB V Tec Cymru V RPB V 3rd sector?
SCOPE	What and How (where and when)	What will be included in 2021 – 2022 ? - Pace of roll out, number of modules developed, parent, clinician, voice of the child, education, and social care and on going business realisation
AS-IS	Pathway Mapping	Cost of current implementation is mapped and intended benefits are set out to include efficiencies, experience and outcomes
TO-BE	Analysis Demand and Capacity Forecasting	We need to understand demand and capacity. Can we arrive at a position to make evidence informed decisions that lead to long term change? (VALUES BASED HEALTH CARE PRINCIPLES).
BENEFITS	Recommendations Process (cost) People (outcomes)	Re-iterate review of development including simplification and improved outcomes and experiences
WHAT WE DID	Benefits Realisation (evidenced improvement)	Co-production of an evaluation framework to measure longer term outcomes and experiences including big data potential (single repository etc)
WHAT'S NEXT	Education Prevention	Cross sector alignment and long term planning. Co- Create a long term vision for Wales

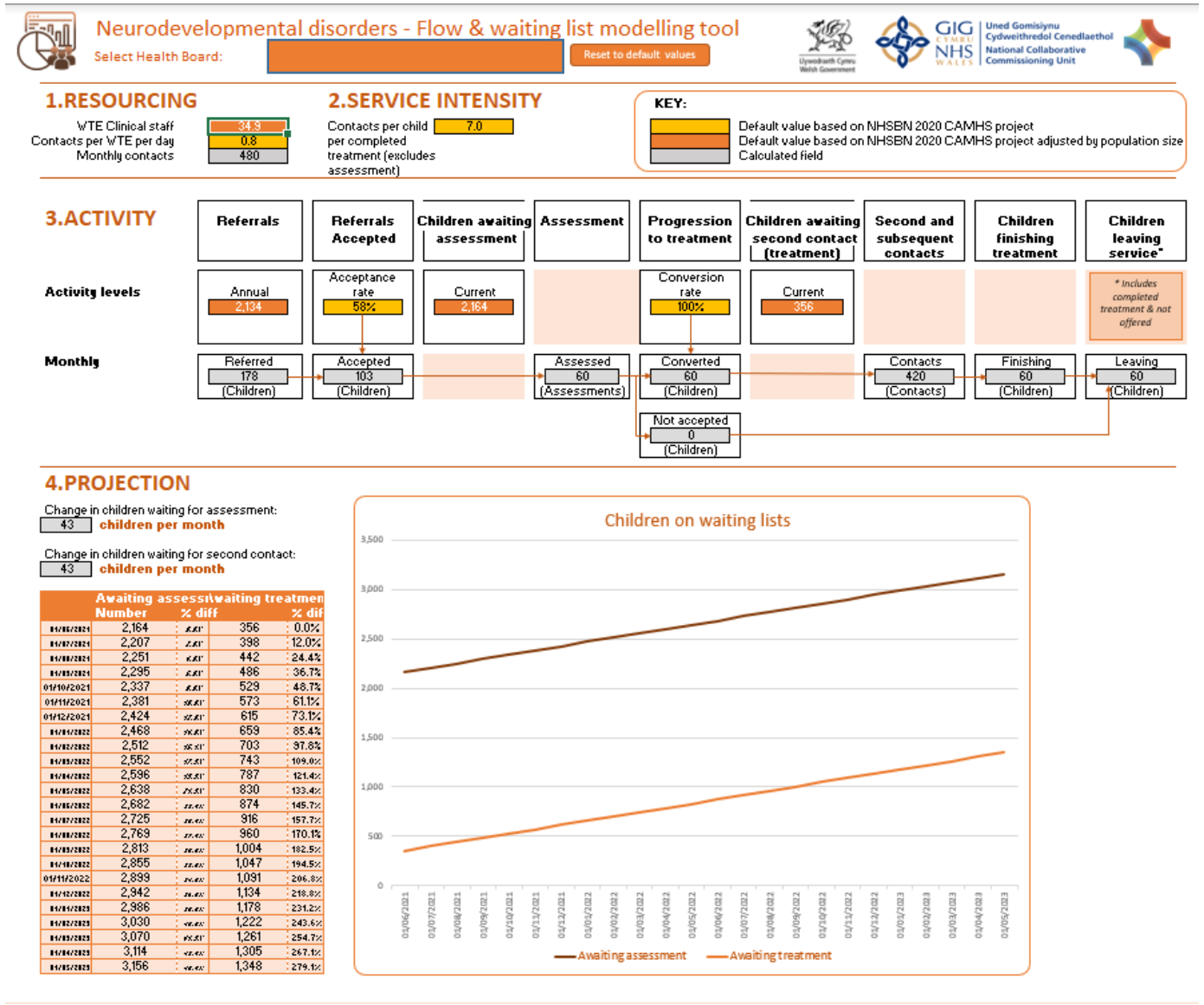
Supporting Demand and Capacity in ND services Across Wales

GIG CYMRU NHS WALES
Uned Gomisiynu Cydweithredol Cenedlaethol
National Collaborative Commissioning Unit

Llywodraeth Cymru
Welsh Government

GIG CYMRU NHS WALES
Delivery Unit
Uned Gyflawni

NHS Benchmarking Tool - pending update



Neurodevelopmental disorders - Flow & waiting list modelling tool

Select Health Board:

Reset to default values

Uned Gomisiynu Cydweithredol Cenedlaethol National Collaborative Commissioning Unit

1.RESOURCING

WTE Clinical staff	34.3
Contacts per WTE per day	0.8
Monthly contacts	480

2.SERVICE INTENSITY

Contacts per child per completed treatment (excludes assessment): 7.0

KEY:

- Default value based on NHSBN 2020 CAMHS project
- Default value based on NHSBN 2020 CAMHS project adjusted by population size
- Calculated field

3.ACTIVITY

	Referrals	Referrals Accepted	Children awaiting assessment	Assessment	Progression to treatment	Children awaiting second contact (treatment)	Second and subsequent contacts	Children finishing treatment	Children leaving service*
Activity levels	Annual 2,184	Acceptance rate 58%	Current 2,164		Conversion rate 100%	Current 356			* Includes completed treatment & not offered
Monthly	Referred 178 (Children)	Accepted 103 (Children)		Assessed 60 (Assessments)	Converted 60 (Children)		Contacts 420 (Contacts)	Finishing 60 (Children)	Leaving 60 (Children)
					Not accepted 0 (Children)				

4.PROJECTION

Change in children waiting for assessment: 43 children per month

Change in children waiting for second contact: 43 children per month

	Awaiting assessm		Awaiting treatmen	
	Number	% diff		% dif
01/06/2021	2,164		356	0.0%
01/07/2021	2,207		398	12.0%
01/08/2021	2,251		442	24.4%
01/09/2021	2,295		486	36.7%
01/10/2021	2,337		529	48.7%
01/11/2021	2,381		573	61.1%
01/12/2021	2,424		615	73.1%
01/01/2022	2,468		659	85.4%
01/02/2022	2,512		703	97.8%
01/03/2022	2,552		743	109.0%
01/04/2022	2,596		787	121.4%
01/05/2022	2,638		830	133.4%
01/06/2022	2,682		874	145.7%
01/07/2022	2,725		916	157.7%
01/08/2022	2,769		960	170.1%
01/09/2022	2,813		1,004	182.5%
01/10/2022	2,855		1,047	194.5%
01/11/2022	2,899		1,091	206.8%
01/12/2022	2,942		1,134	218.8%
01/01/2023	2,986		1,178	231.2%
01/02/2023	3,030		1,222	243.6%
01/03/2023	3,070		1,261	254.7%
01/04/2023	3,114		1,305	267.1%
01/05/2023	3,156		1,348	279.1%

Children on waiting lists

3,500
3,000
2,500
2,000
1,500
1,000
500
0

01/06/2021 01/07/2021 01/08/2021 01/09/2021 01/10/2021 01/11/2021 01/12/2021 01/01/2022 01/02/2022 01/03/2022 01/04/2022 01/05/2022 01/06/2022 01/07/2022 01/08/2022 01/09/2022 01/10/2022 01/11/2022 01/12/2022 01/01/2023 01/02/2023 01/03/2023 01/04/2023 01/05/2023

Awaiting assessment — Awaiting treatment

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Revisiting Key Asks – local level

0n 18 December 2020, the Programme wrote to the Vice Chairs with requests for support. Following a meeting with our ND Clinical Working Group in April, we believe some of these need to be readdressed:

- Supporting clinical teams to access adequate clinical spaces for face to face observations and assessments.
- Supporting the resourcing of clinicians' digital needs in terms of hardware and software.
- Regional support for workforce planning and recruitment
- Support with the above would help with issues reported by the ND teams across all Health Boards such as high caseloads, increasing waiting lists, high staff turnover/change in teams, vacancies and transitions.

Supporting key asks - National level

- Supporting the Balanced Neurodiverse approach.
- Facilitating organisational change and leadership.
- Developing a long term funding formula for ND.
- Supporting the COVID-19 Recovery, Revitalise and Renewal Plan.
- Developing a ten year plan – legacy and beyond.
- Aligning workforce strategy and development across partner agencies and sectors.

Powys THB Finance Department
Financial Performance Report
Delivery & Performance Committee

Period 04 (July 2021)
FY 2021/22

Date Meeting: 2nd September 2021

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

Introduction

Subject:	**FINANCIAL PERFORMANCE REPORT FOR MONTH 4 OF FY 2021/22**
Approved & Presented by:	Pete Hopgood, Director of Finance
Prepared by:	Sam Moss, Deputy Director of Finance
Other Committees and meetings considered at:	Board Delivery & Performance Group

PURPOSE:

This paper provides the Board/Committee with an update on the July 2021 (Month 04) Financial Position including Financial Recovery Plan (FRP) delivery and Covid.

RECOMMENDATION:

It is recommended that the Board/Committee:

- DISCUSS and NOTE the Month 4 2020/21 financial position.
- NOTE that actions required in 2021/22 to deliver a balanced position at the 31st March 2022, including savings delivery.
- NOTE and APPROVE Covid-19 Report position reported on page 8 and in the attachments detailed in appendix 1.
- NOTE additional risks on delivery of balanced position at 31st March 2022.
- NOTE underlying financial position and agree actions to deliver recurrent breakeven for 2022/23.

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	✘

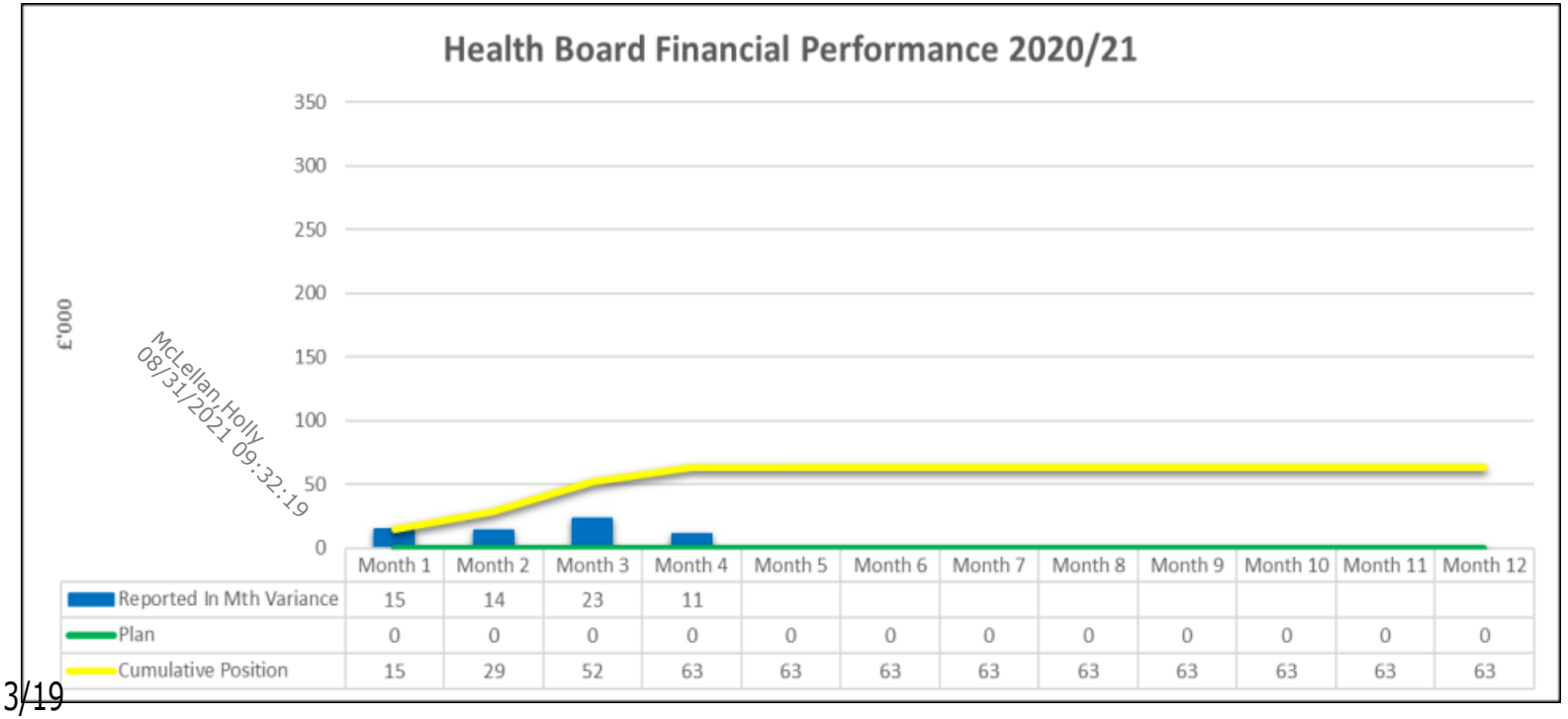
Approval/Ratification/Decision	**Discussion**	**Information**
	✓	

Summary Health Board Position 2021/22

Revenue		
Financial KPIs : To ensure that net operating costs do not exceed the revenue resource limit set by Welsh Government	Value £'000	Trend
Reported in-month financial position – deficit/(surplus) – Amber	11	↓
Reported Year To Date financial position – deficit/(surplus) –Amber	63	↑
Year end – deficit/(surplus) – Forecast Green	0	→

Capital		
Financial KPIs : To ensure that the costs do not exceed the capiral resource limit set by Welsh Government	Value £'000	Trend
Capital Resource Limit	15,125	→
Reported Year to Date expenditure	1,117	↑
Reported year end – deficit/(surplus) – Forecast Green	0	→

PSPP		
PSPP Target : To pay a minimum of 95% of all non NHS creditors within 30 days of receipt of goods or a valid invoice	Value £'000	Trend
Cumulative year to date % of invoices paid within 30 days (by number) @end Q4 -Red	87.1%	↓



	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	15	14	23	11								
Plan	0	0	0	0	0	0	0	0	0	0	0	0
Cumulative Position	15	29	52	63	63	63	63	63	63	63	63	63

Powys THB 2021/22 Plan was approved by the Board and submitted to WG on 31st March 2021, with an update provided on 30th June. Both submissions provided a balance plan for 2021/22.

As per 2020/21 spend in relation to Covid is included in the overall positon but is offset by an anticipated or received allocation from WG, as per the planning assumptions and so is not directly contributing to the YTD £0.063m over spend at Mth 4.

Excluding Covid the areas of overspend which are a concerning at this point in the year are the growth in CHC costs and ongoing increase above historic trend in variable pay.

The table on the next slide provides an overall summary. But this will include Covid spend.

PTHB continues to forecast a balanced year end position but there are significant number of risks and opportunities that the Board need to effectively manage to ensure this can be delivered.

PSPP figure shows a deterioration in the first quarter of 2021/22 compared to the final outturn for 2020/21, which is linked to the late payment of agency invoices. A further update will be provided at the end of Q2

Overall Summary of Variances £000's

	BUDGET YTD	ACTUAL YTD	VARIANCE YTD
01 - Revenue Resource Limit	(121,460)	(121,460)	0
02 - Capital Donations	(43)	(43)	0
03 - Other Income	(2,078)	(1,861)	217
TOTAL INCOME	**(123,581)**	**(123,364)**	**217**
05 - Primary Care - (excluding Drugs)	14,198	14,100	(98)
06 - Primary care - Drugs & Appliances	10,240	10,527	287
07 - Provided services -Pay	29,091	29,533	442
08 - Provided Services - Non Pay	11,214	6,951	(4,262)
09 - Secondary care - Drugs	329	468	139
10 - Healthcare Services - Other NHS Bodies	46,295	48,349	2,054
12 - Continuing Care and FNC	5,071	6,249	1,178
13 - Other Private & Voluntary Sector	1,036	1,141	105
14 - Joint Financing & Other	4,792	4,792	0
15 - DEL Depreciation etc	1,411	1,411	0
16 - AME Depreciation etc	(95)	(95)	0
18 - Profit\Loss Disposal of Assets	0	0	0
TOTAL COSTS	**123,581**	**123,426**	**(154)**
TOTAL	**0**	**63**	**63**

Please refer to pages 5-8 for further information on key variances and actual performance .

Health Board 2021/22 Savings

2020/21 Plan	£ M
Savings Target 2020/21 as per IMTP	5.6
Recurrent Savings Delivered 2020/21	(0.5)
Unmet Savings C/F to Opening Plan 2021/22	**5.1**

2021/22 Plan	£ M
Unmet Saving Target b/f in Opening Plan 2021/22	5.1
Target to be Delivered Recurrently as per Financial Plan	1.7
Savings supported in 2021/22 by Covid Funding Assumptions	3.4

Saving Performance & Delivery 2021/22	£ M
Target 2021/22 as per Plan	1.7
Amber Schemes identified to date	0.0
Green Schemes identified to date	0.0
Shortfall / (Over Achievement) on Identified Schemes	

Chart 1 Summary Identification Schemes against £1.7M Target

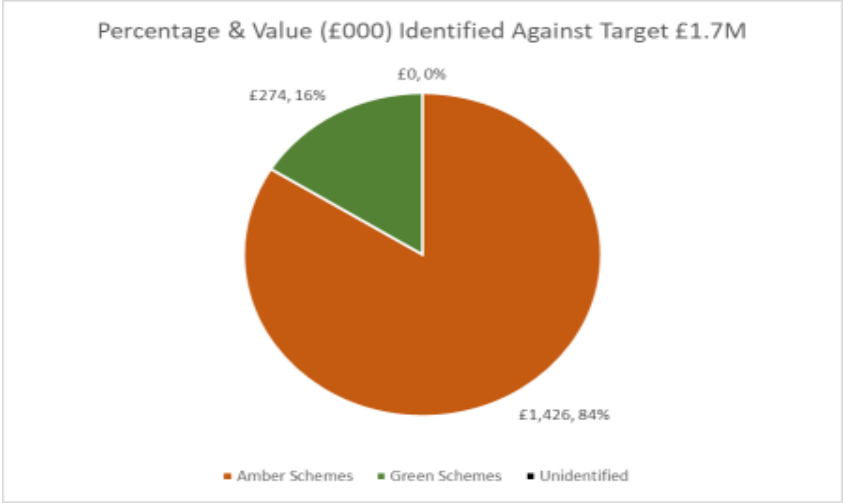
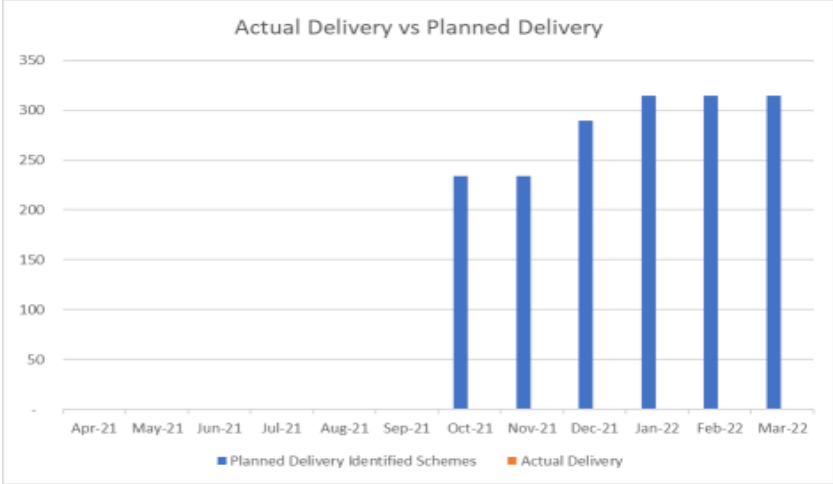


Chart 2 Summary Delivery Against Planned Schemes



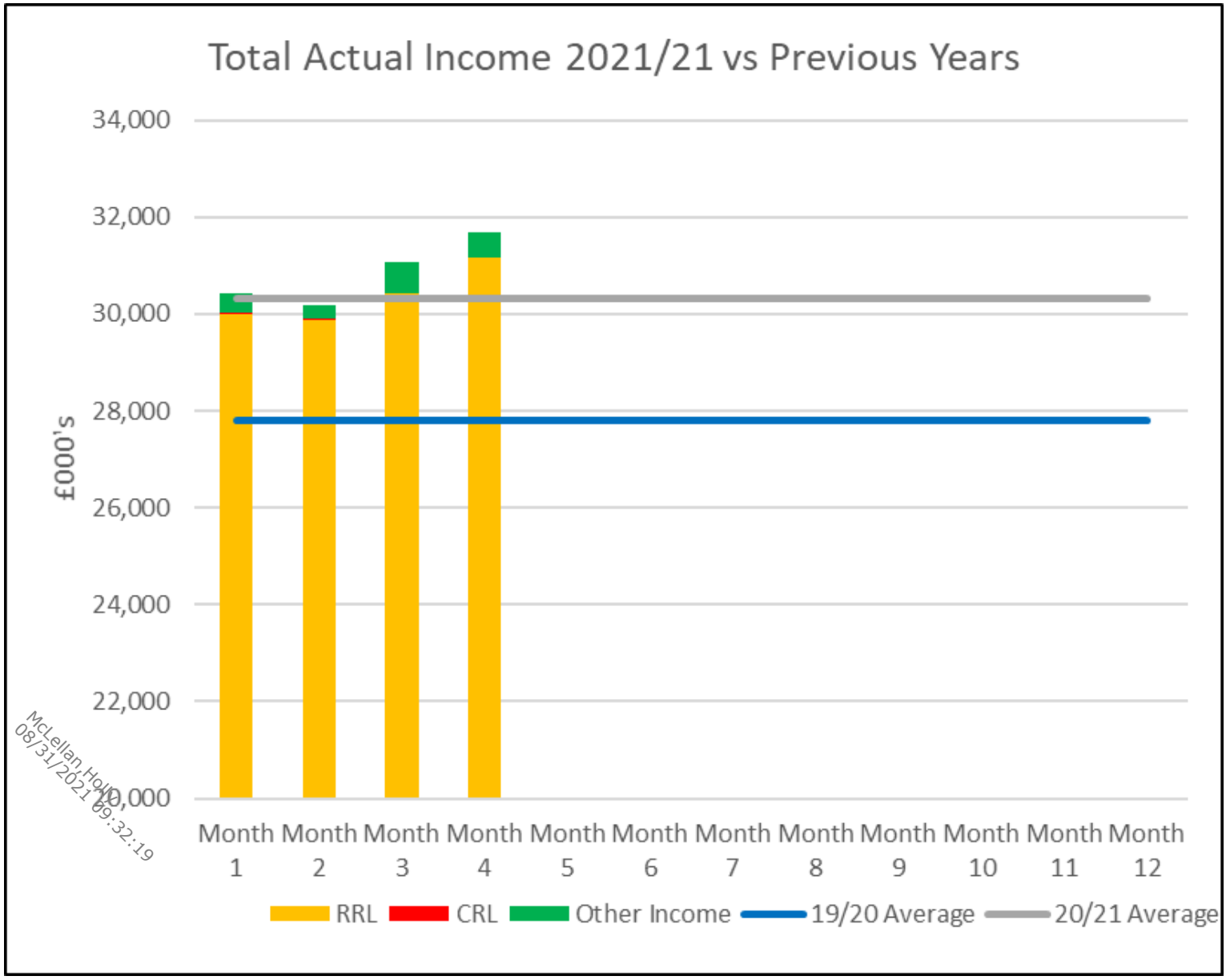
The HB has £5.1m of unmet b/f savings from 2020/21.

To achieve financial balance in 2021/22 £1.7m must be achieved, with the remainder supported by WG Covid funding.

As per Chart 1 for 2021/22 against the target of £1.7m only £0.275m is green and so confirmed to deliver. Details on he schemes identified to date can be found in appendix 6.

Chart 2 shows the schemes identified mapped against when they are planned to deliver by Month (blue bars). This will be updated to include actuals as these are achieved each month from Q3.

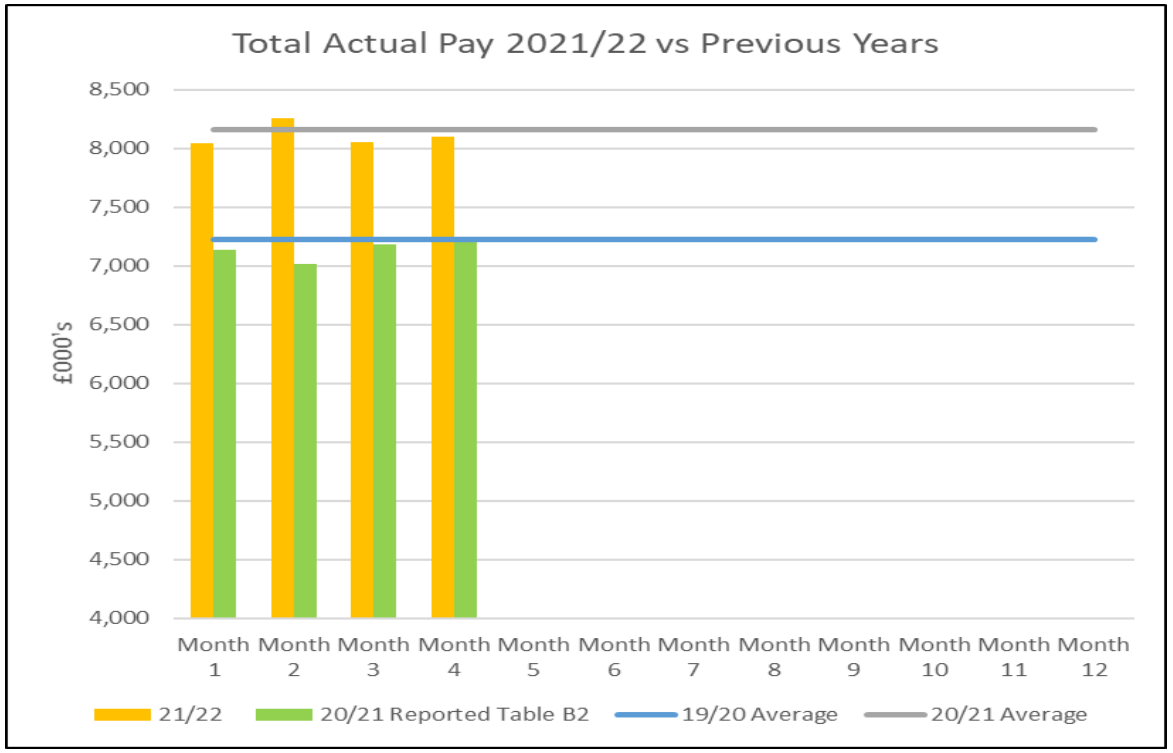
Health Board Actual 2021/22 vs Trend Previous Financial Years

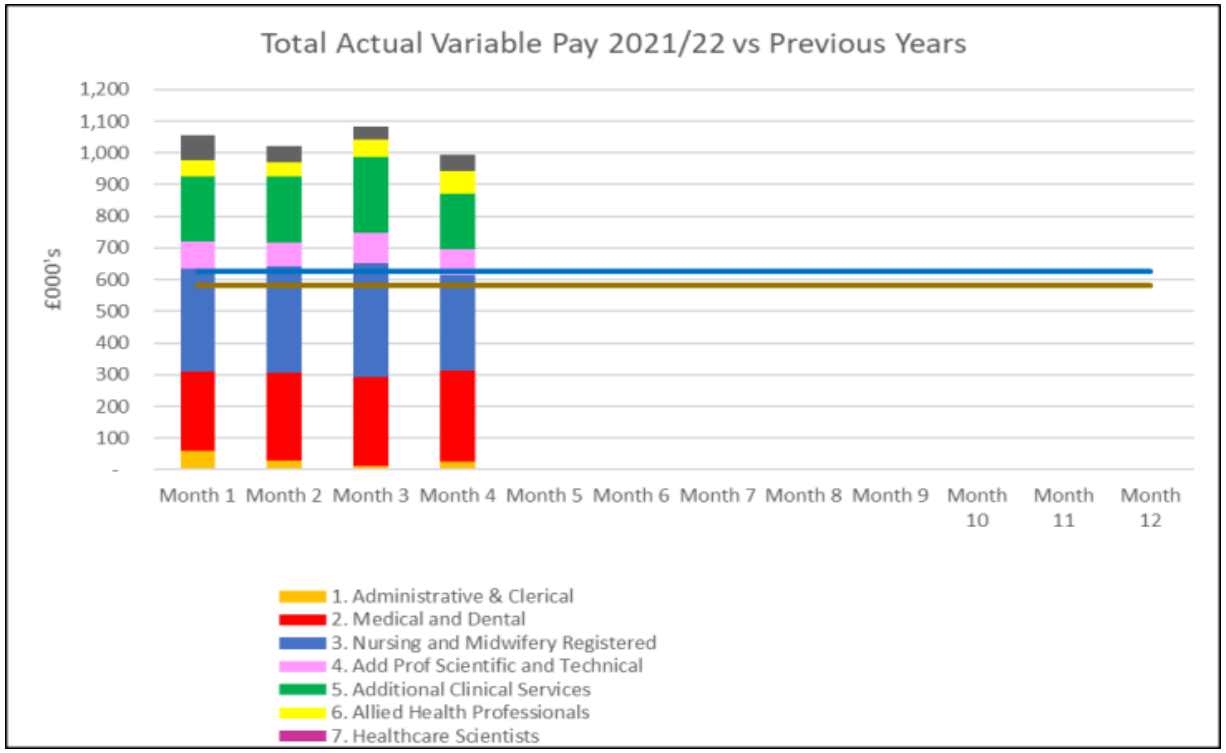


- The total income received in 2020/21 is significantly higher than the average for 2019/20 due to the £31M of covid funding received from WG and reported in detail in Note 34.2 on the 2020/21 Annual Accounts.

- For 2021/22 it is anticipated at this point in the financial year that the total funding for Covid as part of the RRL will be approximately £35M, and an element of this will be included in each month.

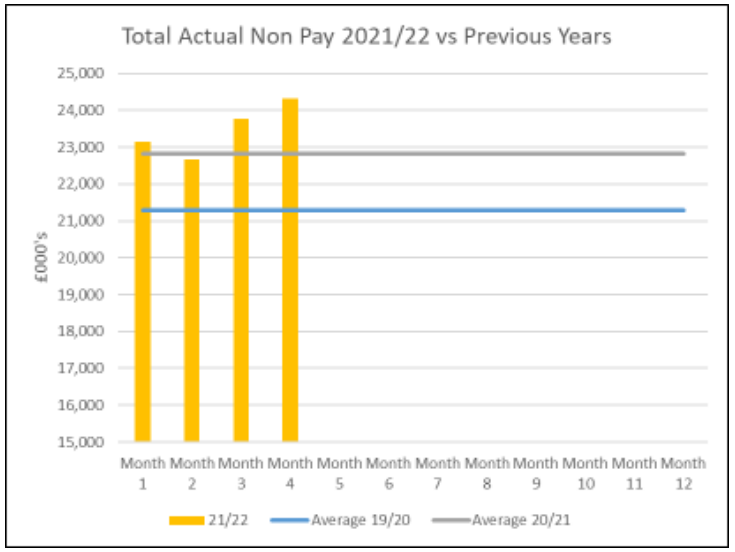
Health Board Actual 2021/22 vs Trend Previous Financial Years

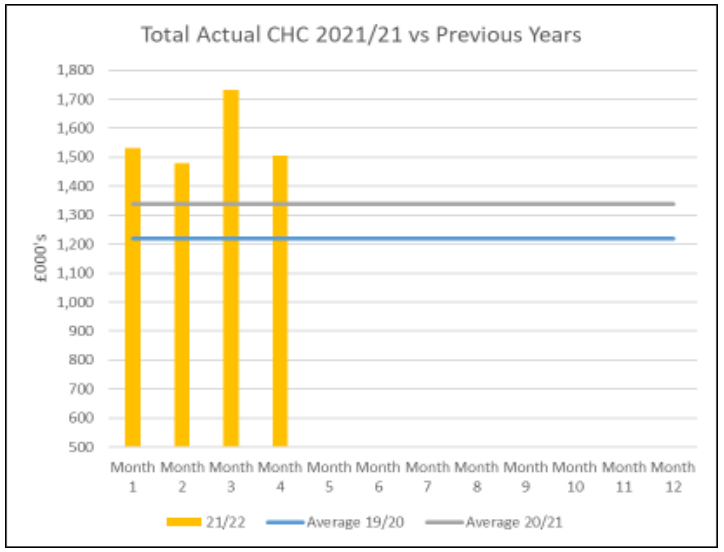


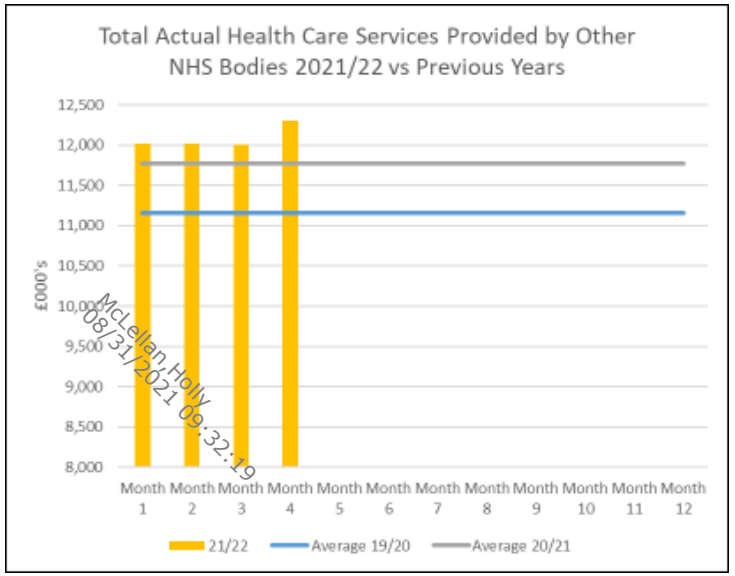


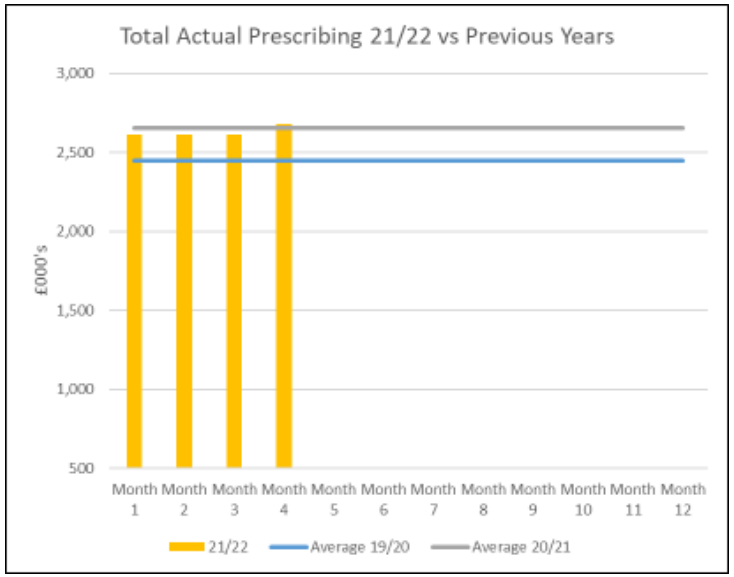
- The month 4 YTD pay is showing an over spend of £0.442M against the year to date plan.
- Chart 1 is comparing that the total pay position for 2021/22 with data from previous financial years. The green bars represent the total pay as per the MMR report (Table B2) in 2020/21 and the yellow the position for 2021/22, which clearly shows a stepped increase. This increase is two-fold. (1) is the additional staff in post supporting Mass Vac and TPP which were not in place in Mth 1-4 of 2020/21. (2) The increase in the Variable Pay position as per Chart 2.
- In comparing the average from 2020/21 to the actuals in 2021/22 it should be noted that the 2020/21 figures include the bonus payment accrued at the end of 2020/21 along with the notional pension adjustment required by WG in March 2021 and the annual leave provision.
- Chart 2 on variable pay demonstrates there has been a significant increase in Mth 1-4 compared to the 2019/20 and 2020/21 average. Discussions are ongoing with the service areas to understand the issues driving this and what actions can be taken to mitigate this growth in actual spend.

Health Board Actual 2021/22 vs Trend Previous Financial Years









- Actual Non Pay spend in 2021/22 YTD is significantly higher than the average trend from 2019/20 and slightly higher than the average for 2020/21, which will contain Covid costs along with 2021/22 uplifts for some areas. There are 3 key areas of focus:

1. Commissioning – currently the LTAs are paid on a Block arrangement as per the guidance from the DoH and WG as a consequence of C-19. This is based on the 2019/20 Mth 9 position for England and Year End Position for Wales plus relevant uplifts. These figures will also contain the growth in WHSSC and EASC, which are both outside the block arrangements.

2. ChC – there has been a significant increase in costs seen in Mth 1-4, which excludes any costs associated with Covid and Adult Social Care guidance. CHC has been included as a significant risk in table 1 page 9 and Appendix 5 provides the forecast to 31st March 2022.

3. Prescribing – the Mth 3 position is based on the Mth 10 PAR information, which has provided a reduction in spend compared to the first 6-9 months of 2020/21. The first PAR reports for 2021/22 has been received but the HB will require 3 months of data before it can assess a robust forecast position for 2021/22.

Covid Summary – Revenue Only

Table 1: Summary Table B3 (see Appendix 1)

Area	Mth 4 Actual £000	Forecast 2021/22 £000
Testing	367	1,250
Tracing	1,272	4,292
Mass Vaccination	3,125	8,363
Extended Flu	-	137
Field Hospitals	-	-
Cleaning Standards	188	564
General Covid	2,771	10,982
Recovery & Renwel Programme	15	3,221
WG Projects#	233	1,016
Total Table B3	**7,971**	**29,825**

Table 2: Breakdown of General Covid

General Covid	Mth 4 Actual £000	Forecast 2021/22 £000
Staffing	579	1,842
Loss Dental Income	300	1,445
Primary Care Prescribing	600	1,800
PPE	85	348
Block LTA	1,113	3,343
Adult Social Care (CHC/FNC)	-	1,236
Other Non Pay	94	967
Total General Covid	**2,771**	**10,982**

- Note relating to Table 1. Within Table B3 are 'projects' that WG deem are also linked to Covid. We are directed by WG to include these within Table B3.

Additional Risk & Opportunities Above Financial Forecast

Table 1: Risk Reflected MMR

Risk	£ '000
Under delivery of Amber Schemes included in Outturn via Trac	-387
Continuing Healthcare	-2,100
Prescribing	-1,017
Pharmacy Contract	0
WHSSC Performance	-89
Other Contract Performance	0
GMS Ring Fenced Allocation Underspend Potential Claw back	0
Dental Ring Fenced Allocation Underspend Potential Claw bac	0
South Powys Programme	-2,000
Total	**-5,593**

Table 2: Opportunities Reflected MMR

Opportuntity	£ '000
Additional Savings Above Plan	200
WRP Slippage	283
Slippage on Funding	1,885
Total	**2,368**

Further details on risk and opportunities underpinning the forecast are documented in the WG Narrative Report attached to Appendix 1

Development of 2022/2023 Plan

The formal Financial Planning process will not commence until the Autumn, with the 2022/23 Allocation Letter issued in December 2021. However the table below starts to provide PtHB with the challenges faced by the organisation for 2022/23 and beyond based on the information available at this point. Please note this is a indicative figure which will change as the financial information and insight available develops.

Indicative Plan 2022/23	£ M
1. 2021/22 Opening Plan Deficit / (Surplus)	**5.600**
2. Recurrent Impact from 2021/22 Financial Year	
- Non Delivery of Recurrent Savings against 2021/22 Target	1.700
- Operational Growth #1	TBC
3. FYE New Investments Agreed via Execs direct IBG Process	0.528
4. FYE New Recurrent Investement Approved linked Renewal & Recovery & Other Areas	0.742
Forecast Gross Opening Plan Deficit / (Surplus) 2022/23	**8.570**
5. FYE Benefits to be delivered via New Investments (linked point 3)	- 1.046
6. Recurrent Saving Identified offset opening Unmet b/f Savings £5.1m	-
Forecast Net Opening Plan Deficit / (Surplus) 2022/23	**7.524**

- this will be expanded as the year progresses and further intelligence is gathered on recurrent pressures /increases in expenditure above the 2021/22 Plan.

Summary

In summary this paper identifies that:

- PTHB is reporting an over spend at month 4 for FY 2021/22 of £0.063M (see page 2).
- Financial Forecast to 31st March 2022 is to maintain a balanced plan based on plan summitted to WG and presented to Board on 31st March and 30th June.
- To date there £0.275m of green savings schemed have been identified by the Health Board for delivery in 2021/22 to meet the required target as per the plan of £1.7M. (see page 4) .
- PTHB has an Capital Resource Limit of £15.125M and has spent £1.117M to date (see appendix 1).

Key Messages

In summary the key issues being managed to support the financial position:

- In addition to the risks detailed in the table on Page 9 there are a number of assumptions that were included in the 2021/22 Financial Plan approved by the Board on the 31st March/30th June which are not reported here is detail but were included within the financial section of the Plan presented and submitted.
- One of the assumptions within the Plan is that the Health Board deliver £1.7M of savings, with the remaining unmet savings to be supported via assumed Covid funding to 31st March 2022.
- Any changes in the expenditure assumed within the plan will have an impact on the HB's ability to deliver a balance position based on the 'Opening Plan' position of £5.6M over committed. The 2021/22 Plan also assumes a level of Covid funding which is included as anticipated but yet to be confirmed in full by WG.
- Based on the principles presented to Board at the end of January no additional savings target was included in 2021/22 plan however this meant that all Budget Holders needed to remain within their funding envelope but as per the table on page 3 demonstrates some areas are not remaining within their budgetary levels.
- If to support patient care and ensure a safe service the costs for CHC and Variable pay continue at the levels seen in Q1 then there is a risk on the Health Boards ability to deliver financial balance is 2021/22.
- There are a number of further significant risks regarding the 2022/23 Financial Position and an initial assessment of the this is provided for the reader on page 10.

Powys THB Finance Department
Financial Performance Report - Appendices

Period 04 (July 2021)
FY 2020/21

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 Working Day 9.

MMR Narrative

Microsoft Word Document

MMR Tables

Microsoft Excel Worksheet

Mass Vac Tables

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Microsoft Excel Worksheet

TTP Tables

Microsoft Excel Worksheet

Recovery Tables

Microsoft Excel Worksheet

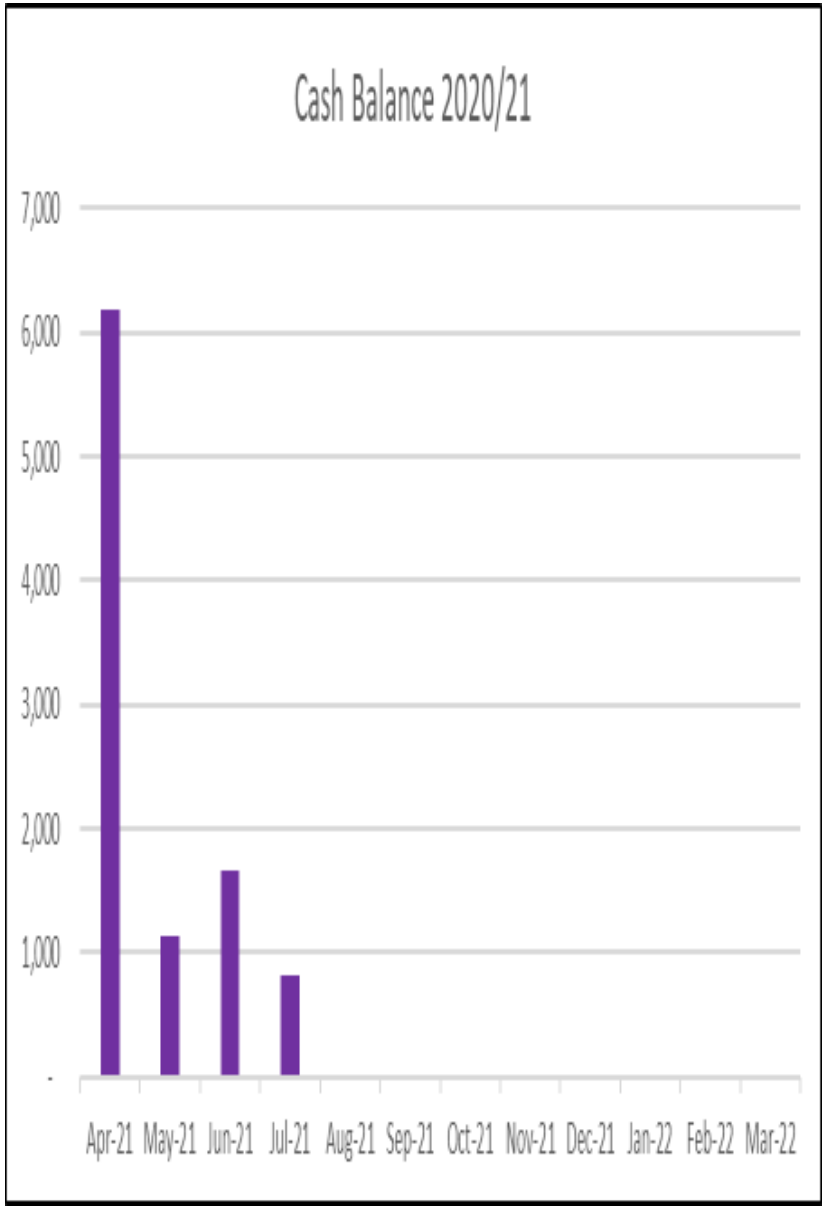
Capital 2021/22

Scheme	Capital Resource Limit	Annual Planned Expenditure	Expenditure to 31st July 2021
WG CRL FUNDING	**£M**	**£M**	**£M**
Discretionary Capital	1.431	1.431	0.413
Anti Ligature	1.001	1.001	0.069
Machynlleth	9.571	9.571	0.619
National Programmes – Fire	0.557	0.557	0.007
National Programmes – Infrastructure	1.331	1.331	0.000
National Programmes – Decarbonisation	0.332	0.332	0.009
National Programmes – Imaging	0.352	0.352	0.000
Covid Recovery 2021-22	0.550	0.550	0.000
Donated assets - Purchase	0.130	0.130	0.000
Donated assets (receipt)	(0.130)	(0.130)	0.000
TOTAL APPROVED FUNDING	**15.125**	**15.125**	**1.117**

Cash Flow 2021/22

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	2,627	6,184	1,123	1,658	822	500	500	500	500	500	500	500
Receipts												
WG Revenue Funding - Cash Limit (excluding NCL) - LHB & SHA	30,800	25,700	34,000	30,809	26,623	32,010	34,400	25,700	33,000	26,700	28,800	34,723
WG Revenue Funding - Non Cash Limited (NCL) - LHB & SHA only	- 160	- 160	- 160	- 160	117	- 160	- 160	- 160	- 160	- 160	- 160	- 160
WG Revenue Funding - Other (e.g. invoices)	1,551	42	13	85	10	10	10	900	10	1,000	10	1,000
WG Capital Funding - Cash Limit - LHB & SHA only	-	-	200	200	2,600	1,477	1,935	1,964	1,790	1,664	1,415	1,880
Income from other Welsh NHS Organisations	473	281	944	427	400	400	400	400	400	400	400	400
Other	1,064	248	353	1,506	400	400	400	400	400	400	400	400
Total Receipts	33,728	26,111	35,350	32,867	30,150	34,137	36,985	29,204	35,440	30,004	30,865	38,243
Payments												
Primary Care Services : General Medical Services	2,588	2,262	2,970	2,864	2,000	2,200	2,600	2,400	3,000	3,000	2,400	2,400
Primary Care Services : Pharmacy Services	448	-	318	898	-	500	1,000	-	1,000	-	500	1,000
Primary Care Services : Prescribed Drugs & Appliances	1,201	-	1,372	2,516	-	1,300	2,600	-	2,600	-	1,300	2,600
Primary Care Services : General Dental Services	342	433	469	434	420	420	420	420	420	420	420	420
Non Cash Limited Payments	77	169	86	84	100	100	100	100	100	100	100	100
Salaries and Wages	7,443	8,866	8,415	7,396	7,400	7,400	7,400	7,400	7,400	7,400	7,400	7,400
Non Pay Expenditure	18,069	19,312	20,729	18,983	18,892	20,517	20,930	16,920	19,130	17,440	17,330	22,293
Capital Payment	3	130	456	528	1,660	1,700	1,935	1,964	1,790	1,644	1,415	2,030
Other items	-	-	-	-	-	-	-	-	-	-	-	-
Total Payments	30,171	31,172	34,815	33,703	30,472	34,137	36,985	29,204	35,440	30,004	30,865	38,243
NET CASH FLOW IN MONTH	3,557	- 5,061	535	- 836	- 322	-	-	-	-	-	-	-
Balance c/f	6,184	1,123	1,658	822	500	500	500	500	500	500	500	500



Balance Sheet Reported 2021/22

	Opening Balance Beginning of Apr 21 £'000	Closing Balance End of Jul 21 £'000	Forecast Closing Balance End of Mar 22 £'000
Tanglible & Intangible Assets	78,394	79,537	79,537
Trade & Other Receivables	26,582	24,468	26,503
Inventories	159	159	159
Cash	2,627	822	500
Total Assets	**107,762**	**104,986**	**106,699**
Trade and other payables	45,831	34,535	42,570
Provisions	23,410	23,388	23,388
Total Liabilities	**69,241**	**57,923**	**65,958**
Total Assets Employed	**38,521**	**47,063**	**40,741**

Financed By					
General Fund	-	2,532	6,010	-	312
Revaluation Reserve		41,053	41,053		41,053
Total Taxpayers' Equity		**38,521**	**47,063**		**40,741**

CHC Forecast 2021/22 vs 2019/20 & 2020/21

Area	19/20 Year end Position	20/21 Year end Position	21/22 Forecast @ Mth 1	21/22 Forecast @ Mth 2	21/22 Forecast @ Mth 3	21/22 Forecast @ Mth 4	Growth From 2020/21 YE to 2021/22 Forecast @ Mth 4
Children	£267,217	£151,234	£156,944	£156,944	£156,944	£156,944	**£5,710**
Learning Disabilities	£957,455	£1,567,929	£1,058,879	£1,061,321	£1,251,771	£1,251,771	**-£316,158**
Mental Health	£7,344,265	£7,800,642	£9,274,740	£9,405,034	£9,635,927	£9,727,500	**£1,926,858**
Mid Locality	£981,064	£925,210	£1,250,038	£1,264,279	£1,315,651	£1,356,893	**£431,683**
North Locality	£1,365,243	£1,537,343	£2,448,278	£2,060,785	£2,145,513	£1,751,465	**£214,122**
South Locality	£1,494,868	£1,958,143	£1,825,436	£1,758,287	£2,100,826	£2,139,433	**£181,290**
Grand Total	**£12,410,112**	**£13,940,501**	**£16,014,315**	**£15,706,650**	**£16,606,632**	**£16,384,006**	**£2,443,505**

Detail on Identified Savings Schemes

Scheme Name	Workstream / Area	RAG Rating for Delivery	2021/22 £000
Lucentis Review (VBHC)	Pathways/VBHC	Amber	76
Frailty Model (VBHC)	Pathways/VBHC	Amber	100
Orthopaedic Coversion Rates (VBHC)	Pathways/VBHC	Amber	120
Nebulisers (VBHC)	Pathways/VBHC	Amber	20
Reduction Variable Pay (Workforce Eff Group)	Workforce	Amber	506
CHC Efficiency Group / Long Term Plan	CHC / Non Pay	Amber	255
Enhanced VAT Review	CHC / Non Pay	Amber	40
VBHC Review Cancer Drugs	Pathways/VBHC	Amber	-
Cataracts	Pathways/VBHC	Amber	-
Drugs of Low Priority/Deprescribing	Medicines Mangement Value	Green	35
Branded Prescribing Review	Medicines Mangement Value	Green	70
Medicines Optimisation	Medicines Mangement Value	Amber	80
Biosimilar	Medicines Mangement Value	Amber	40
Homecare	Medicines Mangement Value	Amber	10
Patent Expiry/Price Reduction	Medicines Mangement Value	Amber	50
Blueteq	Medicines Mangement Value	Amber	-
Rebates	Medicines Mangement Value	Green	165
Woundcare	Medicines Mangement Value	Amber	40
Medical Gases	Medicines Mangement Value	Green	5
Repatriation to Secondary Care	Medicines Mangement Value	Amber	10
Audiology Pathway	Pathways/VBHC	Amber	19
Ophthalmology In Reach	Pathways/VBHC	Amber	12
Rheumatology In Reach	Pathways/VBHC	Amber	6
Improved Procurement & Non Pay Savings	CHC / Non Pay	Amber	42
TOTAL			**1,701**

Further details on the savings are provided:

- On page 4 of this report;
- On tabs C,C1&C2 and C3 of the MMR Report embedded within Appendix 1

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.5

Delivery and Performance Committee	**Date of Meeting: 2 September 2021**
Subject :	**General Medical Services Out of Hours Performance 2020/2021**
Approved and Presented by:	**Executive Director of Primary Care, Community and Mental Health, Jamie Marchant**
Prepared by:	**Assistant Director of Primary Care, Jayne Lawrence**
Other Committees and meetings considered at:	**Delivery and Performance Group – 28th June 2021**

PURPOSE:
The purpose of this paper is to provide the Committee with assurance around the Out of Hours (OOH) service provision for Powys patients.
RECOMMENDATION(S):
The Committee is asked to 1) Note OOH performance during 2020/2021,recognising the challenges and limitations of reporting fully against the national standards and quality indicators. 2) Note and endorse the agreement by the Delivery and Performance Group to progress Commissioning Assurance Framework (CAF) reporting for OOH for implementation by year end 2021/2022

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

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

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

EXECUTIVE SUMMARY:

PTHB contracts with three providers to deliver its OOH services, namely 111, Shropdoc and Swansea Bay University Health Board (SBUHB). This paper summarises the service provided by all 3 providers including performance for 2020/2021.

The all Wales OOH standards are the national metric used to quality measure 111 and OOH services across Wales and were introduced in April 2019.

The PTHB OOH Performance Management Group, chaired by the Assistant Medical Director, monitors the performance management of OOH services across Powys for all three providers supporting the Powys service.

On the 1st Oct 2018 PTHB moved to the national NHS Wales 111 service as the first point of contact to access GMS OOH services and since moving to the 111 first contact model, the provider IT systems (Shropdoc and SBUHB) supporting the PTHB OOH service provision are not able to fully report against the OOH standards. This is an ongoing challenge and the PTHB OOH Performance Management Group seek alternative ways to gain assurance.

Moving forward and to overcome the ongoing assurance reporting deficiencies, PTHB has commissioned a bespoke development to enable PTHB access to a data feed to access all the data involved in a patient OOH contact, irrespective of the provider of the service to enable full reporting against the OOH standards. This will provide PTHB with assurance on both the quality and efficiency of the service it has commissioned with all providers since the inception of 111 in October 2018. Future robust reporting against the OOH standards should be available from quarter 3, 2021/2022.

Accurate national reporting is not solely a Powys issue and given the need for accurate national reporting a replacement IT system for 111 / Out of Hours, called SALUS, is currently being developed.

The 111 OOH offer to PTHB includes call handling and first line triage only. Nationally, 111 continue to have challenges to meet the calls abandoned and answered within 60 seconds. This is due to multiple factors including pandemic spikes, weekend demand variation, increasing patient complexity and the national rollout across Wales which constantly requires additional recruitment.

PTHB holds a contract with Shropdoc for the provision of Out of Hours General Medical Services and OOH medical cover at PTHB community hospitals. The service provides core GMS services (advice and face to face consultations) where assessed as required by the 111 Service component, who refer the patient onto Shropdoc for further clinical management. The face to face service may be accessed via patient attendance at a Powys Out of Hours Centre or via a Home Visit. Shropdoc provide PTHB with monthly reports detailing contract achievement against the All Wales OOH standards. Shropdoc performance against the standards is consistently very good, however an ongoing challenge is meeting the standard around completing home visits within 1 hour and 2 hours. Due to the geography of Powys and the achievement of both these standards will always prove to be challenging.

Rota and shift fill rate in Shropdoc have always been good, achieving in previous years fill rates over and above the all Wales average. During the pandemic fill rates have been exceptional. The current Shropdoc contract terminates in June 2022 and the bespoke reporting development referred to above will support future modelling and service development requirements to inform the next procurement process.

SBUHB, formerly known as ABMUHB have provided an OOH face to face service (only) for a number of years for Ystradgynlais patients. PTHB commissions an annual contract with SBUHB for the continuation of the service. Ystradgynlais patients are seen at a SBUHB OOH Centres during weekdays and offer access at Ystradgynlais Community Hospital on weekends.

Reporting on the relevant standard measures for the Powys element of the service is limited due to the inability of extracting Powys specific data and no data is available regarding assurance around timely patient access. The new national reporting IT system SALUS, will resolve this issue in 2022.

During 2020/2021 the Powys shift fill rate has dramatically improved due to the availability of GPs prepared to cover the YCH base on a Saturday, Sunday & Bank Holidays during the pandemic.

DETAILED BACKGROUND AND ASSESSMENT:

As part of the implementation of the new GMS contract in 2004, Health Boards became responsible for the provision of out of hours general medical services as the National Health Service (General Medical Services Contracts) (Wales) Regulations 2004 gave general practice the ability to opt out of out of hours services.
'the medical practitioner was relieved of responsibility for providing services to his or her patients under paragraph 18(2) of Schedule 2 to the National Health Service (General Medical Services) Regulations 1992(a); and…'

Out of Hours is defined as:

- 6.30pm to 8.00 am Monday to Thursday.
- 6.30pm Friday to 8.00am Monday on Weekends, and
- All day on public and bank holidays.

PTHB contracts with three providers to deliver its OOH services, namely

- 111
- Shropdoc
- Swansea Bay University Health Board (SBUHB)

This paper summarises the service provided by all 3 providers including performance for 2020/2021.

The all Wales OOH standards are the national metric used to quality measure 111 and OOH services across Wales and were introduced in April 2019. In September 2020 the standards were further refined by splitting the original Standards into two separate areas; National Measures (Part A) and Local Measures (Part B). The purpose of the National Measures are to be public facing and reported to Welsh Government on a monthly basis. The Local Measures are for local reporting only. **Appendix 1** details the current National Measures and **Appendix 2** details the Local Measures.

A summary of the National Measure Standards is as follows:

Internal KPI ref	NATIONAL STANDARDS PART A	RAG Rating	
1a	% calls abandoned	>= 5%	<5%
1b	% answered in 60 seconds (Margin/PLT)	>= 95%	<95%
2	% cases passed to 999 within 3 minutes	NO RAG SET	
3a	% cases triaged within 60 mins (P1CT)	>= 90%	<90%
3b	% cases triaged within 120 mins (P2CT)		
3c	% cases triaged within 240 mins (P3CT)		
3d	% cases triaged within 360 mins (Cases marked as P1CT, P2CT & P3CT)	>= 99%	<99%
4a	% cases consulted within 1 hour (P1F2F)	>=90%	<90%
4b	% cases consulted within 2 hours (P2F2F)		
4c	% cases consulted within 6 hours (P3F2F)		
4d	% cases triaged within 480 mins (Cases marked as P1F2F, P2F2F & P3F2F)	>= 99%	<99%
5a	Median time of patients prioritised as P1F2F requiring a Home Visit to be seen as soon as possible following completion of their definitive clinical assessment	>=90%	<90%
5b	% cases visited within 2 hours (P2F2F)		
5c	% cases visited within 6 hour (P3F2F)		
5d	% cases triaged within 480 mins (Cases marked as P1F2F, P2F2F & P3F2F)	>= 99%	<99%
6a	F2F All - 1 hour	>= 90%	<90%
6b	F2F All - 2 hours		
6c	F2F All - 6 hours		

The local measures, (part B) are quality measures covering disposition of calls e.g. dental, 999, referral to other services etc, referral rates, incidents, audit etc.

During covid the monthly reporting requirement to Welsh Government against the standards has not been formally required due to the on-going COVID-19 pandemic and Welsh Government are currently advising a 'light touch' approach. Welsh Government have requested an Annual Report 'Light' for 2020/21 as a risk based approach. PTHB is currently in the process of preparing the report as per the detail in this report.

The PTHB OOH Performance Management Group, chaired by the Assistant Medical Director, monitors the performance management of OOH services across Powys for all three providers supporting the Powys service. The Group was established to provide a forum to monitor OOH performance with current OOH contract holders and to provide assurance to the PTHB Executive regarding performance in relation to the All Wales OOH monitoring standards. Terms of Reference for the group are detailed in **Appendix 3.**

On the 1st Oct 2018 PTHB moved to the national NHS Wales 111 service as the first point of contact to access GMS OOH services (previously this was provided by Shropdoc).

Since moving to the 111 first contact model, the provider IT systems (Shropdoc and SBUHB) supporting the PTHB OOH service provision are not able to fully report against the OOH standards. The reasons for this vary with each provider:

- Shropdoc - It is currently impossible to report against the OOH measures for the whole patient journey as end to end reporting between 111 and Shropdoc is unachievable as the 'time stamp' of referral from the 111 service to the Shropdoc face to face service is not transferred between the systems. However, to manage this and offset this risk, Shropdoc provide monthly reporting against the measures from the time of receipt from 111 into the Shropdoc Adastra system. Further detail on contract assurance is detailed below.
- SBUHB - Due to the lack of inter-operability between 111 and the Adastra SBUHB OOH system causes limitations in being able to specifically report on Powys patients and the Powys data cannot be extracted from the SBUHB data. Further detail on contract assurance is detailed below, noting its limitations.

To overcome the ongoing assurance reporting deficiencies, PTHB has commissioned a bespoke development with Advanced Health and Care Limited (for the Adastra system) to enable PTHB access to a data feed to access all the data involved in a patient OOH contact, irrespective of the provider of the service to enable full reporting against the OOH standards. This will provide PTHB with assurance on both the quality and efficiency of the service it has commissioned with all providers since the inception of 111 in October 2018.

Progress in receiving the data has been delayed due to Covid-19, however the data (backdated to October 2018) was received into PTHB, week commencing the 15th June 2021 and daily activity files are now being received into the PTHB data warehouse. Currently the Information Team are extracting the relevant data to develop PTHB reports on the total patient journey and final patient outcomes to inform future robust reporting against the OOH standards. It is hoped these will be available from quarter 3, 2021/2022.

Reports will also be available, backdated to the inception of 111 in October 2018, should the health board wish to review to inform future modelling and service developments.

Accurate national reporting is not solely a Powys issue and given the need for accurate national reporting a replacement IT system for 111 / Out of Hours, called SALUS, is currently being developed by CAPITA for implementation next financial year. The PTHB Information Team and Shropdoc feed into the SALUS development project to articulate the future PTHB reporting requirements.

111

On the 1st Oct 2018 PTHB moved to the national NHS Wales 111 service as the first point of contact to access GMS OOH services. The 111 service is an amalgamation of NHS Direct Wales and GP out-of-hours services. The service is available 24 hours a day, seven days a week, and can be used both for health information and advice and to access urgent primary care (including dental services).

The national 111 service is hosted by the SBUHB OOH service.

Service provided:
The 111 OOH offer to PTHB includes call handling and first line triage only. Patients requiring further clinical triage are passed either to the Shropdoc service, or for Ystradgynlais patients to SBUHB Clinical Assessment Team and also the SBUHB OOH service.

Performance against OOH standards
In terms of OOH Standards compliance, the 111 service performance is measured against two indicators

Internal KPI ref	NATIONAL STANDARDS PART A	RAG Rating	
1a	% calls abandoned	>= 5%	<5%
1b	% answered in 60 seconds (Margin/PLT)	>= 95%	<95%

Appendix 4 details the 111 performance in these two areas, noting that achievement in these two areas is proving difficult for 111 to achieve. As the service is an All Wales service the calls abandoned and answered within 60 seconds rates across Wales mirror the volume for Powys. During 2020/2021 there were only two months where 111 achieved the standard.

111 challenges relate to:

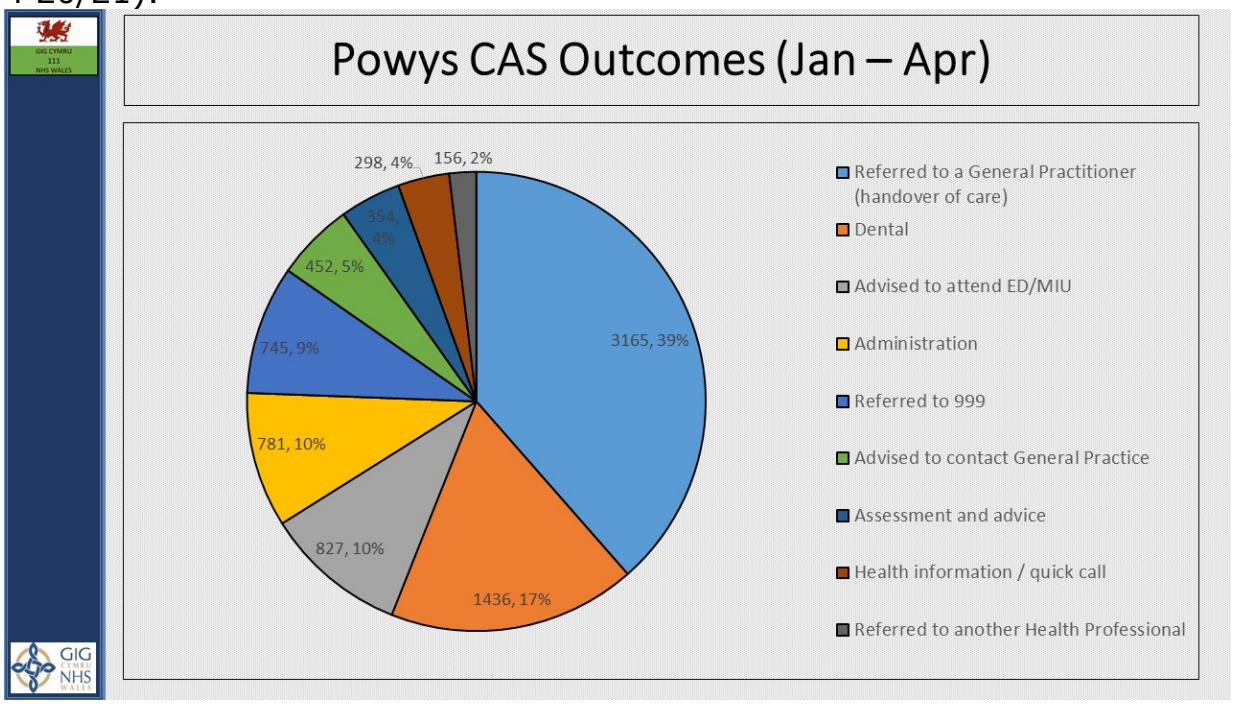
- 111's ability to respond to the demand during the pandemic spikes
- The demand and capacity to manage the weekday demand is fairly static, however the weekend demand is variable which impacts the capacity to manage and this is confirmed in 10, 30 and 90 day demand variation data.
- Recent clinical data suggests that more complex patients are accessing the service and therefore call handlers are transferring an increased level of calls to nurse led clinical response.
- WAST have introduced a 'reception' model to support call handling demand by providing the patient with a 'holding' call back to inform patients of delays and to give assurance to patients they are in the system.

- An additional 40 WTE call handlers were recruited in January 2021 and started in post in May 2021 and this should improve call handling response rates, noting however BCUHB go live with 111 in June/July and although a further recruitment campaign is underway for an additional 20-30 call handlers, it is anticipated there will be a delay from recruitment to start date due to both recruitment process' and required training.

111 carries out patient experience surveys to make sure patient callers receive the most appropriate advice, care and high-quality service. Surveys are carried out over the telephone or by post and participation is voluntary. Survey results will be reviewed at a future OOH Performance Management Group to gain a further understanding on patient experience.

The all Wales 111 service hold national meetings to review the service. PTHB is represented at the All Wales 111/OOH Urgent Primary Care Quality and Safety Forum. Shropdoc also attend the forum and various operational sub groups. **Appendix 5** details the terms of reference of the group. The purpose of the All Wales 111/OOH Urgent Primary Care Quality and Safety Forum is to provide national assurance in relation to arrangements for safeguarding and improving the quality and safety of 111 Wales, provided by WAST and associated Out of Hours (Urgent Primary Care) services provided by Health Boards and welsh government sit on this group.

The pie chart below depicts the Powys 111 calls and their dispositions (quarter 4 20/21):



Shropdoc

Service provided:
PTHB holds a contract with Shropdoc for the provision of Out of Hours

General Medical Services and OOH medical cover at PTHB community hospitals. In addition to this as part of the contract agreement Shropdoc also provides PTHB with a service for Care Coordination Centre, Violent Patient Line, Powys Urgent Response Service at Home (PURSH) and 10 Protected Learning Time cover Days. This paper solely refers to the performance management of Shropdoc OOH services.

The current contract in place with Shropdoc for the OOH service is as follows

Start date:	01/04/2020
End date:	30/06/2022
Duration	2 years and 3 Months

Shropdoc provide PTHB with monthly reports detailing contract achievement against the All Wales OOH standards (Local and National Measures) and also a quarterly view is analysed by the OOH Performance Management Group.

The Shropdoc cover includes out of hours medical cover for all Powys residents (excluding Ystradgynlais patients) during the out of hours period, including medical cover for Powys Teaching Health Board Community Hospitals, including Minor Injury Unit cover at Welshpool, Llandrindod Wells and Brecon Community Hospital. The agreement excludes providing cover at Ystradgynlais Community Hospital.

The service provides core GMS services (advice and face to face consultations) where assessed as required by the 111 Service component who refer the patient onto Shropdoc for further clinical management.

The face to face service may be accessed via patient attendance at a Powys Out of Hours Centre or via a Home Visit.

Shropdoc Out of Hours Centre locations are all on PTHB hospital premises and opening times of the bases are as follows:

Welshpool:
Weekdays: 18.30 to 00.00 Weekends: 08.00 to 19.00

Newtown:
Weekdays: 00.00 to 07.30
Weekends: 10.00 to 16.00, 19.00 to 00.00, 00.00 to 07.30 Monday
Bank Holidays: as for weekend

Llandrindod:
Weekdays: 19.00 to 00.00 (Stand by GP 00.00 to 07.30)
Weekends: 11.00 to 00.00 (Stand by GP 00.00 to 09.00)
Bank Holidays: as for weekend

Brecon:

Weekdays: 18.30 to 07.30

Weekends: 18.30 Friday to 07.30 Monday

Bank Holidays: 24 hours

During opening hours, the OOH centres are manned with a GP and driver unless in exceptional circumstances such as an unfilled shift.

In addition to face to face consultations either at the centre or a home visit, the base GPs also undertake triage for Powys residents. Back up support is also provided from the Shropdoc central triage team in Longbow if required.

Performance against OOH standards

Appendix 6 details Shropdoc' s monthly compliance against the standards for triage and face to face consultations, both at the Primary Care Centres and Home visits. The table below summarises the overall annual performance for 2020/2021.

KPI Ref	Powys OOH KPI -	YTD Calls Lost	YTD Total Calls	YTD %
2	% cases passed to 999 within 3 minutes	388	388	100.00%
3a	% cases triaged within 60 mins (P1CT)	8665	9223	93.95%
3b	% cases triaged within 120 mins (P2CT)	3349	3597	93.11%
3c	% cases triaged within 240 mins (P3CT)	1392	1426	97.62%
4a	F2F Base - 1 hour	65	65	100.00%
4b	F2F Base- 2 hours	522	522	100.00%
4c	F2F Base - 6 hours	2348	2348	100.00%
5a	F2F Home - 1 hour	136	200	68.00%
5b	F2F Home- 2 hours	778	890	87.42%
5c	F2F Home - 6 hours	1166	1186	98.31%
6a	F2F All - 1 hour	201	265	75.85%
6b	F2F All - 2 hours	1300	1412	92.07%
6c	F2F All - 6 hours	3514	3534	99.43%

The Shropdoc challenges in service provision mainly relate to meeting the home visiting requirement, in particular home visits to take place within 1 hour and 2 hours. Due to the geography of Powys and the OOH resources at the defined bases the achievement of both these standards will always prove to be challenging.

Shropdoc provide detail on all breaches against the standards including the length of time exceeded, the patient outcomes and priority of completion of the patient care episode.

In addition to this Shropdoc provide quarterly reporting on their clinical risk register, Incidents, Complaints, Compliments, 111 Health Profession Feedback and Safeguarding issues (covering the qualitative standards requirements). This is reviewed by the OOH Performance Management Group on a quarterly basis.

Shift fill rate

Shift fill rate in Shropdoc has always been good, achieving in previous years fill rates over and above the all Wales average. During the pandemic fill rates have been exceptional as follows.

per day per annum	Base Shift Fill Rate		
Day	Hours Filled	Total Hours	%
Monday	1676	1681	99.70%
Tuesday	1497	1499	99.83%
Wednesday	1528	1529	99.93%
Thursday	1500	1503	99.80%
Friday	1679	1689	99.41%
Saturday	3289	3317	99.16%
Sunday	3281	3304	99.29%
Total	**14450**	**14522**	**99.50%**

Shropdoc notify PTHB every Friday, the cover for the forthcoming weekend, and continue to source cover up until a shift commences. In addition to this a 4 week rolling rota view is also provided, which aids further assurance of immediate rota gaps. Shropdoc utilise resources from other areas (sometimes cross border) when necessary to support the Powys service.

Unfilled shifts are recorded on the PTHB Datix system.

Swansea Bay University Health Board (SBUHB) OOH service

SBUHB, formerly known as ABMUHB have provided an OOH face to face service (only) for a number of years for Ystradgynlais patients. Call handling and triage was previously managed by Shropdoc, then transferred to 111 on the 28th November 2017.

Service provided:

PTHB have an annual contract with SBUHB to provide OOH GMS services and OOH medical cover at Ystradgynlais Community Hospital (YCH).

The contract for 2021/2022 has not yet been agreed and is currently being progressed.

As per the contract between PTHB and SBUHB the service provision includes:

- Monday to Friday, following 111 triage, patients are seen at a SBUHB OOH Centre (mainly at Neath Port Talbot or Morriston Hospital), or if applicable a home visit is undertaken. Patient care input at YCH is also provided.

- Saturday, Sunday & Bank Holidays – A GP is based at YCH from 9am-1pm undertaking OOH GMS and providing medical cover to YCH. After 1pm, patients requiring GMS OOH are directed to an SBUHB OOH Centre and the patient care at YCH is covered from a SBUHB OOH centre also.

The SBUHB treatment centres absorb the Powys patient flow without requiring additional shift cover as a very small number of Powys patients access the service per session.

Following initial contact with the 111 service and when a patient episode is not closed, the patient is referred into the 111 Clinical Assessment hub (who provide a similar role to the Shropdoc triage service) and then if necessary is further referred onward to the SBUHB OOH service.

Performance against OOH standards

Reporting on the relevant standard measures for the Powys element of the service is limited as stated above, due to the inability of extracting Powys specific data; therefore, monitoring the service against the standards is currently not achievable. SBUHB are only able to quantify the number of Ystradgynlais patients accessing the service and the patient outcomes/management as detailed in **Appendix 7**; therefore, there is no data available regarding assurance around timely patient access. The new national reporting IT system SALUS, will resolve this issue in 2022.

An average of 186 111 calls per month (2242 per year) relate to Ystradgynlais patients, of which

- 60 (726 per year) are closed following 111 call handling/nurse triage advice
- 126 (1516 per year) are referred onto the Clinical Assessment Hub/Pharmacist service
- 109 per month are referred into the SBUHB OOH service (1306) per year

Out of the 109 patients referred to the OOH service

- 62% receive GP advice
- 15% receive a prescription
- 18% visit a treatment centre, an average of 20 patients per month
- 5% receive a home visit, an average of 5 visits per month

Shift fill rate

SBUHB notify PTHB every Friday the cover for the forthcoming weekend, however they continue to source cover up until a shift commences. During 2020/2021 the Powys shift fill rate has dramatically improved due to the availability of GPs prepared to cover the YCH base on a Saturday, Sunday & Bank Holidays during the pandemic.

ABMU % Cover by Month	% unfilled Slots by month	% filled Slots by month
APR	60	40
MAY	42	58
JUN	13	88
JUL	0	100
AUG	0	100
SEP	0	100
OCT	0	100
NOV	0	100
DEC	0	100
JAN	30.0	70.0
FEB	25.0	75.0
MAR	50.0	50.0

Unfilled shifts are recorded on the PTHB Datix system.

NEXT STEPS:

1) Provide end to end reports, detailing the patient journey against the national standard measure for implementation in Q2, 2021/22
2) Finalise the SBUHB OOH contract
3) Continue to feed into the national SALUS new system development
4) To develop and progress CAF assurance reporting for OOH for implementation by year end 2021/2022

STANDARDS AND QUALITY INDICATORS – 111 and OOH in Wales – National Measures

Performance and quality
The standards have been divided into two parts:

- Part A = delivery standards which are required to be reported monthly at a national level. This is a public facing document.
  Where 111 service is operating:
  - WAST will be responsible for the CALLS and CLINICAL TRIAGE standards, (which will include both WAST and OOH's clinical triage) and the median timestamps for Clinical triage, where the 111 service is operating.
  - LHBs will be responsible for the FACE TO FACE APPOINTMENTS and the median timestamps for FACE TO FACE APPOINTMENTS where the 111 service is operating.

  Where LHB OOHs service is operating:
  - LHBs will also be responsible for CALLS and CLINICAL TRIAGE standards, and the median timestamps for Clinical triage, where their own OOH service is operating.

- Part B and Part C = quality indicators which require WAST and LHBs to collect and report the information either monthly, quarterly, six monthly or annually at a local level. This information will not be published,

Reporting
Welsh Government require WAST and LHBs to produce an 'annual report' to report against Parts A, B and C. The annual report template will be developed and provided to LHBs and WAST.

Review period
These standards were reviewed in September 2020 to enable changes to be made that can support clinical and service changes to the way in which 111/ OOH services are developed and delivered. The intention is for these standards to be reviewed again once full roll out of the 111 service has been achieved circa 2021.

Amendments to previous standards

Health Boards and WAST will now only have to report Part A of these measures on a national level. We would still expect health boards and WAST to report on Parts B, C and the Developmental Measures at a local level and to include some of this information within their annual reports that they submit to the Welsh Government.

The following measures have been amended:

- Part A – **Median time** of p*atients prioritised as P1F2F requiring a **Home Visit** to be seen **as soon as possible** following completion of their definitive clinical assessment. We would expect to see a reduction in the median time.*

- Part B - **Median time** for patients prioritised as **P1F2F** to be seen by a clinician **(Exception report – 2 hours)**

Split by:

- At base
- Home visit (Exception report – 2 hours)

Development Measures
A number of **Developmental Measures** have been added. These are currently aspirational and will require development once the new IT System for 111/ OOH is adopted. Additional work is also required on data linkage with WAST and NWIS before these can be adopted.

	NEW Standards	Source	Description of measure	What are we trying to achieve
	PART A - NEW Standards	Telephony /IT system	National – 111 Local – LHB	Descriptor
	TELEPHONY			
CALLS	**Abandoned calls** No more than 5% of calls hang up within 60 seconds of the end of the message.	Telephony WAST	National	To measure the percentage of calls where people hang up because their calls are not answered.
	Answered calls 95% of calls are answered within 60 seconds of the end of the message.	Telephony WAST	National	To measure the percentage of calls answered within the timeframe specified.
	% of calls where the caller indicates that they wish to conduct the call in Welsh (Welsh speakers are able to opt for a Welsh response at call handling stage of the 111 service)	Telephony WAST	National	Identify the percentage of callers that opt for a welsh speaking call handler
CLINICAL TRIAGE (CT) ASSESSMENT	**CLINICAL TRIAGE (CT)** Timely clinical triage of patients: • P1CT = 1 hour (the 20 minute response will be retained as an operational measure) • P2CT = 2 hours • P3CT = 4 hours **This is the number of patient contacts that are prioritised by the Out of Hours / 111 call handler and then start their definitive clinical assessment within the relevant time bands**			
	90% of calls prioritised as P1CT to start their first definitive clinical assessment within **1 hour** of the end of the first contact *(Previous target = 98%)*	IT system	National	The percentage of P1 callers that begin their clinical assessment within the 1 hour timeframe
	90% of calls prioritised as P2CT to start their first definitive clinical assessment within **2 hours** of the end of the first contact	IT system	National	The percentage of P2 callers that begin their clinical

	NEW Standards	Source	Description of measure	What are we trying to achieve
	(Previous target = 98%)			assessment within the 2 hour timeframe
	90% of calls prioritised as P3CT to start their first definitive clinical assessment within **4 hours** of the end of the first contact *(Previous target = 98%)*	IT system	National	The percentage of P3 callers that begin their clinical assessment within the 4 hour timeframe
	99% of all calls (P1CT, P2CT and P3CT) to start their first definitive clinical assessment within **6 hours** of the end of the first contact *(99% rather than 100% has been adopted for this measure on clinical advice to allow for clinical discretion)*	IT system	National	99% of callers should begin their clinical assessment no later than 6 hours following their first contact.
FACE TO FACE APPOINTMENTS	**Face to face – F2F** Timely assessment of patients who require face to face appointment at base or home visiting: • P1F2F - 1 hour • P2F2F - 2 hours • P3F2F - 8 hours **This is measured from the end of the clinical assessment to the start of the patient's face to face appointment, whether that is in a PCC base or home visit.**			
	90% of patients prioritised as P1F2F requiring a **Base Appointment** to be seen within **1 hour** following completion of their definitive clinical assessment	IT system	National & Local	The percentage of callers categorised as a P1 who begin their clinical F2F appointment within the 1 hour timeframe.
	90% of patients prioritised as P2F2F requiring a **Base Appointment** to be seen within **2 hours** following completion of their definitive clinical assessment	IT system	National & Local	The percentage of callers categorised as a P2 who begin their clinical F2F appointment within the 2 hour timeframe.

	NEW Standards	Source	Description of measure	What are we trying to achieve
	90% of patients prioritised as P3F2F requiring a **Base Appointment** to be seen within **8 hours** following completion of their definitive clinical assessment	IT system	National & Local	The percentage of callers categorised as a P3 who begin their clinical F2F appointment within the 8 hour timeframe.
	Median time of patients prioritised as P1F2F requiring a **Home Visit** to be seen **as soon as possible** following completion of their definitive clinical assessment	IT system	National & Local	The median time of callers categorised as a P1 who begin their clinical F2F appointment as soon as possible.
	90% of patients prioritised as P2F2F requiring a **Home Visit** to be seen within **2 hours** following completion of their definitive clinical assessment	IT system	National & Local	The percentage of callers categorised as a P2 who begin their clinical F2F appointment within the 2 hour timeframe.
	90% of patients prioritised as P3F2F requiring a **Home Visit** to be seen within **8 hours** following completion of their definitive clinical assessment	IT system	National & Local	The percentage of callers categorised as a P3 who begin their clinical F2F appointment within the 8 hour timeframe.
	99% of all patients **(BASE and HOME VISITS)** (P1F2F, P2F2F and P3F2F) to be seen within **8 hours** following completion of their definitive clinical assessment. *(99% rather than 100% has been adopted for this measure on clinical advice to allow for clinical discretion)*	IT system	National & Local	No caller should begin their face to face appointment later than 8 hours following the completion of their definitive clinical assessment.

STANDARDS AND QUALITY INDICATORS – 111 and OOH in Wales – Local Measures

Performance and quality
The standards have been divided into two parts:

- Part A = delivery standards which are required to be reported monthly at a national level. This is a public facing document.
  Where 111 service is operating:
  - WAST will be responsible for the CALLS and CLINICAL TRIAGE standards, (which will include both WAST and OOH's clinical triage) and the median timestamps for Clinical triage, where the 111 service is operating.
  - LHBs will be responsible for the FACE TO FACE APPOINTMENTS and the median timestamps for FACE TO FACE APPOINTMENTS where the 111 service is operating.

  Where LHB OOHs service is operating:
  - LHBs will also be responsible for CALLS and CLINICAL TRIAGE standards, and the median timestamps for Clinical triage, where their own OOH service is operating.

- Part B and Part C = quality indicators which require WAST and LHBs to collect and report the information either monthly, quarterly, six monthly or annually at a local level. This information will not be published,

Reporting
Welsh Government require WAST and LHBs to produce an 'annual report' to report against Parts A, B and C. The annual report template will be developed and provided to LHBs and WAST.

Review period
These standards were reviewed in September 2020 to enable changes to be made that can support clinical and service changes to the way in which 111/ OOH services are developed and delivered. The intention is for these standards to be reviewed again once full roll out of the 111 service has been achieved circa 2021.

Amendments to previous standards

Health Boards and WAST will now only have to report Part A of these measures on a national level. We would still expect health boards and WAST to report on Parts B, C and the Developmental Measures at a local level and to include some of this information within their annual reports that they submit to the Welsh Government.

The following measures have been amended:

- Part A – **Median time** of p*atients prioritised as P1F2F requiring a **Home Visit** to be seen **as soon as possible** following completion of their definitive clinical assessment. We would expect to see a reduction in the median time.*

- Part B - **Median time** for patients prioritised as **P1F2F** to be seen by a clinician **(Exception report – 2 hours)**

Split by:

- At base
- Home visit (Exception report – 2 hours)

Development Measures
A number of **Developmental Measures** have been added. These are currently aspirational and will require development once the new IT System for 111/ OOH is adopted. Additional work is also required on data linkage with WAST and NWIS before these can be adopted.

		PART B – OOH & 111 Quality Indicators	Source	Description of measure	What are we trying to achieve
Monthly		**Median time** for patients prioritised as **P1CT** to start their clinical assessment	IT System	Local	To check the most frequent time for patients categorised as a P1CT to start their clinical assessment
		Median time for patients prioritised as **P2CT** to start their clinical assessment	IT System	Local	To check the most frequent time for patients categorised as a P2CT to start their clinical assessment
		Median time for patients prioritised as **P3CT** to start their clinical assessment	IT System	Local	To check the most frequent time for patients categorised as a P3CT to start their clinical assessment
		Median time for patients prioritised as **P1F2F** to be seen by a clinician Split by: • At base • Home visit **(Exception report – 2 hours)**	IT system	Local	To check the most frequent time for patients categorised as a P1 to be seen at a Primary Care Centre or via a home visit.
		Median time for patients prioritised as **P2F2F** to be seen by a clinician Split by: • At base • Home visit	IT system	Local	To check the most frequent time for patients categorised as a P2 to be seen at a Primary Care Centre or via a home visit.

		Median time for patients prioritised as **P3F2F** to be seen by a clinician Split by: • At base • Home visit	IT system	Local	To check the most frequent time for patients categorised as a P3 to be seen at a Primary Care Centre or via a home visit.
		PART B – OOH & 111 Quality Indicators	**Source**	**Description of measure**	**What are we trying to achieve**
MONTHLY		**Outcome Activity** List of common outcome disposition by LHB • Administration • Advised to attend ED/MIU • Advised to contact another Health Professional • Advised to contact General Practice • Death • Dental • Failed contact • Health information / quick call • Referred to 999 • Referred to a General Practitioner (handover of care) • Referred to another Health Professional • Referred to Mental Health Team • Referred to Secondary Care • Referred to Social Services	I T System	Local	To learn the most common outcomes for patients presenting to out of hours services and to be able to compare trends and similarities both within LHBs, and between LHBs. This will assist in planning future services.

		• Assessment and Advice **(changed from Self Care)** • No outcome recorded (Data is available from September 2018)			
MONTHLY		**Referral rates by GP Practice/ Cluster level** Patient referrals rates - Ambulance/ Hospital assessment/ admission (at cluster level)	I T System	Local	To understand the demands made by different GP Practices/ cluster both within LHB areas and to explore the patterns between LHB areas to influence changes in working practice.
		PART B – OOH & 111 Quality Indicators	**Source**	**Description of measure**	**What are we trying to achieve**
MONTHLY		**Prescribing formula in place – i.e. antibiotics** Activity data on prescribing practice	IT system	Local	To understand prescribing practice across each LHB. To explore the patterns between LHB areas to influence changes in working practice

	New Standards	Source	Description of measure	What are we trying to achieve
	PART C – OOH & 111 Quality Indicators			
QUARTERLY	100% reporting of 'serious incidents' to Welsh Government in agreed timescale	DATIX	Local	Ensuring adverse incidents are reported
	Clinical audit to be undertaken to learn from 'serious incidents' and demonstrate quality improvement has been adopted, and that reporting is in line with guidance.	DATIX	Local	Ensuring learning from clinical audit is adopted and that reporting is in line with guidance.
BI ANNUAL	Ensure the service compiles with All Wales standards for equality = Audit of language needs - See **DSCN 2017/11** – reference data source for recording of language information - see reporting of welsh callers in PART A and information associated with patients with sensory loss should be recorded - See **DSCN 2018/01** = Audit of sensory loss requirements	NHS Delivery Frame work returns	Local	LHBs to ensure the response to DSCN 2017/11 and DSCN 2018/01 is captured
ANNUAL	Length of introductory message – no longer than 30 seconds to provide life threatening information, but can contain additional information thereafter - 60 seconds for total message.	IT system	Local	To provide consistency, assurance that introductory message complies with guidance
	Undertake Clinical Audit using RCGP toolkit, or other appropriate tools, to review 1% of cases on a monthly basis. Audit should include end to end review of the patient's journey through 111 to points of care.	Clinical Audit	Local	To ensure quality care is provided.

PART C – Quality Indicators			
Risk management In place with clear accountability - evidence of an active and appropriate risk log and managerial action - quarterly	Risk Register	Local	Review of risk register to ensure risks are adequately identified and managed
Data from 111 to be shared amongst Primary Care Clusters to enable peer review	IT system	Local	Encourage peer review amongst clusters to improve good practice
Concerns and complaints are responded to promptly an within agreed time limits	Complaint log	Local	To ensure patients concerns are acknowledged, responded to and lessons are learnt
Gather and use evidence of service user experience to drive improvement	Patient survey	Local	To ensure patient's view are gathered and used to improve the service.
Prescribing formula in place – i.e. antibiotics = clinical review of cases – in line with clinical governance requirements	IT system	Local	Ensure clinical review is undertaken to affirm or reject that prescribing formula is in place.
Adherence to alert letters = Clinical governance requirements	Alert letters	Local	Confirmation that alert letters are appropriately actioned

	Developmental Measures – These are currently aspirational and will require to be developed once the new 111/ OOH IT System is adopted. Additional work is also required on data linkage with WAST and NWIS before these can be adopted.			
		Source	Description of measure	What are we trying to achieve
DEVELOPMENTAL	Clinical content for the 111 service will (in the future procurement) be the responsibility of the IT Supplier *Reporting mechanism to be developed as part of the IT Procurement exercise.*	111 system	Local	Ensure that there is assurance from the supplier when there is a change to the clinical content of the 111 algorithms
	Records across 111, GP OOH and ED with an NHS number are data matched to determine whether patients contacting other parts of the urgent care service within hours of contacting 111 *It will be possible when the new IT system is in place, and patient NHS numbers are known routinely.*	WAST /NWIS data linking	Local	Patients to be tracked to see what advice they followed
	Report the percentage (%) of patients with unplanned re-contact with the OOH/ 111 service within 72 hours i.e. audit of cases and production of report on frequent flyers – link with patient navigation projects *This can be reviewed when the new IT system, is in place, depending on work from Public Health Wales on frequent flyers.*	IT system	Local	Ensure frequent flyers are reviewed and supported appropriately to reduce demand in future
	• Audit the range of pathways available to enable the callers to be directed to the right service including the range of available community services • Audit the use of DOS and outcome dispositions of patients using OOH / 111 service. Reports should also identify gaps in provision and demonstrate work to develop new pathways is being supported.	DOS & IT system	Local	To ensure the range of appropriate pathways is comprehensive, and the utilisation of appropriate pathways, and gaps in provision are identified and new pathways development
	The recognised Quality Improvement Methodology should be used continually to develop local services and share good practice.	Quality Improvement Methods	Local	A report from Medical Director should document methodology used and adapted if appropriate

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Powys Teaching Health Board

Out of Hours (OOH) Performance Management Group

Terms of Reference

January 2019

Document Control

Version History

Version	Date	Brief Summary of Change	Author
1	01/04/2014	Original draft	Jayne Lawrence
1.1	10/01/2019	Update membership to include clinical advisory group (CAG) members and 111 / WAST representation	Sue Hamer
1.2	23/01/2019	3 additions as recommended by the group.	Sue Hamer
1.3	04/07/19	Removed Dr Adrian Fairbanks as left Shropdoc. Added Clare Tibbins. Replaced Dr Stephen Bassett with Dr Stephen Greenfield from ABMU.	Sue Hamer

For Distribution To

Name	Position	Date	Signature
Jeremy Tuck	Chair	16/01/2019	
OOH Performance Management Group members	Members as outlined in TOR	16/01/2019	

Sign-Off

Name	Position	Date	Signature
Jeremy Tuck	Chair		
Jayne Lawrence	Vice Chair		

1. Background

The OOH Performance Management Group was established to;

- provide a forum to monitor OOH performance with current OOH contract holders
- to provide assurance to the Quality & Safety Committee regarding performance in relation to the All Wales OOH monitoring standards.

The Group aims:

- To have an understanding of performance activity and achievement in relation to the all Wales OOH monitoring standards.
- To gain assurance from the existing OOH contract holders that the level of service being provided is a high quality service which provides a safe, effective, consistent, timely and accessible service.
- Escalate issues and concerns to the OOH project board

Membership		
Performance Management Group Membership	**Role**	**Name**
	Chair	**Jeremy Tuck** Assistant Medical Director
	Vice Chair	**Jayne Lawrence** Head of Primary Care (PTHB)
	Shropdoc	**Simon Chapple** Medical Director **Clare Timmins** Operations Director **Emma Feely** Patient Liaison and Risk Manager
	111 / WAST	**Richard Bowen** 111 Programme Director **Stephen Jenkins** 111 Programme Manager **Chris Powell** 111/WAST Head of Operations
	ABMU	**Kevin Duff** Operational Lead **Dr Stephen Greenfield** Clinical Director
	GP Advisor	**Dr Alan Woodall** GP Montgomery **Dr Rob Hegedus** GP Builth Wells **Dr Julie Keely** GP Brecon
	Community Health Council (CHC)	**Katie Blackburn** Chief Officer – Breconshire, Radnor and Montgomeryshire

	Project Administration	**Sue Hamer** Planning & Project Manager (PTHB)
	Non-core members may be invited to respond to specific agenda items. Deputies with devolved responsibility are essential where absence is unavoidable.	
In Attendance	Additional representatives may be requested to attend.	
Frequency	OOH Performance Management Group will meet on a quarterly basis but may occur more frequent depending upon the needs of service. Chair's actions can be taken where decisions are required outside this timescale	
Quorate	4 members, to include either the Chair or Vice Chair and one member from each OOH service.	
Accountability	The Director of Primary, Community and Mental health Care is accountable for the work of the OOH Performance Management Group.	
Administration	▪ An agenda will be prepared in advance of the meeting. ▪ Powys Teaching Health Board will be responsible for agenda setting and venue booking	
Meeting Inputs	▪ Service Performance Reports from each OOH service provider - to include both quantitative and qualitative performance ▪ Other Reports/Papers as appropriate	
Meeting Outputs	▪ Meeting notes and follow-up actions ▪ Risk matrix Notes will be distributed within 1 month of the OOH Performance Management Group meeting.	
Outline Agenda	▪ Apologies ▪ Notes from last meeting ▪ Review of Actions ▪ Performance reports for review/ discussion ▪ Review risks ▪ Date of next meeting ▪ Any other business	
Review Terms	The Terms of Reference will be reviewed yearly.	

NHS Wales 111 - Powys Performance
Abandoned calls and Answered calls

Appendix 4

OOH Standard: Abandoned calls: No more than 5% of calls hang up within 60 seconds of the end of the message
OOH Standard: Answered calls - 95% of calls are answered within 60 seconds of the end of the message

Month	PTHB calls per month	All Wales	PTHB Number of Calls Abandondend per month	PTHB Abandonment rate % (Target <5%)	PTHB Number of calls answered <60 secs	PTHB % of answered calls <60 seconds (target 95%)
Apr-20	2,625	60,851	630	24.00%	1,995	76
May-20	2,500	53,123	233	9.30%	2,268	91
Jun-20	2,005	46,290	60	3.00%	1,945	97
Jul-20	2,154	47,454	112	5.20%	2,042	95
Aug-20	2536	55,615	271	10.70%	2,265	89
Sep-20	2,626	63,288	559	21.30%	2,067	79
Oct-20	2,473	54,898	193	7.80%	2,280	92
Nov-20	2,266	54,276	188	8.30%	2,078	92
Dec-20	2,816	69,695	622	22.10%	2,194	78
Jan-21	2,597	59,789	384	14.80%	2,213	85
Feb-21	2,009	46,888	64	3.20%	1,945	97
Mar-21	2,477	60,003	178	7.20%	2,299	93
Apr-21	2,820	66,969	457	16.20%	2,363	84
Total	31,904	739,139	3,952		27,952	

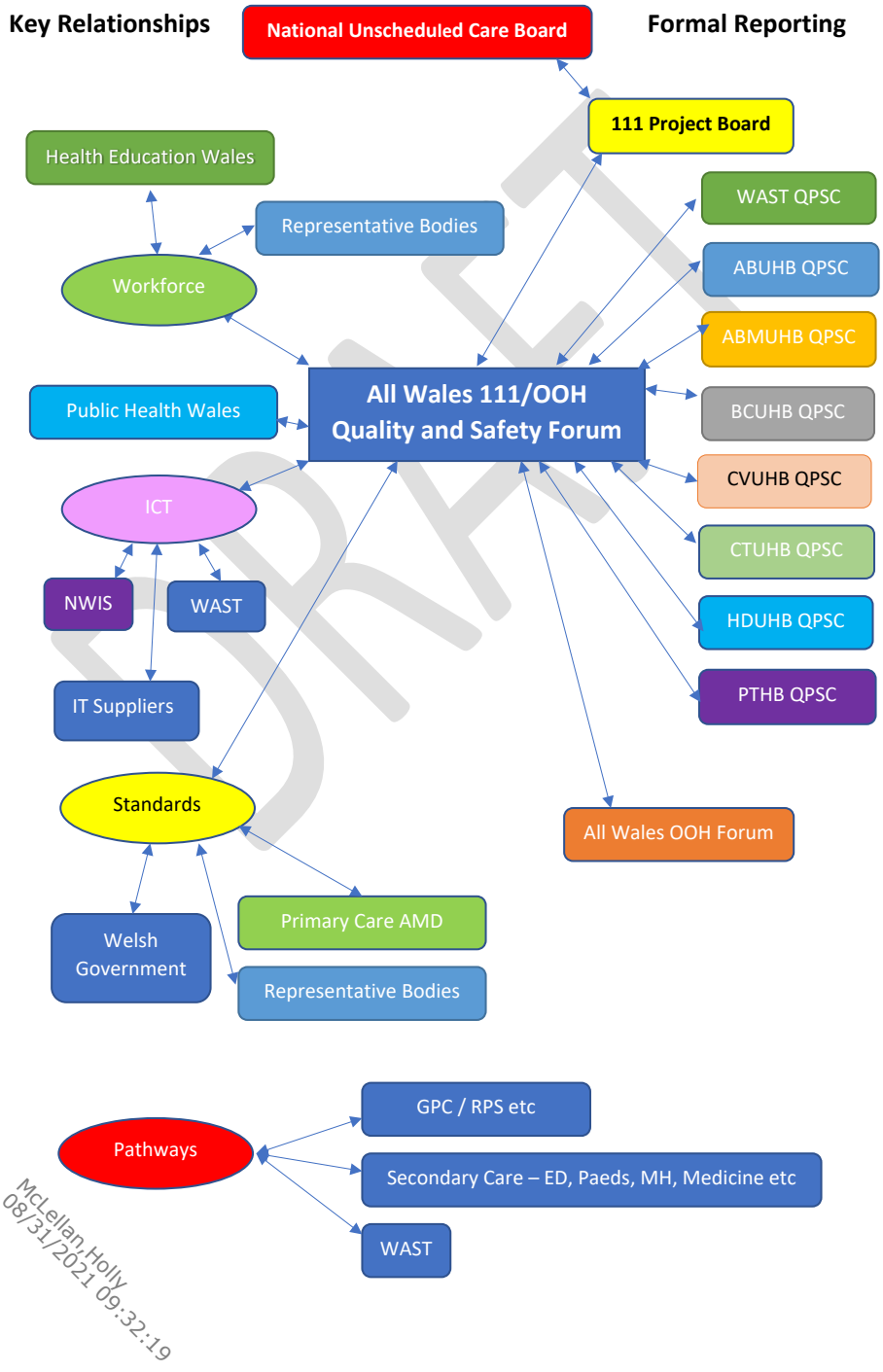
Committee	**All Wales 111/OOH Quality and Safety Forum**
Purpose	The purpose of the All Wales 111/OOH Quality and Safety Forum is to provide Welsh Ambulance NHS Trust (WAST) and Local Health Boards (LHBs) with: • Evidence and timely advice relating to the provision of Urgent Out of Hospital Health Care • Assurance in relation to arrangements for safeguarding and improving the quality and safety of patient centred health care by 111 Wales, provided by WAST and associated Out of Hours (Urgent Primary Care) services provided by LHBs. • Provide specific assurance in relation to the Clinical Support Hub and its cross organisational roles and responsibilities. • Implementation and ongoing improvements for 111 • To receive guidance from the Urgent Primary Care Out of Hours task and finish Forum. In accordance with its stated objectives and the requirements and standards determined for NHS Wales.
Membership	**Chair:** • Clinical Director of an LHB OOHs service **Vice Chair**: • Clinical Director of a LHB OOHs service **WAST / LHB OOH Representatives** – from each organisation • Senior clinician • Operational Manager **Optional Leads** • Pharmacy • Workforce Development • IT & Comms • Nursing **111 Wales Project Team** • Director or 111 Project Lead • Senior Clinician (Incident Coordinator) **A representative from**: • AMD • Welsh Government – Primary or Community Care • Public Health Wales • HEIW • Human Resources

	• The Postgraduate Education Deanery • RGCP **By Invitation** The Forum may extend invitations to attend as required to representatives within Wales NHS including but not limited to: • Emergency Medicine • Mental Health • Paediatrics • Dentistry • Microbiology • Optometry • Professions Allied to Medicine • Representatives from key professional bodies • Palliative Care professionals **In attendance** Executive Directors / or deputies holding portfolios containing aspects of quality, safety, complaints or service improvement can attend from time to time, or as requested by the Forum's Chair **Secretary:** Secretarial Support will be provided through the 111 Wales Project Team ***Costs for member's*** time to attend shall be borne by their representative organisation.
Duties:	The Forum will in respect of its provision of advice to WAST and the LHBs: *(Italics = Specific advice to WAST CSPT sign off processes when time permits).* **Quality:** • *The Forum can specifically review and advise on the Decision Support Software for call handlers and clinicians provided as a solution within the 111/OOH IT solution.* • *The Forum can approve and endorse local (and in time national or all Wales) modifications on decision support software considering NHS Wales policy – e.g. pandemic or other localised public health outbreaks or incidents.* • The Forum will make national recommendations on antimicrobial use in the urgent primary care setting, taking in account of LHB Policies and guidance. This in turn will assist in the standardisation of antimicrobial availability across Welsh OOH services.

	Safety • Lessons are learned and shared across 111 and Out of Hours service from patient safety incidents, complaints and claims. • Significant national risks are actively identified, shared and robustly managed across 111 Wales and Out of Hours services • Noting the outcomes from the above, the forum (with the endorsement of LHB and WAST Medical Directors) should consider the implications for NHS Wales following the publication of any review/investigation reports arising from external regulators. • To ensure robust clinical audit is taking place in organisations and relevant training is in place. **Workforce** • Highlights national issues or concerns regarding the workforce regarding selection, training, support, responsiveness and health and well-being. **Quality, Safety and Performance Management** • Advise on the initial development of NHS Wales strategies for the development of a high quality and safe services, or pathways for patient seeking advice relating to new or urgent health needs whilst in the community. • Consider the implications for quality and safety relating to corporate strategies across NHS Wales in relation to meeting the needs of patients presenting with new or urgent health problems within the community • Consider the quality and safety implications for NHS Wales resulting from reports on service performance against Healthcare Standards for Wales with respect to 111 Wales and LHB Out of Hours Urgent Primary Care Services. • The Forum will advise Welsh Government, WAST and LHBs on the adoption of a set of key indicators of the quality of care, against which NHS Wales performance will be regularly assessed and reported on through Annual Reports. • The Forum will endorse an annual report summarising national performance and local variance against the key indicators.
Access	• The Forum will have oversight on performance and access indicators for 111 (and by agreement with LHBs) on OOH standards and can provide peer support on wider service delivery and transformation.

	• The Forum can also offer wider input on the delivery of regional solutions to OOHs and 111 working to facilitate improved patient safety and quality of care.
Meetings Frequency:	At least 8 members of the Forum should be quorate with at least one of the members being the Chair or Vice Chair Meetings shall be held no less than quarterly but usually alternate months or otherwise as agreed appropriate by the Chair of the Forum.
Reporting	The minutes and associated recommendations will be reported to the Quality and Safety Committees of WAST and LHBs, with copies being shared with Welsh Government and All Wales Out of Hours Forum.
Feeder Forums	The Forum may, subject to approval by the 111 National Board establish specific task and finish Forums to carry out aspects of their work as and when required.
Applicability of Standing Orders	It is not envisaged that the work of this Forum will directly impact on individual organisation's Standing Orders however if there is any potential conflict then this will be reviewed by the Board Secretaries and /or Medical Directors in the first instance.
Review	The terms of reference and operating arrangements shall be reviewed annually by the Forum, the 111 National Programme and shared with appropriate organisations across NHS Wales

Commented [PT1]: Richard Bowen updated on the 3rd January 2018



Current KPIs

KPI Ref	Powys OOH KPI -	RAG Rating		
1a	% calls abandoned	>= 5%	<5%	
1b	% answered in 60 seconds (Margin/PLT)	>= 95%	<95%	
2	% cases passed to 999 within 3 minutes	NO RAG SET		
3a	% cases triaged within 60 mins (P1CT)	>= 90%	<90%	
3b	% cases triaged within 120 mins (P2CT)			
3c	% cases triaged within 240 mins (P3CT)			
4a	% cases consulted within 1 hour (P1F2F)	>=90%	<90%	Measurement based on end of clinical assessment to the start of the face to face appointment
4b	% cases consulted within 2 hours (P2F2F)			
4c	% cases consulted within 6 hours (P3F2F)			
5a	% cases visited within 1 hour (P1F2F)			
5b	% cases visited within 2 hours (P2F2F)			
5c	% cases visited within 6 hour (P3F2F)			
6a	F2F All - 1 hour	>= 90%	<90%	
6b	F2F All - 2 hours			
6c	F2F All - 6 hours			

Median time to start of their clinical assessment
Median time for patients pioritised as F2F to being seen by a clinician
Prescribing formula in place i.e. antibiotics - Activity data on prescribing practice
Data from 111 to be shared amongst Primary Care Clusters to enable peer review

Proposed New KPIs

KPI Ref	Powys OOH KPI -	RAG Rating	
1a	% calls abandoned	>= 5%	<5%
1b	% answered in 60 seconds (Margin/PLT)	>= 95%	<95%
2	% cases passed to 999 within 3 minutes	NO RAG SET	
3a	% cases triaged within 60 mins (P1CT)	>= 90%	<90%
3b	% cases triaged within 120 mins (P2CT)		
3c	% cases triaged within 240 mins (P3CT)		
3d	% cases triaged within 360 mins (Cases marked as P1CT, P2CT & P3CT)	>= 99%	<99%
4a	% cases consulted within 1 hour (P1F2F)	>=90%	<90%
4b	% cases consulted within 2 hours (P2F2F)		
4c	% cases consulted within 6 hours (P3F2F)		
4d	% cases triaged within 480 mins (Cases marked as P1F2F, P2F2F & P3F2F)	>= 99%	<99%
5a	Median time of patients prioritised as P1F2F r	>=90%	<90%
5b	% cases visited within 2 hours (P2F2F)		
5c	% cases visited within 6 hour (P3F2F)		
5d	% cases triaged within 480 mins (Cases marked as P1F2F, P2F2F & P3F2F)	>= 99%	<99%
6a	F2F All - 1 hour	>= 90%	<90%
6b	F2F All - 2 hours		
6c	F2F All - 6 hours		

Extra Measurements	Comment
P1CT P2CT P3CT	
P1F2F P2F2F P3F2F	
	What activity??
	What data??

McLellan,Holly
08/31/2021 09:32:19

KPI Ref	Powys OOH KPI -	Apr-20			May-20			Jun-20			Jul-20			Aug-20			Sep-20			Oct-20			Nov-20			Dec-20			Jan-21			Feb-21			Mar-21			YTD		
		In time	Total	%	In time	Total	%	In time	Total	%	In time	Total	%	In time	Total	%	In time	Total	%	In time	Total	%	In time	Total	%	In time	Total	%	In time	Total	%	In time	Total	%	In time	Total	%	Calls Lost	Total Calls	%
2	% cases passed to 999 within 3 minutes	30	30	100.00%	35	35	100.00%	32	32	100.00%	23	23	100.00%	33	33	100.00%	23	23	100.00%	47	47	100.00%	34	34	100.00%	31	31	100.00%	36	36	100.00%	26	26	100.00%	38	38	100.00%	388	388	100.00%
3a	% cases triaged within 60 mins (P1CT)	790	847	93.27%	757	845	89.59%	665	707	94.06%	661	692	95.52%	782	827	94.56%	655	687	95.34%	752	781	96.29%	706	749	94.26%	736	786	93.64%	816	848	96.23%	647	682	94.87%	698	772	90.41%	8665	9223	93.95%
3b	% cases triaged within 120 mins (P2CT)	251	285	88.07%	320	369	86.72%	275	293	93.86%	275	280	98.21%	330	353	93.48%	231	251	92.03%	297	300	99.00%	283	290	97.59%	296	320	92.50%	312	324	96.30%	268	288	93.06%	211	244	86.48%	3349	3597	93.11%
3c	% cases triaged within 240 mins (P3CT)	154	163	94.48%	151	156	96.79%	102	104	98.08%	114	114	100.00%	147	149	98.66%	92	95	96.84%	116	116	100.00%	107	107	100.00%	114	118	96.61%	115	115	100.00%	87	90	96.67%	93	99	93.94%	1392	1426	97.62%
4a	F2F Base - 1 hour	8	8	100.00%	2	2	100.00%	3	3	100.00%	4	4	100.00%	8	8	100.00%	7	7	100.00%	6	6	100.00%	3	3	100.00%	2	2	100.00%	9	9	100.00%	7	7	100.00%	6	6	100.00%	65	65	100.00%
4b	F2F Base- 2 hours	29	29	100.00%	36	36	100.00%	29	29	100.00%	31	31	100.00%	55	55	100.00%	48	48	100.00%	49	49	100.00%	49	49	100.00%	46	46	100.00%	64	64	100.00%	44	44	100.00%	42	42	100.00%	522	522	100.00%
4c	F2F Base - 6 hours	178	178	100.00%	248	248	100.00%	190	190	100.00%	158	158	100.00%	239	239	100.00%	202	202	100.00%	198	198	100.00%	179	179	100.00%	220	220	100.00%	157	157	100.00%	172	172	100.00%	207	207	100.00%	2348	2348	100.00%
5a	F2F Home - 1 hour	11	14	78.57%	8	9	88.89%	18	21	85.71%	15	20	75.00%	9	12	75.00%	10	14	71.43%	10	17	58.82%	15	21	71.43%	11	18	61.11%	14	21	66.67%	10	18	55.56%	5	15	33.33%	136	200	68.00%
5b	F2F Home- 2 hours	62	74	83.78%	52	57	91.23%	59	65	90.77%	84	91	92.31%	71	80	88.75%	53	63	84.13%	72	76	94.74%	58	70	82.86%	68	82	82.93%	82	99	82.83%	60	66	90.91%	57	67	85.07%	778	890	87.42%
5c	F2F Home - 6 hours	103	106	97.17%	107	109	98.17%	82	84	97.62%	81	81	100.00%	100	102	98.04%	81	81	100.00%	97	101	96.04%	96	97	98.97%	92	93	98.92%	119	122	97.54%	96	97	98.97%	112	113	99.12%	1166	1186	98.31%
6a	F2F All - 1 hour	19	22	86.36%	10	11	90.91%	21	24	87.50%	19	24	79.17%	17	20	85.00%	17	21	80.95%	16	23	69.57%	18	24	75.00%	13	20	65.00%	23	30	76.67%	17	25	68.00%	11	21	52.38%	201	265	75.85%
6b	F2F All - 2 hours	91	103	88.35%	88	93	94.62%	88	94	93.62%	115	122	94.26%	126	135	93.33%	101	111	90.99%	121	125	96.80%	107	119	89.92%	114	128	89.06%	146	163	89.57%	104	110	94.55%	99	109	90.83%	1300	1412	92.07%
6c	F2F All - 6 hours	281	284	98.94%	355	357	99.44%	272	274	99.27%	239	239	100.00%	339	341	99.41%	283	283	100.00%	295	299	98.66%	275	276	99.64%	312	313	99.68%	276	279	98.92%	268	269	99.63%	319	320	99.69%	3514	3534	99.43%

No calls were requested to be carried out in Welsh across the whole year.

Ystradgynlais	Doctor Advice	Prescription Pick Up	Treatment Centre	Home Visits	OOH Total	Pharmacists	Clinical Support Hub	Total	NHS 111 Nurse Advice	Total
Apr-20	140	22	6	6	**174**	8	12	**194**	50	**244**
May-20	74	13	19	3	**109**	4	10	**123**	73	**196**
Jun-20	68	10	19	3	**100**	3	10	**113**	55	**168**
Jul-20	67	12	13	8	**100**	4	7	**111**	69	**180**
Aug-20	66	16	26	5	**113**	6	12	**131**	59	**190**
Sep-20	60	16	35	3	**114**	4	15	**133**	52	**185**
Oct-20	11	18	20	7	**56**	4	11	**71**	63	**134**
Nov-20	63	16	21	7	**107**	2	12	**121**	55	**176**
Dec-20	62	21	14	5	**102**	6	17	**125**	59	**184**
Jan-21	64	30	25	5	**124**	6	11	**141**	60	**201**
Feb-21	64	9	17	9	**99**	4	14	**117**	56	**173**
Mar-21	66	13	25	4	**108**	4	24	**136**	75	**211**
Totals	**805**	**196**	**240**	**65**	**1306**	**55**	**155**	**1516**	**726**	**2242**
Total % for each area against total calls received for full year	***36%***	***9%***	***11%***	***3%***	***58%***	***2%***	***7%***	***68%***	***32%***	
Total % for each area against total OOH for full year	***62%***	***15%***	***18%***	***5%***						
Total % for each area against total for pharmacy and clinical support hub for full year						***4%***	***10%***			

Ystradgynlais	Doctor Advice	Prescription Pick Up	Treatment Centre	Home Visits	Total	OOH	Pharmacists	Clinical Support Hub	NHS 111 Nurse Advice	Total
Apr-20	67%	12%	13%	8%	**100%**	56%	2%	4%	38%	**100%**
May-20	58%	14%	23%	4%	**100%**	59%	3%	6%	31%	**100%**
Jun-20	53%	14%	31%	3%	**100%**	62%	2%	8%	28%	**100%**
Jul-20	52%	24%	20%	4%	**100%**	62%	3%	5%	30%	**100%**
Aug-20	65%	9%	17%	9%	**100%**	61%	1%	7%	31%	**100%**
Sep-20	61%	12%	23%	4%	**100%**	51%	2%	11%	36%	**100%**
Oct-20	20%	32%	36%	13%	**100%**	42%	3%	8%	47%	**100%**
Nov-20	59%	15%	20%	7%	**100%**	61%	1%	7%	31%	**100%**
Dec-20	61%	21%	14%	5%	**100%**	55%	3%	9%	32%	**100%**
Jan-21	52%	24%	20%	4%	**100%**	62%	3%	5%	30%	**100%**
Feb-21	65%	9%	17%	9%	**100%**	61%	1%	7%	31%	**100%**
Mar-21	61%	12%	23%	4%	**100%**	51%	2%	11%	36%	**100%**

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

AGENDA ITEM: 3.6

Performance and Resources Committee	**Date of Meeting: 2nd September 2021**
Subject:	**Mental Health Learning Disability and Adult Funded Nursing Care, Continuing Health Care and Children and Young Persons Continuing Care**
Approved by:	Director of Nursing and Midwifery
Presented by:	Deputy Director of Nursing
Prepared by:	Senior Nurse, Continuing Health Care/ Care Home Governance Head of Complex Risk Management and Placement Team Assistant Head of Children's Nursing Deputy Director of Nursing
Other Committees and meetings considered at:	Quality, Safety and Experience Group: Funded Nursing Care and Continuing Healthcare Complex Care Specialist Nurses Meetings

PURPOSE:

This paper provides an update for the Performance and Resource' Committee on Funded Nursing Care (FNC) and Continuing Health Care (CHC) provided to adults and children and young people's Continuing Care (CC) in 2020-21, and to identify future plans for oversight and reporting.

RECOMMENDATION(S):

The Performance and Resources Committee is asked to:

- Discuss the content of this report

- Note plans to improve the reporting arrangements in relation to Funded Nursing Care, Continuing Health Care and children and young people's Continuing Care, to develop an integrated report inclusive of a population focus, rather than service specific, balancing quality performance and finance.
- There are a number of improvements planned for 2021-22 and will include some joint work with the Local Authority to agree a joint policy and Standard Operating Procedure.
- Receive a practical demonstration of the use of the Complex Care Dashboard

Approval/Ratification/Decision	Discussion	Information
✓	✓	✓

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

EXECUTIVE SUMMARY:

The Health Board commissions care for individuals within their own home and those requiring long term nursing care in care homes. This report specifically refers to adults receiving Funded Nursing Care (FNC), Continuing Nursing Care (CHC) and Children and Young People's Continuing Care (CYP CC) and builds on reports currently provided to other groups and committees.

The Health Board seeks assurance in relation to the quality of services provided in a variety of ways. It is noted that in 2020-21 there has been a significant impact from the Covid-19 pandemic which is described in this report. Over the year a wider focus to view the service on a population basis has been taken, and the opportunity to maximise the presentation and interpretation though data and intelligence which helps to inform and develop a value-based approach to care provision.

In addition to this paper, a practical demonstration of the use of the live Complex Care Dashboard will be presented.

BACKGROUND

Powys Teaching Health Board commissions care for individuals within care homes, their own home, inclusive of children and young people requiring long term care, and commissioned services within hospital placement for mental health and learning disability. The Health Board is responsible for implementing and maintaining good practice, ensuring quality standards are met and sustained. This is achieved through holistic assessment and review of need; providing education, training and support to care providers, including ensuring safe delegation, identifying and acting on issues arising, ensuring best practice in assessment and record keeping.

Regular reports are currently provided to other groups and committees within the Health Board as defined by the requirements of the CHC and CYP CC Performance Framework.

There was a delay in revising the CHC 2014 National Framework due to Covid-19. A consultation was held during 2020-21 and the new framework was published on the 31st July 2021. This has an implementation date of 30th November 2021, and the Health Board is working towards adopting this new guidance, which will include multi-agency workshops in Powys led by Gaynor Williams, the National Director for Complex Care.

The CYP CC All Wales Framework was published in October 2019 and has been implemented within Powys.

1. Assessment

1.1 At month 12 there were 225 people receiving Continuing NHS Health Care and 194 people receiving Funded Nursing Care commissioned by Powys Teaching Health Board. Table 1. summarises the groups of individuals receiving continuing health care within Powys and provides a rationale for future reporting on a population wide basis, given the need in most population groups:

Table 1: Powys residents receiving continuing health care

Groups of people receiving continuing health care	**Quantity**
Adult Mental Health	63
Adult Palliative Care	15
Children	3
Community Based/Home Care Support	14
Elderly Mentally Ill Nursing Home	58
General Nursing	47
Learning Disability	25
Total	**225**

In total over the financial year there were 341 Continuing Health Care applications received and 181 Funded Nursing Care applications received.

1.2 The Complex Care Nursing Teams in Powys, are headed by two senior nurses for Care Home Governance and one senior nurse for CYP CC; who are responsible for commissioning care for patients within a care home setting and also domiciliary care within a person's own home and also hospital settings for mental health and learning disability.

It is essential that the Health Board receives assurance that the quality of care commissioned from other providers are safe and of high standard. The Social Services and Wellbeing Act (2014) has underlined the importance of agencies working together to help and support individuals who are dependent on care, along with their carers. The Health Board works in partnership with Powys County Council and care providers to ensure the well-being of individuals who need support in every area of their lives is at the forefront of decision making. Care Inspectorate Wales are the regulatory body for this sector.

The Health Board has the following mechanisms in place to help gather

assurance on the quality of care provided by care agencies to people in their own homes and by care providers:

1.2.1 Multi-Disciplinary Team (MDT) approach:

Throughout Covid-19, regular meetings have taken place, the frequency determined by need and have been daily when required. The MDT has representation from key stakeholders including commissioning, environmental health and infection prevention and control. Concerns are escalated to senior leaders, who support the MDT in addressing them. The MDT have been able to coordinate the support activity provided to homes, enabling individual agencies and services to focus their activity in an intelligence-led approach.

Engagement with care homes is through a range of channels, for example, weekly collective conference calls with all commissioned service providers and follow-up weekly provider letters. This has allowed dissemination of key information and learning to homes, but also to respond directly to issues or queries raised by participants.

Regular support calls to care homes from Environmental Health Officers, Commissioning Officers, Complex Care Nurses and community professionals such as District Nurses. The frequency of these has varied according to homes' individual circumstances and needs, supporting care homes to identify and manage issues as they arise.

1.2.2 Proposed Role and Functions of the MDT (post Covid-19)

The MDT has had very specific functions to undertake during the Covid-19 pandemic, however it is proposed that it will need to fulfil the following functions as part of the transition to 'business as usual' post pandemic:

1. Meet to review operational data regarding older adults' accommodation; share information and intelligence; identify, address, and coordinate any commissioning or operational support issues concerning the homes that require a joint approach between PCC and PTHB. Frequency of these meetings will be determined by the MDT dependent on operational needs.
2. Gather, analyse, and share core monitoring data concerning older adults' accommodation in Powys via the MDT quality monitoring dashboard. Contributing this data to the S.33 Integrated Performance Report and Commissioning Assurance Framework as appropriate.

3. Identifying, and where needed, escalating to S.33 operational group any trends or market-wide issues affecting the older people's accommodation market in Powys.
4. Referring any safety, quality or home closure issues to the Powys Joint Integrated Monitoring Panel to be pursued through the JIMP's standing procedures.
5. Providing operational insight and expertise as required to inform the understanding and decision of the S.33 operational group.
6. Undertaking such joint operational planning and delivery activity as may be determined by the S.33 operational group regarding the future market development of Powys' residential and nursing care home provision.

The children and young people's MDT meet weekly to discuss identified children and young people who are of concern to all agencies to work together to plan, develop and commission services for those with complex needs to oversee the delivery of these commissioned services. The MDT has oversight of care delivery, ensuring needs are met.

1.2.3 Complex Care Dashboard:

The need for increased levels of scrutiny, oversight and support during the pandemic become evident. The quality monitoring dashboard was developed to aid the complex care teams to understand the experience of residents in care homes and gather assurance that residents' needs were being met. The dashboard has enabled informed decision making about the type and level of support needed by care homes, along with need to involve or refer to others, for example, safeguarding. A Blue, Red, Amber, Green (BRAG) rating was developed to support frequency of care home contact.

During calls to the care homes, the complex care teams monitored the wellbeing of residents affected by Covid-19. This included considering the robustness of assessment and any intervention, care planning and ensuring regular medical review where this was needed, noting the outcome of that contact, family involvement in decision making and discussions held with families regarding their loved one's health and well-being.

The identification of quality metrics complimented the information collected by Powys County Council via the business intelligence dashboard, developed jointly, which is a self-reporting system that the care homes populate. The information collated by the Complex Care Nurses is shared at the Multi-Disciplinary Team Meeting along with information on business intelligence to

support decision making.

Within Quarter 4, Powys Teaching Health Board and Powys County Council have worked collaboratively to develop ways of increasing the information care homes populate onto the dashboard. It will include information such as falls, staffing, infection prevention and control, as well as any safeguarding which have been escalated. This information will then inform PTHB and PCC of any increased activity of concern within the home which will allow the respective teams to respond.

Where concerns exist, the Escalating Concerns Policy is utilised. During 2020-2021 the policy was triggered in response to the management of Covid-19 outbreaks. The response to these situations has included health, social care services and environmental health working together in a co-ordinated way to support the home through the outbreak and in subsequent recovery. This process is overseen within the MDT and also through the Joint Interagency Monitoring Panel.

During the pandemic clinical support from PTHB district nursing and the complex care team were also extended to residential homes in the Powys area, to carry out reviews of patient's care plans to ensure resident's safety.

In addition to existing governance noted above, mental health and learning disability services commission residential placements for adults of working age via the all Wales Collaborative Commissioning Unit.

1.2.4 Infection Prevention and Control:

In November 2020 the Health Board appointed a dedicated infection control resource to support care homes and primary care. The Band 8a Senior Nurse for Enhanced Care worked with the MDT to identify homes for priority visits to support infection, prevention and control advice and training. Where there have been outbreaks and specific concerns, joint visits with the Environmental Health Officer have been conducted and a programme of action agreed. The learning from these visits is currently being collated and will be presented in the annual IPC report.

In October 2020 in accordance with the Welsh national lockdown, visits were restricted to exceptional circumstances only, to support the reduction of coronavirus cases and protect our care home populations.

Powys care homes were supported with making decisions around recommencing visits based on the local intelligence of that care home, using

the local Incident Management Team, the Multi-Disciplinary Team, and input from Public Health Wales and Environmental Health. Care home providers were supported to make decisions about how they could commence visits safely in their individual homes, given their responsibility for the safety of people living there. Even with the restrictions in place on routine visits, care home providers considered appropriate and sensitive arrangements were made to support indoor visits in exceptional circumstances. This included, but was not restricted to, end of life visits.

Lateral flow testing for visitors was offered to selected care homes in Powys during Quarter 3. The initiative by the Welsh Government involved testing any visitor to the home worked to provided assurance to residents and staff that that external staff who had tested negative could access the home to review residents face to face.

The joint approach to visits is being further developed in 2021, and joint reports are now produced as a result of each visit and shared with the Care Home Incident Management Team, chaired by the Director of Public Health. The Senior Nurse for IPC in Enhanced Care will be developing this approach further with the MDT in 2021/22 to ensure this approach is embedded into our normal practice after the pandemic.

1.2.5 Joint Interagency Monitoring Panel:

The Joint Interagency Monitoring Panel *(JIMP)* oversees the implementation of statutory guidance and also to respond to escalating concerns for all health and social care services provided for adults in Powys. This includes statutory, voluntary and private providers.

The panel ensures partner agencies to their shared responsibility develop a collaborative approach to monitor the quality, performance and viability of providers of health and social care services for adults in Powys. It also co-ordinates the response across agencies to issues that may affect the operation or quality of the service provided and/or that may put those using the service at risk of harm. Although over the last year the predominant concern has been the impact of the pandemic the panel would have an oversight role for example relating to issues of safeguarding, lack of Responsible Individuals and staffing challenges.

During Quarter 2 there was emphasis on gaining clarity between the purpose of the Powys JIMP and the Care Homes (MDT). There are fundamental differences in the remit, powers, membership, and activity of the JIMP and

MDT. These are summarised and can be found at Appendix 3.

1.2.6 Integrated Disability Service

This service brings together staff and resources from health, education and children's services to work with children and young people with disabilities and their families, through the 'Team Around the Family' approach to enable them to reach their full potential and independence as an adult.

Through Covid-19 the group has come together weekly to maintain oversight of those children and young people deemed to be the most vulnerable.

1.2.6 Joint Decision-Making Forum

Staff from PTHB and PCC meet monthly to discuss decisions relating to both the Continuing Care process and the Disability Resource Panel in relation to children and young people. The purpose of the meeting is to identify and agree whether package of care meets the CC threshold for children and young people and who should fund the package. This panel is developing terms of reference, attendees and agenda. This will be further embedded in the latter part of 2021.

1.2.7 Multi Agency Approval Panel (MAAP)

The purpose of the Multi Agency Approval Panel (MAAP) is to provide a forum in which partner agencies can work together to plan, develop and commission services for children and young people with complex needs where an out of county placement is being considered, and to oversee the delivery of these commissioned services. This panel meets fortnightly and complex packages of care are discussed, the group does also consider challenges in CC decisions.

2. Quality and Patient Experience

Prior to August 2020, Powys Teaching Health Board held a quarterly steering group meeting, which discussed processes, Welsh Government updates, and any financial implications CHC would have on the Health Board. Over the last year it has been recognised that the focus of the work needed to be broader to encompass the quality of services to the person receiving care, ensuring optimal safety and in capturing the experience of the individual and family.

Powys Teaching Health Board were also subject to an internal audit in 2019/2020 and recommendations from the audit were developed in to an action plan. The action plan is discussed at the Quality, Safety and Experience which is chaired by the Deputy Director of Nursing. One area of

ongoing work is the CHC Policy and Standard Operating Procedure. Significant work has been undertaken and well-developed drafts have been developed and discussions to agree these two documents are being held with Powys County Council. This will be a focus of work in 2021-22.

The Quality, Safety and Experience: Funded Nursing Care and Continuing Healthcare Group allows an integrated oversight, professional leadership and guidance in respect of the quality and safety of continuing healthcare provided in an individual's own home, along with care homes, in and out of county, who provide funded nursing care and continuing health care to residents of Powys. Terms of Reference for this meeting are attached as Appendix 1.

Dashboards are currently under development, in partnership with Local Authority to support joint agency working to demonstrate quality metrics. This will provide up to date daily and monthly information from the care homes, both in and out of county. The dashboard will provide an overall picture of quality in care homes, which will be used to support commissioning, contract delivery and identify any safeguarding issues. There is an ambition in 2021-22 to explore integration of approaches across all services, including children, mental health and learning disabilities.

Quarterly updates will be provided to the Performance and Resources Committee and Experience, Quality and Safety Committee, to provide assurance and oversight of this programme. The programme includes the response to the internal audit conducted in 2019/20 which had a rating of 'limited assurance', and finalising the operational Standard Operating Procedure for working with social services.

The group will also oversee the risks associated with this work programme and escalate any concerns, both through formal regular reporting and outside of this through to the appropriate Executive Director.

In conjunction with this approach, the development of a Value Based Health-Care approach to the design and provision of continuing health care is anticipated during 2021-2022. This approach will enable constructive challenge and create opportunities for alternative approaches, including consideration of any opportunity for the Health Board to develop and directly provide services. Since the introduction of a Value Based Panel in 2020-21 Table 2. demonstrates the number of panels and cases discussed.

Table 2: No. of cases discussed at the VBP

Date of VB Panel	No of cases discussed
16.03.2021	4
15.04.2021	6
28.05.2021	3

Mental health and learning disability along with children and young people are currently working towards aligning their processes in 2021-22 to enable them to participate within the Value Based panel. For further information please see Appendix 4 for terms of reference.

3. Reviews of Commissioned Care

Individuals who are in receipt of commissioned care from PTHB are reviewed regularly. Reviews help to inform decisions about the quality, safety and effectiveness of the service and what changes could be considered to improve service delivery.

The review process is conducted through the use of a formal assessment which considers all the services being provided to the individual. An initial review is undertaken of the care plan within the initial three months of commissioned care, and then each year as a minimum thereafter. If the individual's condition deteriorates, a more frequent review is conducted and scheduling of further assessments are tailored to the needs of the patient and their family / carers. In an urgent situation, assessments are conducted within two weeks.

During the pandemic reviews (where possible and in agreement with the patient and family) were completed virtually. Families are always invited to participate within a review and an outcome letter sent to the family to keep them informed, providing them an opportunity to discuss any concerns or areas of good practice.

The number of reviews, both projected and actual are shown in Table 3. As the table shows the number of reviews conducted exceeded those projected indicating more regular reviews and support were able to be provided during this period than initially thought. The expectation for 2021/2022 would be for CYP CC reviews to be added to the Performa.

Table 3 Completed Reviews

Area	Number of CHC reviews	Number of FNC reviews
General Adult	45	138
MH & LD	148	45
Total	**193**	**183**

4. The Strategic Programme for Primary Care

The Strategic Programme for Primary Care is an All Wales Health Board led programme that works in collaboration with the Welsh Government and responds to the strategic programme of 'A Healthier Wales'. The programme aims to bring together and develop all previous primary care strategies and reviews at an accelerated pace and scale, whilst addressing emerging priorities.

The programme includes the development of an All Wales Care Home Framework and in November 2020 the Health Board completed a self-assessment against the requirements of this. This demonstrated some areas of non-compliance and an action plan developed (Appendix 2).
Areas for improvement include:

- Development of the training offer to care homes through engagement with an All Wales approach
- Development of an infection prevention and control link-worker group which was initiated in 2020-21, Quarter 4
- Further development of quality dashboards, described earlier in this report
- Development of an escalation system across regional and national borders which is being led by the Primary Nurse lead for Wales

This action plan will be monitored and updated through the newly developing arrangements for Quality, Safety and Experience Group for Funded Nursing Care and Continuing Health Care.

5. Finance and Covid Hardship Fund

5.1 Covid Hardship Fund

The Welsh Government has provided additional funding to care homes, which has been distributed by the Local Authority. More than £60 million has been provided to local authorities across Wales over the period April to September 2020 to support adult social care providers to respond to Covid-19.

The guidance issued to local authorities set out how this funding was to be used to address the reasonable, additional costs resulting directly from the pandemic that providers of adult social care were experiencing. The funding is focussed on in-house and local authority commissioned social care and as such, did not provide comprehensive provision for the additional costs experienced by providers delivering nursing care, funded nursing care or continuing healthcare.

During Quarter 3 the Welsh Government confirmed an allocation of £22.4 million to directly support local Health Board commissioned care and joint packages of care across domiciliary care and residential care. In most cases this will apply from 1 April to 30 September to cater for the additional costs' providers would have incurred since that time.

On the 6th December 2020 the Welsh Government updated their guidance asking Health Board continue to implement this guidance for the remainder of 2020-21 to assist adult care providers with the additional costs they are incurring as a consequence of the pandemic.

5.2 Finance

The CHC spend has increased by 1,368.622 during 2020-21. This has been attributed to the increase in complex cases requiring managing within care settings throughout Covid-19. Table 4. summarises the spend over the year and terms of reference for the finance meeting scrutinising spend is attached as Appendix 5.

Table 4: Annual CHC/FNC spend

Month	Spend	Variance
Month 1	12,840.028	Even with 19/20
Month 2	12,571.878	Even with 19/20
Month 3	12,643.398	Even with 19/20
Month 4	12,881.945	Even with 19/20
Month 5	12,678.742	Even with 19/20
Month 6	12,943.292	Even with 19/20
Month 7	12,458.356 to 13,023.521	increase from forecast

Month 8	12,382.138 to 13.049,566	increase from forecast
Month 12	11,579.044 to 13,940,500	1,368.622 increase in a year

6. Summary and Recommendations:

Powys Teaching Health Board seeks assurance in relation to the quality of services provided in a variety of ways. This has been impacted by the Covid 19 pandemic which is described in this report. Over 2020-21 a wider focus to view the service on a population bases have been taken and the opportunity to maximise the presentation and interpretation though data and intelligence which helps to inform and develop a value-based approach to care provision.

The members of the Performance and Resources Committee are asked to:

- Discuss the content of this report
- Note plans to improve the reporting arrangements in relation to Funded Nursing Care, Continuing Health Care and children and young people's Continuing Care to develop an integrated report inclusive of a population focus, rather than service specific, balancing quality performance and finance.
- Note there are a number of improvements planned for 2021-22 and will include some joint work with the Local Authority to agree a joint policy and Standard Operating Procedure.
- Receive a demonstration of the use of the Complex Care Dashboard

Next Steps

- Further develop an integrated approach to funded and continuing healthcare for residents of Powys
- Agree revised policy and Standard Operating Procedure
- Further development of the quality / performance dashboard.
- Map the governance arrangements for funded and continuing healthcare to support patient needs are met with a provider.

Quality, Safety and Experience: Funded Nursing Care, Continuing Healthcare and Cottage View

Terms of Reference, October 2020

1. Purpose

Provide integrated oversight, professional leadership and guidance in respect of the quality and safety of continuing healthcare provided in an individual's own home, along with care homes, in and out of county, who provide funded nursing care and continuing health care to residents of Powys.

2. Objectives

- Provide an organisational wide setting in which to share national strategic direction and good practice
- Jointly develop policy, protocol and guidelines to maximise the provision of safe and effective care in home and other settings
- Provide oversight of the quality and safety of funded nursing care and continuing health care for the residents of Powys in and out of county
- Ensure the application of good governance in relation to education, training learning and competency-based aspects of working with other providers commissioned by the health board
- Inform and contribute to the production of quality reports to the delivery and performance group, along with the annual report and any other requirement
- Receive reports in relation to specific services including those provided to children, young people, adults, people with learning disability and those with general and mental health needs
- Escalate any themes and trends that cannot be addressed locally to the Director of Community, Primary Care and Mental Health consideration and inclusion on risk register, and the Quality Governance Group for sight, to inform planning and indicate level of assurance
- In relation to quality and safety, including safe delegation, review the requirements as set out in contracts

3. Membership

- Deputy Director of Nursing (Chair)
- Assistant Director Women and Children
- Assistant Director of Community Services
- Assistant Director Mental Health & Learning Disability
- Assistant Director Safeguarding PTHB
- Head of Nursing Women and Children
- Professional Head of Nursing Community Services
- Head of Nursing Mental Health
- Head of Nursing Learning Disability
- Senior Nurse Care Home Governance
- Lead Nurse CYP Continuing Heath Care

- Head of Complex Risk Management, Mental Health
- Pharmacy representative
- Therapies representative
- Palliative care representative
- IPC representative

4. Meetings

Meetings will be held on a 2 monthly basis in the first instance. The frequency of meetings will be kept under review and updated as required.

5. Reporting, Governance and Quoracy

The group:

5.1 is an advisory body. Any decisions regarding policy or procedure will be approved via existing scheme of delegation arrangements.
5.2 Reporting and accountability for decision making is to the relevant service group
5.3 Quoracy equates to the attendance of at least 3 members present excluding the chair directors (or nominated deputy), one from each agency, to ensure a majority view
5.4 The Terms of Reference will be reviewed on an as required basis

All Wales Care Home Framework

Powys Teaching Health Board Self-Assessment – November 2020

Statement		Relationship to Key Themes	Adopt Adapt Justify	Action Required? Y/N (if yes note summary of next steps)
1	The identified lead Executive Director (DPCC or equivalent) engages with all other executive directors, along with other appropriate senior staff, in the planning of health care services to care homes. The approach is one of integrated working across all relevant Health Board directorates and must demonstrate Board level support. The engagement should include those involved in 24/7 services including 111, primary care (GMS and urgent primary care (Out of Hours) services and the Welsh Ambulance Service Trust.	Provides equitable access? Drives consistency? Ensures connectivity? Delivers resident focused outcomes?		**Status: No further action required** • Director of Nursing & Midwifery has executive lead for the quality and safety of FNC & CHC. Director of Primary Care, Community & Mental Health has executive lead for service delivery, performance and finance. Both work closely to integrate the approach. • Regular scheduled reporting to Board Committees in relation to all aspects • Care homes is a key focus in contingency planning and revised governance arrangements during Covid. This includes: jointly chaired workstreams between PCC & PTHB; reporting regularly into PCC and PTHB Gold command • Regular GP and PTHB executive meetings held throughout the pandemic with open agenda, care homes regularly discussed. • Care home MDT consisting of PCC and PTHB operational and service leads meets twice weekly to daily dependent on need. In place since March 2020. • Section 33 arrangements in place enabling strategic and operational joint within between health board and county council. • WAST involved in discussion re clinical model during

All Wales Care Home Framework

Powys Teaching Health Board Self-Assessment – November 2020

				Covid. • Focus on children's homes, in and out of county, maintained throughout the pandemic and continues with scheduled communication and escalation of issues • Continued dialogue with OOH & DPCCMH regarding care homes including focus on verification of death • On call availability 24/7 from PTHB, PCC and EHO. • Quarter 3/4 planning clearly articulates approach to care homes • Recommendations from John Bolton's work considered and built into local approach
2	Services are planned with consideration of the impacts on individual care home residents as a key part of the planning process. Equity of access to care and services regardless of crisis or location should be the norm.	Provides equitable access? Drives consistency? Ensures connectivity? Delivers resident focused outcomes?		**Status: No further action required** • Integrated approach in place described in detail in section 1. • MDT makes use of a dashboard. • Issues are identified for discussion in the MDT that require urgent action. • Support and advice provided through provided through GP contracts; Joint Integrated Management Panel; therapy services. • HB Quality, Safety and Experience: Funded Nursing Care and Continuing Healthcare Meeting in place since August 2020. • Quality assured around individual resident health and social care needs.

All Wales Care Home Framework

Powys Teaching Health Board Self-Assessment – November 2020

3	The principle of 'once for Wales' and of collating the learning from COVID-19 (as well as wider learning from, for example, seasonal pressures) in one place has been implemented by the Heath Board.	Provides equitable access?	Adopt	**Status: Requires further action** • Complex Care Team supporting patient flow. • Information gained from MDT is shared with unscheduled care. • Senior Nurse for Infection, Prevention and Control in place for Enhanced Settings (care homes and primary care) • IP&C work programme includes issues relating to care homes and visits undertaken where evidence of positive Covid cases working closely with the Environmental Health Officers. **Action required:** • Education/training offered to care homes. This offer is being formalised currently. • Development of IP&C link worker network in Q3/4. • Investigation of nosocomial infection commenced in the health board using drafted all wales toolkits. The intention to extend this to care homes patients and staff is being explored in Q3/4.
		Drives consistency?	Adopt	
		Ensures connectivity?	Adopt	
		Delivers resident focused outcomes?	Adopt	
4	In order to 'future proof', primary and community health care services have been reviewed to reflect the learning from the COVID-19 with specific	Provides equitable access?	Justify	**Status: Requires further action** • Patient testing in hospital prior to discharge. • Resident remains in isolation on arrival to the care home for 14 days.
		Drives consistency?	Adopt	

	consideration of the experiences of care homes as part of that.	Ensures connectivity?		• Weekly staff testing has resumed and whole home testing, depending on severity of Covid within the area. • FFP3 fit mask testing provided to in-county care homes. **Action required:** • Developing dashboard for in county and out of county care homes where Powys residents are placed. • Development of contingency plans for staffing issues in care homes. • Health and social care academy in development which will support the training provision and shared learning between health and social care staff.
		Delivers resident focused outcomes?	Adopt	
5	Service planning recognises that whilst care homes will operate in different ways that reflect: their purpose; services provided; workforce and location, a person-centred care approach will form the basis of the planning process.	Provides equitable access?		**Status: Requires further action** • Care Homes have a statement of purpose around the resident's needs they are meeting. **Action required:** • Developing work on the resident's experience whilst in care in Q 3/4. • The approach will include Powys residents both within in county and out of county homes. • No mechanism currently to capture the residents wishes and feelings. Exploring the use of the activity co-ordinator role in care homes to support responses.
		Drives consistency?		
		Ensures connectivity?	Adapt	
		Delivers resident focused outcomes?	Adopt	

All Wales Care Home Framework

Powys Teaching Health Board Self-Assessment – November 2020

6	The Health Board has an effective communication process in place with the care homes within their geographical area. This includes named relationship managers, identified by the lead executive director, and appropriate to the care home registration in place in each Health Board. These will act as the points of contact for care homes when they need to escalate issues or seek urgent intervention. For those funded out of area Health Boards have a communication mechanism in place that is appropriate and effective.	Provides equitable access? Drives consistency? Ensures connectivity? Delivers resident focused outcomes?	 Adapt 	**Status: Requires further action** • Powys is divided into 3 areas North, Mid and South. Each area has a contact name Monday – Friday and out of hours cover if required. • Contact is made with the care home depending on the escalation level. If a care home is blue then it would be at least weekly, Green x 2 weekly and would increase as escalation rises. **Action required:** • There is not an established system to inform other health boards of an escalation and, where this does occur, this is usually through peer to peer contact.
7	The service model operates in line with the Framework set out in this paper to ensure a consistent set of principles are in place across Wales and outcomes for individuals are consistent regardless of local variation.	Provides equitable access? Drives consistency? Ensures connectivity? Delivers resident focused outcomes?	 	**Status: No further action required**

All Wales Care Home Framework

Powys Teaching Health Board Self-Assessment – November 2020

8	The Health Board has a clear description of the primary and community health care services that it provides and signposts to how these are accessed consistently using existing directories of information, both in and out of hours including any referral criteria if applicable.	Provides equitable access?		**Status: No further action required**
		Drives consistency?		
		Ensures connectivity?		
		Delivers resident focused outcomes?		
9	The Health Board should have a clear understanding of the range of information collected from care homes and the actions required as a result of these. There should be an appropriate feedback loop in place to ensure care homes are updated on relevant actions	Provides equitable access?		**Status: No further action required** • Names of positive residents obtained. • Date symptoms started, date tested, ACP, DNACPR, Last GP visit, Family involvement, general condition. • Number of positive staff, impact on service, support with BCP.
		Drives consistency?		
		Ensures connectivity?		
		Delivers resident focused outcomes?		

	JIMP	MDT
Legal basis	Based on Welsh Government regulations	None (Local decision to establish group in response to Covid-19)
Governance	Accountable to PCC and PTHB independent management structures	Accountable to EOG (Care Homes)/S.33 OG
Remit	Concerned with safety and quality concerns for OP and LD/MH residential care and supported living arrangements	Concerned with all operational issues arising from Covid-19 in relation to older adults' accommodation
Scope	• Considers issues with individual settings on an exception basis. • Maintains an overview of trends regarding safeguarding	• Covid-19 infections (all settings) • Vacancies and closures (all settings) • Market sustainability (all settings)
Meeting Frequency	Every two Months	Twice a Week

Membership ***(members common to both groups highlighted in yellow)***	• Senior Quality Assurance Manager - PCC • Change Manager Health and Social Care (Age Well) - PCC • Contract and Safeguarding Senior Manager – PCC • Senior Manager (Adults) - PCC • Strategic Commissioning Manager (Dom Care) - PCC • Strategic Commissioning Manager (Older Adults Accommodation) – PCC • Strategic Commissioning Manager (Live Well)- PCC • Senior Nurse Safeguarding – PTHB • Senior Manager Safeguarding – PCC • Team Managers – CiW • Assistant Director of Nursing - PTHB	• Assistant Director of Nursing PTHB: co-chair • Change Manager Health and Social Care (Ageing Well) PCC: • Assistant Director of Community Services PTHB • Strategic Commissioning Manager Ageing Well PCC • Senior Contracts Manager Adult Social Care PCC • Contract Monitoring Officer Care Homes PCC • Lead Nurse for CHC and Care Home Governance • Head of Nursing Community Services PTHB • Head of Complex Care Risk management MH • Senior Manager Safeguarding PCC • PCC Environmental Health • Public Health Wales
Safeguarding	Safeguarding represented	Safeguarding represented
CIW	CIW representation	No representation from CIW
Escalation (1)	Via contract monitoring officers, local investigations, CIW relationships, Escalating Concerns, HOSG etc.	Real time actions to be taken by PTHB/PCC staff

Terms of Reference

Value Based Continuing Health Care Panel

(Adult Services) General, Mental Health, Learning Disability

& Children's Services

1. Purpose

Chaired jointly by the Director of Nursing & Midwifery and Director of Primary Care Community & Mental Health, to:

1.1 Support and enable a value-based approach to continuing healthcare within adult services Mental Health, Learning Disability & Children's Services

1.2 Seek assurance related to the decision making in instances where continuing health care packages exceed the scheme of delegation of individuals within service groups.

1.3 Demonstrate financial probity

1.4 Report to the Efficiency Framework Group via the non-pay, procurement and continuing healthcare subgroup.

2. Role of panel

The process will include analysing the outcome decision made by the Multi-Disciplinary Team (MDT) and to ensure that the CHC Quality Assurance panel (QAP) has considered the most appropriate commissioning options to ensure equality and individual needs are met.

2.1 The panel is convened when the budgetary constraints of the chair of the weekly QAP exceeds delegated budgetary responsibilities.

2.2 Ensure decisions on eligibility are based on assessed need, independent of budgetary constraint.

2.3 Ensure there is separation between conclusions of the MDT and the commissioning of the services required to deliver the care plan.

2.4 Ensure that the Health Board can demonstrate a clear rationale for its decision on the CHC package to be commissioned, and should reflect the principles detailed in the Framework.

2.5 Provide constructive challenge to the team to maximise discussion and create opportunity for alternative approaches including consideration of any opportunity for the health board to develop and directly provide services.

2.6 Receive key metrics via a high-level dashboard, showing themes are trends related to high cost packages of care

Panel Membership

Director of Primary Care, Community Services & Mental Health Services
Director of Nursing and Midwifery
Director of Finance – or delegated representative
Head of Nursing for general and Mental Health when required.
Lead Nurse for CHC and Care Home Governance
Complex Care Specialist Nurse
Complex Care Team Administrative Assistant (minutes)

Reporting, Governance and Quoracy

- The timing in terms of holding a Panel will not have a detrimental effect on the commencement of care
- Meetings will be scheduled as required, dependent upon demand, reviewed regularly by the membership
- Quoracy agreed as at least one director, a member from the complex care team and a finance representative.
- Individual requests are presented to panel by a Complex Care Specialist Nurse, or appropriate representative. Evidence is submitted via SBAR supported by QAP documentation.
- An endorsed Quality Assurance document must be returned to the Complex Care Team within 2 working weeks of receipt, this is to allow process of payment to be made to the provider.
- Reporting and accountability for decision making as in figure as per the scheme of delegation.
- The Panel will be supported administratively by the Complex Care Team Administrative Assistant

Date 21.01.2021

Finance meetings

FNC/CHC

Purpose

The Finance meeting is to monitor and review the CHC budget, discuss current issues, to maintain links between finance and operational staff.

- Ensuring that the Complex care teams; Adult general, Mental Health, Learning Disability and young people operate within the All Wales financial sustainability policy.
- Ensure that care provision withstands prudent health care.
- Assess the financial performance of each department
- Determine what strategies for managing financial risk there are and need to be in place.
- Provide overview and area operational performance.
- Identify any key issues and risks which require discussions and escalation.
- Any new information from WG and PTHB position.
- To review operational initiatives.

Frequency

- Meetings shall be held monthly in line with the highlight report.

Members

Deputy Director of Finance.

Deputy Director Community Primary care

Finance lead

Lead Nurse for CH

Lead Nurse for MH/LD

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.7

DELIVERY AND PERFORMANCE COMMITTEE	**Date of Meeting: 2 September 2021**
Subject:	**CAPITAL AND ESTATES PERFORMANCE UPDATE**
Approved and Presented by:	Hayley Thomas, Director of Planning and Performance
Prepared by:	Wayne Tannahill, Assistant Director Estates and Property
Other Committees and meetings considered at:	Innovative Environments Group: 23 August 2021

PURPOSE:

The paper has been prepared for the Delivery and Performance Committee to receive an update on the position in relation to Capital and Estates performance.

Issues of particular importance or risk are highlighted by exception.

RECOMMENDATION(S):

The position for Capital and Estates performance is provided for **discussion** and **information.**

Approval/Ratification/Decision	**Discussion**	**Information**
✖	✓	✖

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

Strategic Objectives:	1. Focus on Wellbeing	✖
	2. Provide Early Help and Support	✖
	3. Tackle the Big Four	✖
	4. Enable Joined up Care	✖
	5. Develop Workforce Futures	✖

	6. Promote Innovative Environments	✓
	7. Put Digital First	×
	8. Transforming in Partnership	×
Health and Care Standards:	1. Staying Healthy	×
	2. Safe Care	×
	3. Effective Care	×
	4. Dignified Care	×
	5. Timely Care	×
	6. Individual Care	×
	7. Staff and Resources	×
	8. Governance, Leadership & Accountability	✓

EXECUTIVE SUMMARY:

CAPITAL: the Health Board has benefitted from a significant increase in capital allocation in 2021/22 with the Welsh Government (**WG**) committed Capital Resource Limit (**CRL**) at £14.575M, which is already the highest level, by far, for many years and does not include potential further project approvals, slippage or other funding streams. This will put pressure on the existing internal capital team resource to deliver against this step-change in activity, however, progress has been made to engage a further three substantive Project Managers, funded by capital monies, to keep pace with the workload.

Challenges also include the construction industry material supply issue, which could impact availability, cost and project programmes; to date, this has caused limited disruption in terms of a defined range of product lines in particular. COVID-19 remains an underlying issue affecting project activity, with driver shortages and delivery delays an example of this.

The following matters will be covered by the Capital element of the paper:

Discretionary Capital Programme 2021/22: overall CRL in excess of £14M inclusive of the £1.431 Discretionary Capital allowance - Capital Programme schemes agreed at Board included at **Appendix A** for reference with changes to the programme noted.

Estates Funding Advisory Board (**EFAB**): PTHB successfully secured £2.2M additional funding across a number of technical / specialist areas including; decarbonisation, fire and infrastructure. This has meant that exceptional items, such as one-off roof repairs previously included in the initial draft Capital Programme, no longer need to funded by Discretionary Capital.

All Wales Capital Funding (AWCF) / Integrated Care Funding (ICF) – major project update: there are a number of major projects including North

Powys Programme, Llandrindod Phase 2 and Brecon Car Park where PTHB has developed and submitted business cases to WG. Approval of the Full Business Case was received for Machynlleth in April and works on site are advancing well, with status for other business cases set out in the detailed section of this paper.

Welsh Government COVID/Recovery Capital: circa £550K has been secured to support the pandemic recovery – this is largely equipment related. Additionally, a request was received from WG on 11 August, with a response required by Monday 16 August, to identify any COVID-19 or associated recovery capital bids.

ESTATES: the workload continues to be a challenge as support is required for mass vaccination sites in addition to the business as usual activity, which reflects the demands of maintaining an aging estate with limited funding and resource. Update on performance will address:-

- HSE Improvement Notice status for Hand Arm Vibration Syndrome (**HAVS**)
- Grounds maintenance
- Audit: current Control of Contractors internal audit
- Decarbonisation
- Estates compliance pressures
- Estates and Facilities Performance Management System (**EFPMS**)
- Ventilation – hot weather

Risks associated with each discipline are also identified.

DETAILED BACKGROUND AND ASSESSMENT:

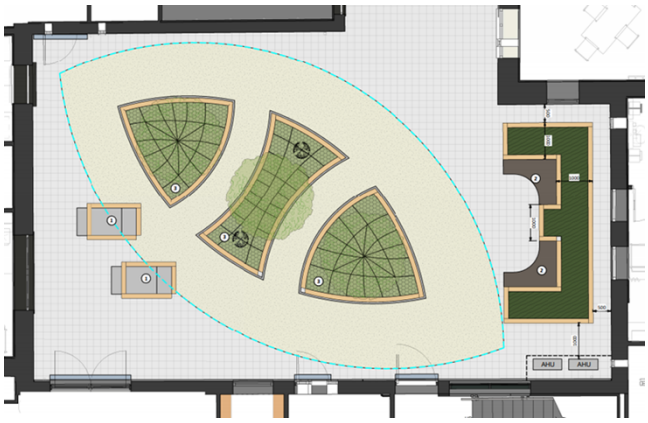
CAPITAL

Current Discretionary Capital Programme 2021/22, 2022/23: the Board approved the 2021/22, 2022/23 discretionary capital programme at its meeting on 31 March 2021 and is included at Appendix A, with consideration for the need for an agile approach, the Capital Programme reflects the positive nature of the changes resulting from the successful EFAB bids.

Major Capital Project, AWCF/ICF update: There are currently a number of schemes which have either been approved or are currently being reviewed by WG. The position in relation to AWCF would currently be: -

Project Title	Status
AWCF: Mental Health Pan Powys **Anti-ligature**	£1.17K has been allocated for anti-ligature schemes. Around £600k of that will be used for AMI at Bronllys and new IT systems in Bryntirion. £170K was allocated in 2020/21 with a further **£1M** committed this financial year, with work progressing well.
Blended Funding: AWCF, ICF & Regeneration: **North Powys Project**	Programme Business Case (**PBC**) submitted with all scrutiny comments responded to, including specifically; 'synergies', 'infrastructure' and 'decarbonisation'. Work progressing on Strategic Outline Cases (**SOC**).
Community / AWCF: **Brecon Car Park**	**£1.4M** Business Justification Case submitted to WG. Scrutiny comments received 25 May with the team drafting a response.
WG COVID-19 **Recovery capital** funding	**£0.5M** awarded for equipment. Further opportunity for bids notified in mid-August with outcome awaited.

Machynlleth Redevelopment (All Wales Capital Funding: ringfenced Primary Care Phase 1 funded): approval was received 24 March 2021 in the sum of £15.188M (including funding allocated in previous years) which also included an extra £256K in respect of a photo voltaic (PV) array to the roof linked to decarbonisation measures. Work commenced on site, 17 May 2021, with a 79-week programme. Work progressing well with community engagement activity planned.



Machynlleth: proposed new sensory garden plan & image

Llandrindod Wells Reconfiguration (All Wales Capital Funding): the £11-14M Programme Business Case for **Phase 2** has been submitted to WG, with scrutiny feedback returned. The first Business Justification Case is important to protect the investment from Phase 1 in the front of the hospital and WG are supportive of a submission which largely addresses building fabric and infrastructure services (window replacement, roof repairs, lift replacement,

boiler replacement, uplift of main entrance, etc.). Work needs to progress on the development of the BJC as a priority and this was supported by the outcome findings from the Gateway Assurance Review. The work on the further operational and clinical development of the hospital will need to begin, to support further BJC bids in due course to strengthen resilience and services at the Regional Rural Centre.

Llandrindod Air Handling Unit (AHU) – legal update: The Board was appraised of the issues related to design deficiencies related to the Endoscopy air handling unit and other design deficiencies in September 2019 and the requirement to remedy the defects and initiate a process to reclaim costs expended. On 10 June 2020, the Executive Committee supported the appointment of legal advisors for a cost of up to £12.5K plus VAT to provide initial legal advice with subsequent approval for further expenditure, circa £15K plus VAT to continue the commission with Bevan Brittan to engage expert opinion and provide guidance on the issue of a letter of claim. Current status is that the Principal Designer has been formally put on notice of claim and the expert advice, which has reflected positively on the PTHB position, is being incorporated into a letter of claim along with details of the financial value; this will enable an initial claim meeting to take place. If there is no offer of settlement, then a formal process will be entered into - any key decisions on settlement will be brought to the appropriate PTHB forum for agreement.

Integrated Care Funding (ICF): Bronllys, Health and Care Academy: good progress with completion of building work scheduled for August with subsequent IT fit out. Opportunities to secure further funding to complete subsequent phases, including external learning spaces and the conversion of a bungalow on site to provide an 'adaptive of daily living' suite approved via Cross Cutting and Resource Oversight Group. Welsh Government ICF Panel considered the application on 9 August and endorsed the submission with the caveat that some further 'match funding', in the order of £100K to £200k, was provided. This would release circa £600K to £700K from ICF for expenditure in the current financial year. A request for Powys County Council to make a capital contribution has been made and the balance of funds would be sought from WG capital funds.

Imaging for Basil Webb, Health and Care Academy

Brecon Car Park: the Business Justification Case was submitted to WG in January 2021, with the scrutiny grid prompting PTHB to further explore the potential to strengthen the decarbonisation element of the project in support of electric vehicle (**EV**) charging. The community fund raising has been significant in support of this project and the parking issues continue to be a restrictive factor for service delivery and patient accessibility. The scheme will have a positive impact for electric vehicles and decarbonisation but the initial groundwork on this steeply sloping site would dictate a summer start on site and this would not be practical in the winter period, when access to WG capital slippage support is most likely. The tenders for the project were received at the end of 2020, and whilst the contractors have been contacted and will currently stand by their prices, this is not likely to be the case as time elapses and any potential material shortages become apparent (which should be relatively limited on this scheme).

Estates Funding Advisory Board (EFAB): Welsh Government ringfenced £34M in 2021/2022 to specifically address compliance and backlog maintenance issues across a number of technical / specialist areas, which would not normally attract business case submissions, in the following categories: Decarbonisation, Infrastructure, Fire and Mental Health.

In order to maximise this opportunity a number of project bids were developed across the specified topic areas to the value of £5M. PTHB has successfully secured £2,218,576 of additional funding, equating to 6.27% of overall national budget. Approved schemes are: -

- **Fire**: £556K to complete fire compartmentation at Welshpool and Knighton
- **Infrastructure**:
  - Ystradgynlais roof (phased) £968K
  - Brecon roof: £183K
  - Newtown boilers: £180K

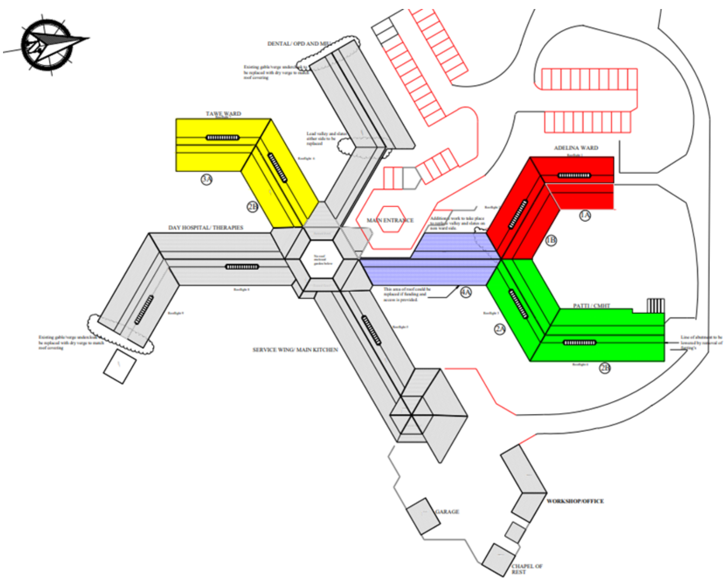
- **Decarbonisation**: £331K for 3 Building Management System scheme upgrades, which will improve heating control and monitoring, enabling remote management of building services systems.

Securing these schemes in these categories will provide significant assistance in accelerating estates compliance programmes of work across the estate and, therefore, act to mitigate targeted risks in a reduced timeframe.

This is a pilot scheme led by NWSSP-SES, and should this pilot be successful, it is likely that further funding will be made available in future years to continue to support estates compliance and backlog maintenance to act to mitigate and reduce the current, circa £73M of backlog maintenance in the health board.

WG and NWSSP-SES have been very clear in respect of the availability of this additional targeted funding, and that it must be an accelerator to act to diminish backlog maintenance values across Wales, and not displace existing ringfenced monies set aside for this same purpose.

Currently, the schemes are progressing well, with significant operational support offered for the **Ystradgynlais roofing project**, which is critical to address the numerous roof leaks during wet weather that, at times, have affected bed availability at this hospital. This is a significant project with relatively complex decant, including off-site decant to Brecon, logistics to manage along with the challenging prospect of construction activity during a winter period as dictated by the funding cycle.



Ystradgynlais roofing project: 3 phases in red/green/yellow

Welsh Government COVID/recovery capital: whilst some funding for recovery has already been secured, circa £550K for equipment such as endoscopy washers in Brecon, a further opportunity has arisen for capital availability at very short notice. The turn around time for the proposals to WG have been extremely tight as the notification came through on Wednesday 11

August with the return required by Monday 16 August. This is a relatively familiar process towards end of financial year related to capital 'slippage' funds, and schemes are usually kept 'on the shelf' for this purpose or this provides an opportunity to address emerging priorities. Deliverability is a key consideration as the funding is always required to be fully expended within financial year constraints and, in an already very busy year for capital, the limitations of resource capacity is also a key factor. The submission to WG included the following:

- Electrical infrastructure upgrade, Welshpool: £190K
- Ventilation work, Basil Webb, Bronllys: £200K
- Resurfacing car parks, Bronllys: £230K
- Building work in support of endoscopy washer replacement, Brecon £130K
- Replacement boilers, Llandrindod: £200K
- IT network infrastructure improvement and hardware: £385K
- Endoscope purchase: £55K

Innovative Environments Strategic Framework: further more detailed work to develop the framework was delayed by COVID-19 activity, but is included as a priority in the 2021/22 Annual Plan commitment.

Capital Risks:

- **Resource**: the Health Board has developed an ambitious programme of capital projects and propose an increase to resources in support. Future department plans need to take account of the particular recruitment challenges due to Powys' rurality and geographical spread. The revised capital team structure, therefore, includes suitable development and succession planning opportunities which is an important element of the long-term plan for Capital workforce development.
- **Project Prioritisation**: as further funding is secured or priorities change rapidly due to emerging operational risks (boiler failures, roof leaks, etc.), the pipeline needs to continue to be flexible in terms of prioritisation and reassessment/ re-prioritisation as need demands, whilst also maintaining a suitable governance approach. Currently, visibility is via the Innovative Environments Group.
- **Pressure on Discretionary Capital**: it remains important to note that any overspend on major capital projects is required to be absorbed by Discretionary Capital funding, which is a comparatively low value when compared to the scale of the major project programme, meaning a relatively small percentage cost pressure would have a significant impact on the discretionary capital programme. PTHB will continue to seek additional contingency level support from WG for major projects in recognition of this risk.
- **Construction industry material shortages**: the significant step up in construction activity in 2021 has coincided with Brexit and coronavirus

leading to limited availability of certain material groups (cement, metals, timber, etc.) – this is leading to price increases, shortages and delay in supply which are likely to affect cost and timeframes on projects. Welsh Government have recognised this potential pressure but are yet to advise if any support measures will be put in place – the risk will sit with client organisations for exceptional and unforeseen circumstances of this kind, and this will put significant pressure on contingency allowances.

- **Brecon Car Park**: whilst the business case has been submitted and, at the suggestion of WG, the decarbonisation and EV element is being strengthened, the nature of this project means that it would not ordinarily be seen as a high priority project. WG remain supportive but it is also important to receive approval as soon as possible to enable a start on site with the groundworks before the worst of the winter weather, which would create an elevated risk profile. Active and positive dialogue ongoing.
- **Llandrindod Phase 2**: the PBC is awaiting endorsement from WG, however, as recommended by the Gateway Assurance report, it is important to progress the development of BJC 1 in relation to the ongoing and critical infrastructure issues including lift failures, roof leaks, etc. The writing of the BJC could be undertaken inhouse, although this would have impact for the team, but some consultant design and cost advice would be required. If work started immediately, it is anticipated it would take circa 6 months or more to the point of submission. The costs of the consultant support would be at risk pending approval of the business case and could be estimated to be in the order of £50K.

ESTATES: the workload continues to be a challenge as support is required for mass vaccination sites in addition to the business as usual activity, which reflects the demands of maintaining an aging estate with limited funding and resource. A further update on the resource status for the Estates Works team is being developed. General position as follows:

HSE Improvement Notice status for Hand Arm Vibration Syndrome: the Improvement Notices have been closed out and the current arrangements for HAVS have been noted by HSE as satisfactory – some historical issues to be addressed.

Grounds maintenance: ongoing discussion with Support Services / Facilities in relation to the transfer of activity for Machynlleth, Llanidloes and Llandrindod across to Estates, partially in response to HAVS.

Audit, Control of Contractors internal audit: the fieldwork has been completed by NWSSP Audit and Assurance team with draft audit presented for consideration.

Decarbonisation: many of the measures which will act to deliver decarbonisation benefits relate to Estates activities, and some work is currently being undertaken to map the 46 initiatives from the NHS Decarbonisation

Strategic Delivery Plan into a delivery framework. Funding from EFAB decarbonisation and the proposal to engage Welsh Government Energy Service/Re-fit Cymru will help drive improvements, will in many cases will also act to mitigate compliance risks (e.g. replacing failing boilers with more efficient plant).

Estates compliance pressures: the main pressures currently evident relate to:

- **Site electrical infrastructure capacity** where additional loadings due to ventilation, EV charging, etc. are being introduced – schemes are being developed to enhance capacity as this could constitute a challenge to site development / risk.
- **Roof leaks** have been experienced across the estate with a programme of activity now initiated, with support from EFAB, etc. with further pressure expected this winter.
- **Boiler replacement** has been recognised as a pan-Powys issue for some time with a piece of work already undertaken to design the programme and awaiting funding. We have experienced recent problems at Llandrindod and Brecon.
- **Lifts –** PTHB has only very limited numbers of lifts but these are all in need of replacement. Llandrindod is planned for Phase 2 project activity and there have been a series of recent failures for the lift at Welshpool Renal Unit.
- **Estates and Facilities Performance Management System (EFPMS)**: the return of data is now complete, awaiting formal issue of WG/NWSSP-SES reports.
- **Ventilation – hot weather:** the Infection, Prevention and Control (IPC) Group requested that the Ventilation Group be convened, with the first meeting responding to issues raised by staff and staff side colleagues in relation to the use of desk fans in the workplace. The use of fans was prohibited at the onset of the pandemic, but the position is now being reconsidered as the attributes of COVID-19 are becoming clearer. This is benchmarked against other health boards and a paper is being taken to Executive Committee to enable use in hot weather, in conjunction with a suitable risk assessment, to support staff well-being and Estates will be enabling the activity.

Estates Risks:

A detailed paper, 'Overview of Estates Compliance and associate risk', was presented to Performance and Resource Committee in June 2021.

NEXT STEPS:

CAPITAL

- Delivery of the Discretionary and EFAB and other capital schemes in financial year, within cost, time and quality constraints.
- Support major project activity for Machynlleth, North Powys, Llandrindod Phase 2 and Brecon Car Park.
- Recruit to additional resource within the capital team to enable successful delivery of the step up in project activity within financial year constraints for 2021/22.
- Develop the Innovative Environments Strategic Framework as a priority to provide the context and ambition for capital investment for the health board's long term planning.

ESTATES

- Maintain risk-based approach across all sectors of activity, ensuring appropriate escalation and visibility of risk.
- Continue to seek sufficient funds and resource to support an active capital project agenda.
- Continue to review and support internal workforce and structure to manage risk and improvement activity.

APPENDIX A; DISCRETIONARY CAPITAL PROGRAMME

2021/2022-2022/23 Discretionary Capital budget 1.431M per annum

General Projects

PROJECT DESCRIPTION:	2021/22	2022/23
Equipment budget (ringfenced)	£150,000	£150,000
IT Budget (ringfenced)	£50,000	£50,000
**Improved Access Ynys Y Plant	£4,000	
Redesign of Physiotherapy Gym, Llanidloes	£45,000	
Renew Integrated Plumbing System (IPS), Ystradgynlais	£60,000	
Replace extractor fans, skylights and kitchen in Cottage View, Knighton	£25,000	
Essential ward improvements, Machynlleth	£42,000	
**Llandrindod Means of Escape	£25,000	
Replace Windows: Ward/Therapy and Outpatients MCI, Newtown	£8,000	
Replacement of Windows at Park Street, Newtown	£10,000	
Patient Services Flat Roof Repairs, Brecon - EFAB	£0	
Roof Repairs, Ystradgynlais - EFAB	£0	
Reconfiguration of Hazels, Llandrindod	£50,000	
Fire Escape improvement work to Admin Block, Newtown	£13,000	
Improvements to Hospital Reception area, Brecon	£30,000	
Replace front doors, Park Street Clinic, Newtown	£20,000	
Clinical area electrical upgrade, Adelina Patti Ward, Ystradgynlais	£25,000	
Outpatients reception/waiting area, Ystradgynlais	£14,000	
Health & Care Academy (Basil Webb), Bronllys	£175,000	
Secure Records Store, Bronllys	£35000	
Monnow Ward Reconfiguration, Bronllys	£95,000	
**Vaccination Carpark Bronllys	£12,000	
Provision of Medical Records Storage, Welshpool		£64,000
Storage Enhancement, Welshpool		tba
Extension and Upgrade of Brecon Mortuary		tba
Conversion of Community Workshops into record storage, Caersws		£38,000
Flooring replacement, Felindre Ward, Bronllys		£6,500
Outpatients Department Office - facilitate improved working conditions & people flow, Llanidloes		£31,000
Bronllys, Concert Hall roof repairs		£150,000
Crug Day Hospital, Brecon - alterations to the layout to maximise space utilisation and functionality		£32,000
Refurbishment of Podiatry Waiting area		£26,000
IT Data Enclosures, pan-Powys		£40,000
**Nurses Station and door replacement, Ystrad.		various options
**Installation of a sink in the dining room behind Llewellyn Ward, to create a clinic space, Bronllys		£7,000
**Refurbishment of Birth Centre, Llanidloes		£100,000

**Height and Weight Measurement Facility at Children's Centre, Brecon		£24,000
**Refurbishment of Occupational Therapy Workshop room, Bronllys		£17,500
**Relocation of Orthotics Lab, Brecon		TBC
**Refurbishment to bring Audiology Clinic room up to standard, Llandrindod		£9,000
**Bronllys Car Parking issues - Phase 1		£82,000
**Nurse call upgrades, pan-Powys		£50,000
Total	**£888,000**	**£877,000**
Balance of funds/ contingency	**£66,000**	**£77,500**

Items in green indicate completed schemes

Estates Compliance Schemes: £0.447M of £1.431M Discretionary Capital ringfenced

PROJECT DESCRIPTION: ESTATES COMPLIANCE	**2021/22**	**2022/23**
BMS Upgrade Phase 2; Pan-Powys - EFAB	£0	£40,000
Fire compartmentation programme - EFAB	£0	£60,000
Water - TMV compliance programme	£60,000	£60,000
**Electrical: switchgear replacement, Brecon	£0	£60,000
Ventilation fire damper programme	£0	£40,000
Fire Doors - remedial work and replacement: pan-Powys	£3,000	£25,000
Asbestos encapsulation, Boiler House, Bronllys	£15,000	
Med Gas pipeline improvement work, Brecon	£15,000	
Electrical generator fuel tank upgrade, Brecon	£25,000	
Liquid Pollution Mitigation, pan-Powys	£25,000	
Fire alarm; system replacement, Newtown	£65,000	
Access to roof plant infrastructure: Llandrindod	£20,000	
** Replacement boilers and calorifiers	£30,000	
**Access to roof plant infrastructure	£40,000	
**Electrical substation capacity upgrade	£136,000	
DISCRETIONARY VALUE: SUB-TOTAL	**£414K**	**£285K**
ESTATES COMPLIANCE sum ringfenced within £1.431M Discretionary allowance	£477K	£477K
Balance of Estates Compliance Funding to be allocated (Contingency)	£63K	£192K

Overall Contingency allowance £0.129M of £1.431M for 2021/22

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.8

DELIVERY AND PERFORMANCE COMMITTEE	**Date of Meeting: 02 September 2021**
Subject :	**Information Governance Key Performance and Compliance Metrics**
Approved and Presented by:	Rani Mallison, Board Secretary
Prepared by:	Amanda Smart, Data Protection Officer and Information Governance Manager
Other Committees and meetings considered at:	Scheduled for Executive Committee

PURPOSE:

The purpose of this paper is to inform the Delivery and Performance Committee of the information governance key performance and compliance figures for the period **1 April 2021 – 30 June 2021**.

RECOMMENDATION(S):

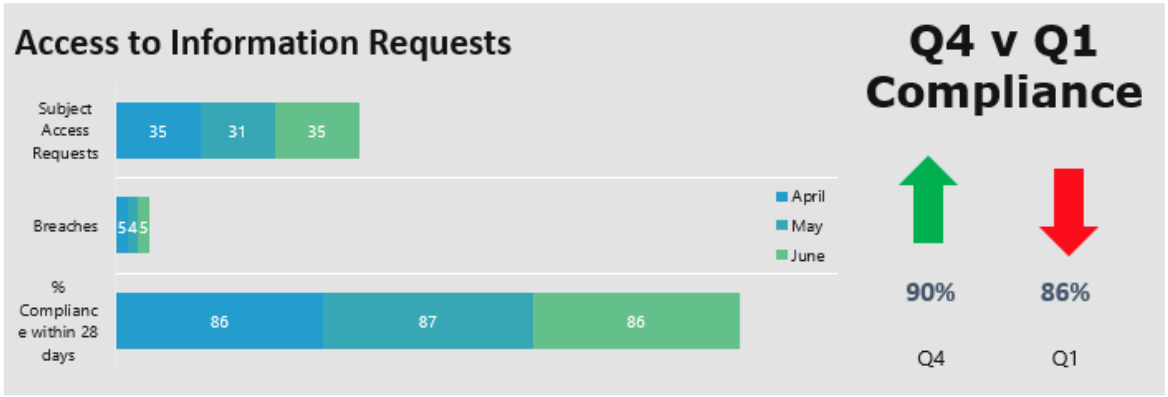
The Delivery and Performance Committee is asked to DISCUSS and NOTE the contents of this report and to identify any areas of further assurance required.

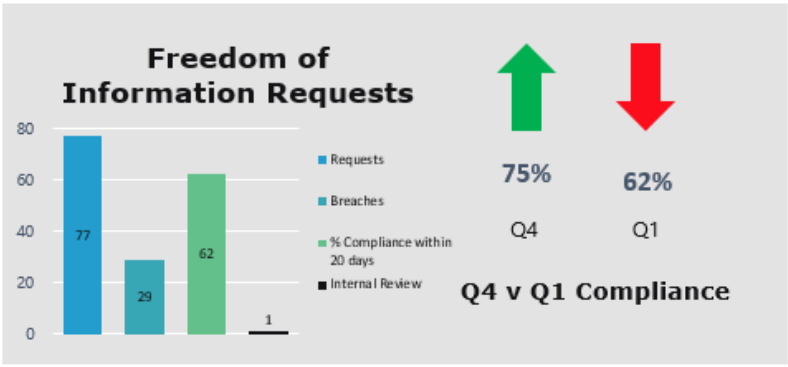
Approval/Ratification/Decision	**Discussion**	**Information**
	✓	✓

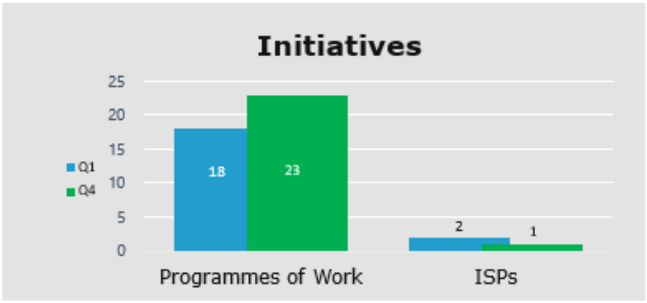
THE PAPER IS ALIGNED TO THE DELIVERY OF THE FOLLOWING STRATEGIC OBJECTIVE(S) AND HEALTH AND CARE STANDARD(S):		
Strategic Objectives:	1. Focus on Wellbeing	x
	2. Provide Early Help and Support	x
	3. Tackle the Big Four	x
	4. Enable Joined up Care	x
	5. Develop Workforce Futures	x
	6. Promote Innovative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

EXECUTIVE SUMMARY:

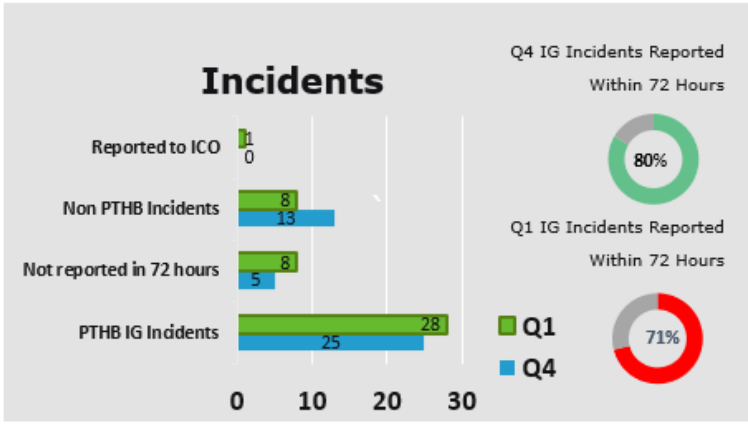
This paper has been developed to show compliance and an assessment against key information governance (IG) performance and compliance indicators. The Committee is asked to NOTE the reporting period is 1 April 2021 to 30 June 2021.

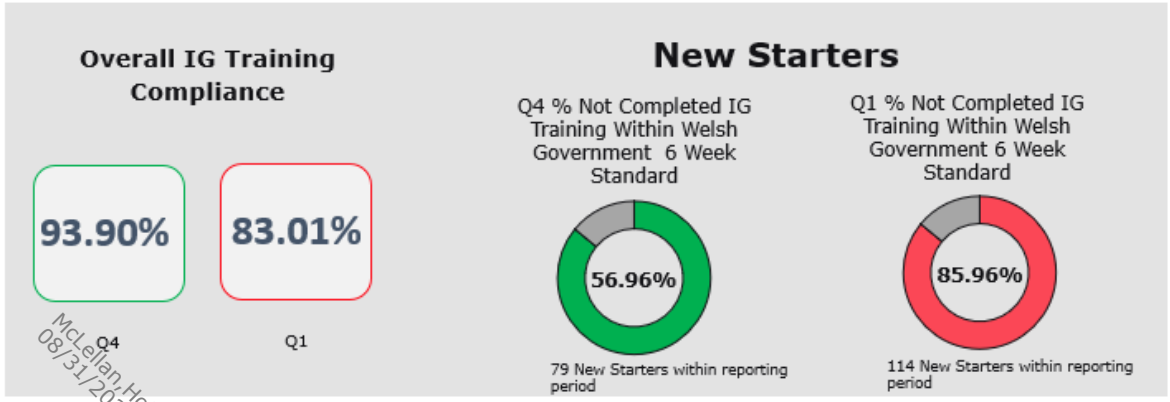


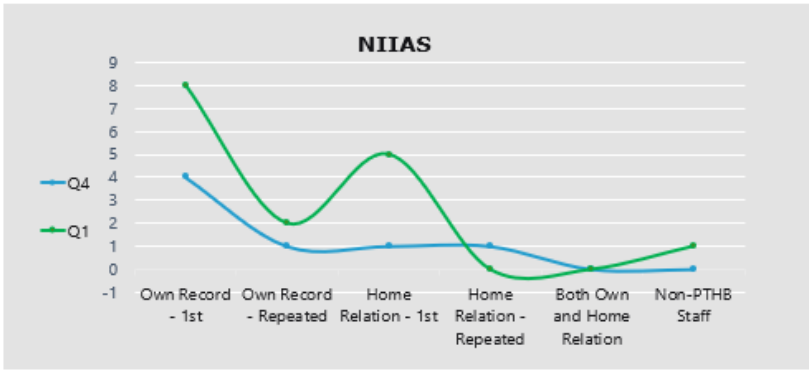




IG Dashboard







DETAILED BACKGROUND AND ASSESSMENT:

Freedom of Information (FOI) and Environmental Information Regulation (EIR) Requests

The Freedom of Information Act 2000 (the Act) reflects the government's commitment to promote greater openness by public authorities. The Act's purpose is to ensure that all areas of public bodies, including the NHS are open and transparent, ensuring that more information about public services are made readily available.

As a health board we recognise that the public have the right to know how the services of the Health Board are organised and run. As part of this right members of the public are able to make a Freedom of Information Act request into the Health Board to ask for information we hold.

To assist the public in accessing such information and in line with the Act, the Health Board has produced a Publication Scheme. It follows the format of the seven classes of information referred to in the Model Publication Scheme and in the Definition Document for Health Bodies in Wales. The Information Commissioner's Office has recently reviewed this guidance and the new version will be released towards the end of this year. Work will commence once the new version has been released to ensure the Health Board's Publication Scheme will be up to date and compliant. One area that has been further developed and completed in recent months is ensuring previous FOI responses are uploaded in a timely manner to the Disclosure Log.

To ensure the Executive Team is informed on compliance rates, a fortnightly statistical report showing the number of requests received, including breaches of the legislative timeframe continues to be disseminated for their attention/action via the Board Secretary.

The number of requests received since the last Committee report (1 April – 30 June 2021) totals **77** requests. This is a **28%** increase when compared to the same period in 2020 (**60** requests).

The Act requires a response to requests within 20 working days. Compliance for the period 1 April – 30 June 2021, is shown below alongside Q4 2020-21 for comparison:

	Q4 2020 - 21	Apr 2021	May 2021	Jun 2021	Q1 Total
No of Requests	**92**	19	29	29	**77**
No. Of Breaches	**24**	5	12	12	**29**
% compliance	**75%**	74%	59%	59%	**62%**

Compliance rates during this time period have dropped and remains below the Information Commissioner's target of 90%. The IG Team continue to monitor compliance and escalate issues to services leads and the Executive Team. The IG Team is reviewing compliance against services and will offer FOI training to service areas where needed.

The main causes for breaches during this timeframe were:

- delays caused by staff commitments to provide responses within the time frame
- delays spent by the IG Team chasing services and formatting of responses
- Complex requests
- Reduced capacity within the IG Team

Requests received during this period have been received from a number of sources, these are shown in the table below:

Requester Type	**Apr**	**May**	**Jun**	**Total**
Company	2	3	2	**7**
Organisation	2	2	6	**10**
Individual	12	14	11	**37**
Police	0	0	0	**0**
Media	3	8	9	**20**
Welsh Government	0	0	1	**1**
Charity	0	1	0	**1**
NHS	0	1	0	**1**
TOTAL	**19**	**29**	**29**	**77**

Internal Reviews

The FOI Act allows a requestor the right to request an internal review if they are dissatisfied with the health board's original response. The legislative timeframe to complete an internal review is 20 working days from the date it has been received into the organisation. During this reporting period the Health Board received **1** request for internal review, the exemption was upheld and to date no further challenges have been received from the requestor.

EIR Requests

EIR requests are managed in line with FOI requests under the same health board procedure. There were **no** EIR requests submitted during this period.

All Wales Comparison

Unfortunately, the all wales comparative figures are not available for this time period, however, the national FOI Community of Practice group has now restarted and these figures should be available for the next reporting period.

Welsh Government Requests

We have received **1** request from Welsh Government in relation to FOI request they had received in which information they were looking to disclose pertained to PTHB. Their request was for us to review the content of and provide a response to enable them to respond. This was completed in the timeframe required.

Access to Information requests

Under the UK General Data Protection Regulation/Data Protection Act 2018, individuals have the right to request access to information the health board holds about them e.g. staff records or medication records. This is called a subject access request. In certain circumstances an individual may wish to make a request about someone else e.g. family member or someone who is deceased. These types of request are called third party requests or requests under the Access to Health Records Act (deceased individuals). All access to information requests are co-ordinated and managed by the Information Governance Team.

To ensure the Executive Team is informed on compliance rates, a fortnightly statistical report showing the number of requests received, including breaches of the legislative timeframe continues to be disseminated for their attention/action.

A total of **149** requests have been received in the reporting period 1 April 2021 to 30 June 2021. This figure includes **124** requests dealt with by the health board and **25** requests received by the health board's managed practice. The total number of requests received are 20% higher than the same reporting period in 2020.

Compliance for the period 1 April – 30 June 2021, is shown below alongside Q4 2020-21 for comparison:

	Q4 2020/21	**Apr 2021**	**May 2021**	**Jun 2021**	**Q1 Total**
Subject Access Requests (DPA = Living)	88	35	31	35	**99**
Breaches	10	5	4	5	**14**
% of compliance within 28 days (UK GDPR)	90%	86%	87%	86%	**86%**

There have been **14** subject access requests which were not responded to within the statutory one month (28 days). The reasons for delays are summarised below:

- Staffing in service areas that source the records, in particular Women and Children's, and Mental Health Service Groups;
- Reduced capacity within the IG team;
- The IG team has received a number of complex requests including full audits of who has accessed an individual's records, and requests for email searches.

These requests may require an extension to the 28 day deadline, and the co-ordination of information from services and Digital Health and Care Wales;
- The volume of records being requested has increased in this quarter. The requests received have stipulated a requirement for everything held by the Health Board, rather than a specific service or timeframe.

In order to mitigate the number of breaches, the team is liaising with respective services to try and send the records for disclosure electronically to the team to avoid any un-necessary delay where possible.

Access requests for Deceased Patients and 3rd party DPA requests:

There were no breaches relating to requests for the health records of deceased patients, this is comparable for the same reporting period in 2020.

Health board compliance for the period 1 April – 30 June 2021, is shown below, with Q4 for comparison:

	Q4 2020/21	**Apr 21**	**May 21**	**Jun 21**	**Q1 Total**
3rd party DPA requests not subject to timescale e.g. Police	19	3	8	3	**14**
Requests for Deceased (AHRA)*	7	2	2	1	**5**
Breaches	1	0	0	0	**0**
% of compliance within 40 days	92%	100%	100%	100%	**100%**

Requests for Rectification, Erasure and Restricting Processing
Under the UK GDPR, individuals have the right to request the health board amends factual inaccuracies in relation to their medical record (rectification) e.g. name spelt incorrectly, or wrong DOB. They can also request the health board to delete their personal data (erasure) or stop the health board using their data (restrict processing) if they believe there has been a breach in security. These are not absolute rights for health data, and requests must be made in writing the health board Data Protection Officer (Information Governance Manager) to consider, on a case by case basis.

During this reporting period the IG team received **1** request for erasure in relation to a clinical platform used within the Health Board. After consideration and collaboration with the clinical team and confirmation that no clinical information had been stored or provided to the individual, this request for erasure was accepted and the data confirmed deleted.

Information Governance Related Complaints

The IG Team has received **1** complaint relating to how requests have been managed during the reporting period. This related to Women and Children's Service Group records, and as a result of the investigations, improvements are being implemented by the Assistant Director overseeing this service with support from the IG team.

IG Training

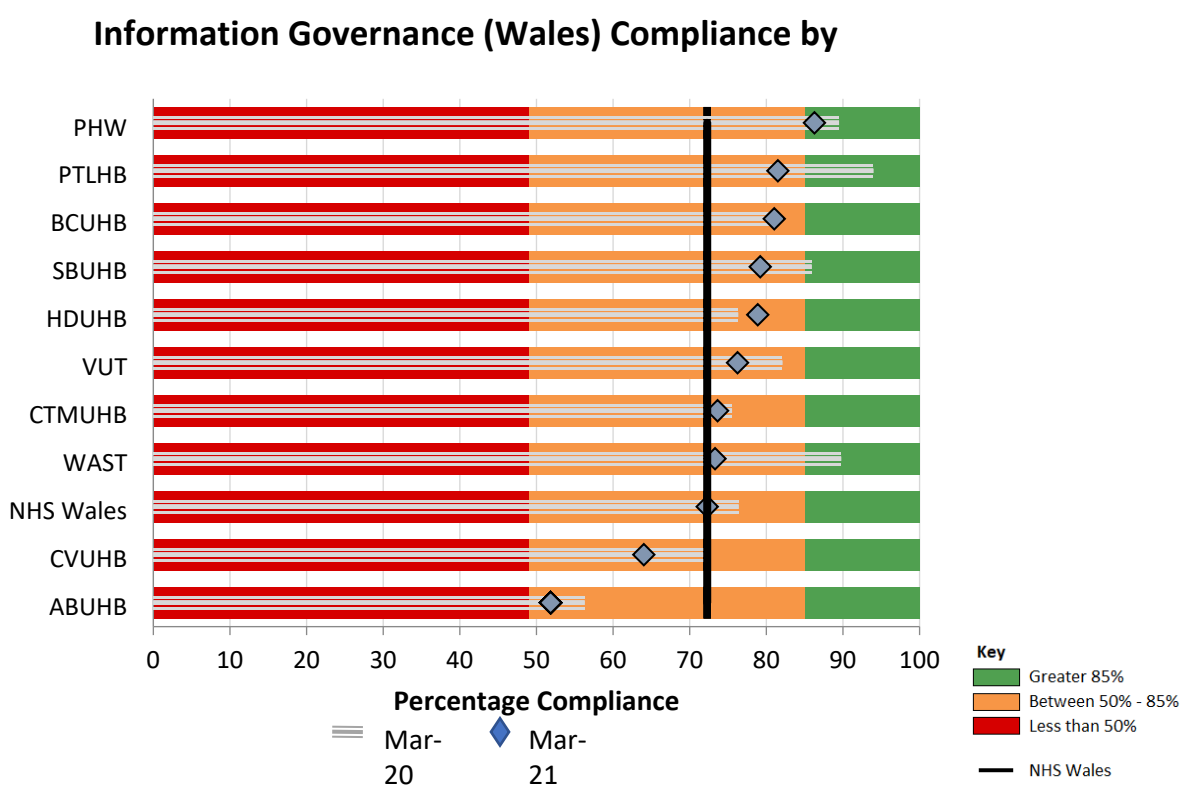
As at 30 June 2021, the overall compliance rate of the IG E-Learning mandatory training for the health board was at **83.01%.** The table below breaks down the compliance by directorate:

Directorate	**Compliance %**
CHC	87.78%
COVID 19 Prevention and Response	90.91%
Chief Executive Office	52.94%
Community Care & Therapies	85.16%
Community Dental Service	86.44%
Corporate Governance	82.35%
FID Finance Directorate	89.66%
Facilities - WOD	82.41%
HCRW	84.51%
MED Medical Directorate	53.85%
MHD Mental Health	77.44%
Medicines Management	78.79%
NUD Nursing Directorate	80.56%
PHD Public Health Directorate	77.78%
PLD Planning Directorate	89.89%
Primary Care	87.88%
WOD Directorate	93.88%
Women and Children Directorate	79.82%

The IG Team has noted the decrease in compliance compared with the last reporting period. Work will commence in the forthcoming months to undertake a target email exercise to remind non-compliant staff to complete this training in the hope this will help improve compliance rates.

National E-Learning Compliance

The All Wales compliance figures have now been populated following the Covid-19 pandemic. The information in the table below shows PTHB ranked second in IG Training Compliance with **83.01%** and ahead of the NHS Wales average.



New Starters

Welsh Government requires that all mandatory training is undertaken within 6 weeks of commencing employment and figures show that during this reporting period **85.96%** (114 new members of staff) did not complete their IG Training within the required 6-week period, 78.07% (89) have not completed and 8.77% (10) not completed within 6 weeks of commenced employment. Please see table below which breaks down new starters from 1 April – 30 June 2021:

Completed	% Compliance	Headcount
Not Completed	78.07%	89
Completed prior to joining	5.26%	6
Completed within 6 weeks	8.77%	10
Completed after 6 weeks	7.89%	9

The IG Team will liaise with the WOD Directorate to discuss the process and follow up on the 78.07% of those who are working within the health board but have not completed their mandatory training. In addition, the IG Team will be undertaking a target email exercise to remind non-compliant staff to complete this training. Should there be an incident the Information Commissioner's Office will not look favourably that staff have not undertaken this training.

Local IG Training undertaken:
The IG team has commenced providing tailored training sessions upon request by services. This current quarter two training sessions have taken place, which have focused on training in relation to Subject Access Requests for new service representatives, and an opportunity of refresher training for those already assisting with SARs.

Future IG learning tools:
To enhance learning and awareness around Information Governance, the IG Team has started to explore new ways of providing IG awareness electronically.

Policy Schedule and Compliance

Local policy and procedure development work is included in the IG workplan and work continues to progress. The team has finalised the Information Governance Incident Reporting Standard Operating Procedure to support the Once for Wales Reporting System (OFWRS). The SOP has been uploaded to the intranet to support the rollout of the programme.

Datix Incidents (Breach Reporting)

The UK General Data Protection Regulation (UK GDPR) introduced a duty on all organisations to report certain types of personal data breach to the relevant supervisory authority i.e. the Information Commissioner's Office (ICO) within 72 hours of the organisation becoming aware of the breach. These breaches (incidents) are reported using the Once for Wales Concerns Management System and those with IG relevance are reviewed daily by the Information Governance Team. To manage this, the Team has implemented a robust process for breach detection, investigation and reporting and to support this a record of IG incidents is maintained. A personal data breach risk assessment is carried out for each incident and the outcome and scoring is added to the Datix Incident Management system. This facilitates the decision-making about whether or not to notify the ICO and the affected individuals.

In the reporting period of 1 April to 30 June 2021, **28** Information Governance incidents have been reported. **8** of the **28** incidents were not reported on Datix within 72 hours. This was due to service delays in reporting.

Those non-PTHB incidents are incidents that have affected the health board but did not originate within the health board e.g. district general hospital or GP Practice. In these circumstances should a common theme appear when reviewing the data, the IG Team will liaise with the service lead, IG lead in the neighbouring organisations or GP practice directly to alert them to the incident and work with them to ensure recurrence of these types of incidents do not happen again. Should there be key areas of learning, changes or updates may be added to local policies and procedures to eliminate the risk from happening internally.

The table below shows the breakdown of the number of incidents for reporting period 1 April – 30 June 2021 (Q1) alongside the previous quarter:

	Q4	Q1	Total
Number of PTHB IG Incidents reported	25	28	**53**
Number of IG incidents NOT reported within the 72 hours onto the Datix system (including non PTHB incidents)	5	8	**13**
Non PTHB incidents	13	8	**21**

Incident Themes

The incidents for this time period have been reviewed with themes identified. The top 3 themes for this reporting period were:

- Confidentiality - Breach of patient or staff confidentiality (4 incidents)
- Records Management – Letter/Email sent to the wrong address (3 incidents)
- Records Management – Wrong patient recorded (3 incidents)

Following investigations into these incidents there were particular issues, for example: breach of patient confidentiality where documents, including PII, have been left on desks and printers with details showing. As part of the Datix process, we have contacted the teams involved to remind them of their responsibilities when handling PII documentation and using shared printers. Another issue which has been consistent is no address or name on envelope/package. We have raised this as a joint issue with the Facilities team, and have agreed a process to address these incidents as they arise. We have contacted the teams involved and their line managers to escalate.

To reinforce good practice, the IG team has continued to issue IG Alerts, which has included themes identified within the Datix reviews. The team also contact services directly to remind them of their responsibilities in terms of policies and procedures. Should any gaps in IG guidance be identified, this will be added to the IG workplan for development.

The table below shows a full breakdown of the themes of reported incidents:

Incident type	Incident detail (theme)	No. of incidents	Total
Records Management	missing records	3	
	Referral Process	1	
	Missing documentation	2	
	Wrong patient recorded	3	

	Email addresses left visible	1	
	Letter/Email sent to the wrong address	3	
	Incorrect address on envelope	1	
	Wrong patient information in letter	1	
	No address or name on envelope/package	1	
	PII left face up on printer	1	
Communication	Poor communication between staff	1	
	Records not locked away securely	2	
	Access to others emails	1	
	WCCIS Issue	2	
Confidentiality	Breach of patient/staff confidentiality	4	
	Staff opening letter not addressed to them	1	
TOTAL NO PTHB IG INCIDENTS			**28**
	PII of different patient in discharge pack	2	
	Missing discharge documentation from DGH	3	
	Misdirected email/mail	2	
	Breach of patient confidentiality	1	
TOTAL NO OF NON PTHB INCIDENTS			**8**

It has been highlighted that there has been a slight increase in incidents recorded compared to Q4 this maybe contributed to the new system being implemented and raising staff awareness. The number of PTHB incidents in this reporting period is comparable with the same time period in 2020 (**25** incidents) resulting in there being an increase in incidents reported. Similarly, the number of non PTHB incidents reported for the same period in 2020 (**8**) has been the same.

Incident Management and Reporting to the Information Commissioner's Office (ICO)

Following the submission of a personal data breach report, the ICO investigate the breach, and may provide recommendations back to the health board where they feel improvements need to be made. All recommendations made by the ICO are added to the ICO Recommendations log which is due to be presented to the Executive Team in the forthcoming months for adoption. In addition, any IG actions required as a result of these recommendations have been added to the IG Workplan.

Of the 28 incidents reported, **one** of these were deemed a significant breach that was reported to the ICO. Of which no financial action was taken by the ICO, however recommendations were made for the service to implement. These have been communicated to the service and added to the ICO recommendations spreadsheet to monitor compliance and completion by the service. The IG Team is

working to develop a tracking system for actions issued by the ICO and will be embedded into future reporting.

Complaints & Learning in relation to the IG Team:

No IG related complaints have been raised as reported during this reporting period.

The National Intelligent Integrated Audit Solution (NIIAS)

National Intelligent Integrated Audit System (NIIAS) is a national tool procured by NHS Wales to detect potential misuse of national information systems. It highlights instances when employees may have abused their access rights to view personal information that they may not be entitled to. The purpose of the tool is to assist the organisation in complying with its Data Protection responsibilities. This gives the public and its partners more confidence in the Health Board's ability to ensure confidentiality and privacy of their personal data.

The IG Team runs the NIIAS report weekly, notifications are investigated and respective line managers and the Workforce & OD Team are engaged in the process when necessary.

The Department of Health and Care Wales (DHCW) has developed a national NIIAS Usage Report which is reported to the monthly All-Wales Medical Directors' meeting. The purpose of the report is to inform and build mutual assurance and trust with each health board to enable the further sharing of patient data between organisations and to show organisational commitment to auditing access to national systems.

Powys Teaching Health Board report on the number of individuals who have potentially accessed their own record, or that of a family member (home relation). There were **16** NIIAS notifications reported for the period 1 April – 30 June 2021. **14** were first time offences and **2** were repeat offences which in turn were reported to the member of staff's line manager and Workforce & Organisational Department as per agreed process. None of the notifications were deemed to be a reportable breach to the ICO following investigation. The table below shows a breakdown of the notifications received:

Month	Q4	April	May	June	Total
Own Record - 1st offence	4	1	5	2	**12**
Own Record - repeated	1	0	1	1	**3**
Home Relations (Family) Record - 1st offence	1	1	4	0	**6**
Home Relations (Family) Record - repeated	1	0	0	0	**1**
Both home relations and own record accessed	0	0	0	0	**0**

Notification for Non-PTHB member of staff	0	0	0	1	**1**
Total	**7**	**2**	**10**	**4**	**23**

The figures during this reporting period are slightly lower compared with the same reporting period in 2020 (**17**). The IG team provide reminders to staff on the NIIAS process in IG Alerts.

Initiatives/ Programmes Requiring IG Input

Background

Under the UK General Data Protection Regulation (UK GDPR) there is a requirement that any new initiative or project should complete a Data Protection Impact Assessment (DPIA) prior to processing patient or staff data. A DPIA is a process that helps to identify and minimise the data protection risks of a project or proposed new way of sharing information. A DPIA can be a lengthy process when the project is substantial or the data involved is special category data. The DPIA process may require direct supplier input and we may also need to involve the health board Senior Information Risk Owner (SIRO) or Caldicott Guardian. Senior members of the IG team will review a DPIA, and will guide the service to ensure the relevant information is included. The health board Data Protection Officer (DPO) then advises if the DPIA review has concluded there are appropriate technical and organisational security measures in place to enable sign off.

The IG team have representation on the Powys Digital Governance Board, and a large proportion of the work undertaken by the team is to impartially support the procurement of software, systems, and new ways of data sharing, where appropriate. This would include supporting services in populating Data Protection Impact Assessments (DPIA), Data Processing Agreements (DPA), contracts, Information Sharing Protocols (ISPs) and any review work associated with ensuring that we comply with the UK GDPR and other data protection legislation. It is important to note that not all programmes of work have required a DPIA, DPA or ISP. In some circumstances, IG involvement has included researching guidance and providing advice regarding all data protection legislation. There is no set timeframe for completing DPIAs, DPAs and ISPs, IG support is provided on a first come, first served basis but the team will prioritise urgent requests where needed.

Initiative Work Undertaken

From the 1 April to 30 June 2021, the IG Team has been asked to provide IG input on the following in relation to Initiatives/Programmes of Work:

- **18** new programmes of work (15 Local, 2 National and 1 both Local and National), **5** of which have been completed.
- The team are providing support to **151** initiatives/programmes of work. All of which have been progressed, and some of which have been completed but are yet to be updated and closed on the Programme of Work due to capacity within

the team. The team continues to prioritise those of greatest urgency/Covid related.
- These **151** remain in progress due to: reduced capacity in the IG team, or they may have been returned to the service for further work/information required.

Where a project cannot be signed off by the teams within the governance groups due to the level of risk, the Senior Information Risk Owner (SIRO) will consider each risk and any mitigations to make an informed decision on whether the health board can accept the risk and use that system/supplier. The IG team maintains a register of approvals agreed by the SIRO, of which there was 2 for this reporting period, detailed below:

- "Paediatric Dictaphone" – Paediatrics Department
- "Bookings App" – Mass Vaccination Team

Information Sharing Protocols (ISP)

Many organisations directly concerned with the health, education, safety, crime prevention and social wellbeing of people in Wales have signed up to the Wales Accord on the Sharing of Personal Information (WASPI). WASPI is tool to support the sharing of information between these organisations effectively and lawfully, whether that is the network providing support and good practice guidance, or the collective development and use of template documents such as an Information Sharing Protocol (ISP) agreement. Although the development of ISPs is not mandatory, it is promoted across Wales as good practice and is endorsed by the ICO. It underpins the WASPI framework and supports the regular, reciprocal sharing of personal information between organisations.

Information Sharing Protocols are included to the IG work programme under initiatives and projects. During the reporting period, the following ISP's have been reviewed or supported by the IG team:

- Information Sharing as part of the Child Health Team (Education Flow for Vaccination Programmes)
- Homeless Prevention

Once approved at local level, these ISPs are then presented nationally as part of the WASPI quality assurance group if requiring approval. The IG team will continue to promote the development of ISPs, where possible. Work also continues to review outstanding and identify new agreements.

The team has continued to progress work to support the transition period for Brexit, the national roll out of Microsoft Office 365, and continue to support service improvement programmes throughout the Health Board.

NEXT STEPS:

Continued assurance reports will be submitted to the Delivery and Performance Committee.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.9

DELIVERY & PERFORMANCE COMMITTEE	**Date of Meeting: 02 September 2021**
Subject:	**RECORDS MANAGEMENT IMPROVEMENT PLAN**
Approved and Presented by:	Rani Mallison, Board Secretary & Pete Hopgood, Director of Finance & IT
Prepared by:	Information Governance and ICT Team Members
Other Committees and meetings considered at:	The Internal Audit Review of Records Management and the responding Improvement Plan was presented to the Executive Committee and Audit, Risk & Assurance Committee in November 2019.

PURPOSE:

The purpose of this paper is to provide the Delivery & Performance Committee with an outline of progress made in implementing the Records Management Improvement Plan, approved in November 2019.

RECOMMENDATION(S):

The Delivery & Performance Committee is asked to:

- NOTE the progress made to date; and
- NOTE those actions where progress has been delayed due to the impact of COVID-19.

Approval/Ratification/Decision	**Discussion**	**Information**
✘	✓	✘

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

SITUATION:

Under the terms of the Public Record Act 1958 all records created in the Health Board are regarded as public records. The act imposes a statutory duty on the Health Board to make arrangements for the safe keeping and eventual disposal of records.

Further, as a Public Authority subject to the Freedom of Information Act (FOIA) the Health Board has a duty to follow the Code of Practice for Records Management published by the Lord Chancellor in accordance with *section 46* of the FOIA. The code provides guidance to public authorities on keeping, managing and destroying records.

Records Management is the process by which the Health Board manages all aspects of records whether internally or externally generated and in any format or media type, from their creation through their lifecycle to their eventual disposal.

The Health Board, via the Records Management Framework, has committed to a systematic and planned approach to the secure and effective management of all records within the organisation, particularly patients' records. It takes its responsibility towards patient confidentiality seriously. Records should always be held in an environment which affords an appropriate level of security to the sensitivity of the records held and should only be accessed on a need to know basis.

The Health Board's documents and records are its corporate memory, providing evidence of actions and decisions and represent a valuable asset to support daily functions and operations. Records support policy formation and managerial decision-making, protect the interests of the health board and the rights of patients, staff and members of the public. They support consistency, continuity, efficiency and productivity and help deliver services and patient care in consistent and equitable ways. Health records are contemporaneous and form the basis for the organisation's accountability for clinical care.

The Health Board retains legal responsibility for the information held by its documents and records management systems until their disposal i.e. they are destroyed or if they are of archival value, transferred to a Place of Deposit.

BACKGROUND:

In August 2019, Internal Audit undertook a review of records management. The objective of the review was to assess the adequacy of the arrangements in place for the management of health records, including compliance with policies and procedures.

The review sought to provide assurance that:

- roles, responsibilities and arrangements for the creation, storage, management, retention and disposal of records are clearly documented and reflect the GDPR;
- records are securely shared and stored, including the tracking and transportation of information, accessibility / availability and maintenance of records (including archiving and disposal);
- any record management issues have been identified, risk prioritised and reported; and
- sufficient resources are afforded to train staff (including induction training) and that staff overseeing the management of records have sufficient knowledge and experience.

Internal Audit's conclusion of the review was that the level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with records management was 'No Assurance'. The findings and recommendations of Internal Audit are attached at **Appendix A**.

Internal Audit's report recommended six high rated recommendations for action and so a Records Management Improvement Plan was developed to ensure compliance with the legal and regulatory framework in which PTHB should manage its records (all records including health, employee and corporate). In delivering the Improvement Plan, the recommendations raised by Internal Audit would be achieved. The Improvement Plan is attached at **Appendix B**.

In approving the Improvement Plan in November 2019, the Executive Committee and Audit, Risk and Assurance Committee, recognised that the Improvement Plan was ambitious and that resource would need to be identified to co-ordinate and support its delivery. In addition, it was agreed that the Improvement Plan would be co-ordinated by the Board Secretary, however a number of Executive Directors would be responsible for actions within it and therefore the Plan would be owned by the Executive Team as a collective. In January 2020, an Interim Service Improvement Manager was appointed to support the development and implementation of improvements in records management across the organisation.

ASSESSMENT:

COVID-19 was declared a pandemic by the World Health Organisation on 11 March 2020, and this has subsequently led to NHS organisations, including Powys Teaching Health Board, needing to focus on preparations and plans for responding to the pandemic as it progresses. The capacity required to respond appropriately to the pandemic, particularly in the first and second waves, has inevitably impacted the ability to progress the Records Management Improvement Plan which requires input from across the organisation. Further, the Service Improvement Manager was re-deployed into the Mass Vaccination Service in January 2021 and subsequently appointed to another role within the organisation.

An overview of progress in implementing the Records Management Improvement Plan is provided below. **Key:**

Complete	Delayed/Not commenced	Commenced but past agreed timescale	On track

PTHB Action		Lead	Date for Completion	Status	Update at 30/06/21
1. GOVERNANCE & ACCOUNTABILITY					
1.1	Review and update the Health Board's Records Management Policy and supporting Procedures to ensure clarity on roles, responsibilities and the framework for operation in the organisation	Board Secretary	To be approved February 2020		Records Management Framework approved and published December 2020. Health Records Procedure reviewed and published January 2021.
1.2	Publish the updated Policy and Procedures, raising awareness across the organisation	Board Secretary	March 2020		
1.3	Introduce of a programme of records management training for clinicians and staff, including management of identified risks	Board Secretary	April 2020 onwards		Delayed in-light of COVID-19. A national e-learning module is under development.
1.4	Ensure that risks associated with records management, including those arising from the Internal Audit review, are identified and recorded managed in-line with the Risk Management Framework	Board Secretary	November 2019		Records Management Project Risk Register developed and added to the Board Secretary's Directorate Risk Register, which is managed in accordance with the Risk Management Framework.
2. RECORDS MANAGEMENT FRAMEWORK					
2.1	Review and update the Health Board's Records Management Policy and supporting Procedures to ensure clarity on roles, responsibilities and the framework for operation in the organisation	Board Secretary	To be approved February 2020		Records Management Framework approved and published December 2020. Health Records Procedure reviewed and published January 2021.
2.2	Review and update arrangements for Access to Information Requests, e.g. Subject Access Requests, ensuring clarity on roles and responsibilities	Board Secretary & Executive Directors	April 2020		• Procedure for Requests under the Freedom of Information Act (FOI) 2000, and the Environmental Information Act (EIR) 2004, reviewed and published January 2021. • Procedure for Subject Access Requests under development.

PTHB Action		Lead	Date for Completion	Status	Update at 30/06/21
2.3	Review arrangements for the reporting and management of information governance related breaches and incidents	Board Secretary	January 2020		Information Governance Incident Reporting: Standard Operational Procedure, Development and Published May 2021
3. STORAGE, SECURITY & RETRIEVAL					
3.1	Undertake a scoping exercise to assess the location, status and identity of all records in the organisation, informing the ongoing development of the Information Asset Register	Board Secretary with Executive Directors	March 2020		Whilst initial mapping work has commenced, COVID-19 has impacted the ability to progress this action which requires the involvement of all services across the organisation.
3.2	Review and update procedures and guidance to support effective tracking of records	Board Secretary with Director of Finance & IT	March 2020		Guidance and training in place which are regularly communicated to all WPAS users and is updated in accordance with system changes • Training is provided to all new users and refresher training undertaken. Drop in sessions are available to users on an ongoing basis. • Regular data quality and performance reports are made available to service leads
3.3	Develop a business case for the further role out of Intelligence Tracking across all provided services	Director of Finance & IT	April 2020		The rollout of Intelligent Tracking for services who use the general i.e. green hospital casenotes is complete.
3.4	Ensure adequate Business Continuity Planning arrangements are in place relating to records management	Board Secretary with Executive Directors	April 2020		Whilst an initial assessment of business continuity plans has commenced, COVID-19 has impacted the ability to progress this action which requires the involvement of all services across the organisation.
3.5	Review and update arrangements for the retrieval and transportation	Board Secretary with Director	March 2020		Delayed in-light of COVID-19 and the impact on support services' ability to progress this work in partnership with operational services

PTHB Action		Lead	Date for Completion	Status	Update at 30/06/21
	of records, ensuring consistency in approach across the organisation	of Workforce, OD & Support Services			and Service Improvement Manager for Records.
3.6	Review and update the Information Security Policy with awareness raising across the organisation	Board Secretary with Director of Finance & IT	February 2020		All Wales Information Security Policy published and promoted January 2021.
3.7	Explore and secure suitable storage spaces (on-site or off-site) for the storage of active records	Board Secretary with Director of Planning and Performance	April 2020		A number of options for on and off-site storage were considered in autumn 2020. Many on-site records stores are already breaching capacity and the Property Manager has confirmed there is no scope for releasing space. Applying social distancing measures, providing storage for PPE and expanding patient capacity due to the COVID-19 pandemic placed an additional burden on an already saturated resource. Further, some existing sites are not fit for purpose e.g. Bronllys creche, the garage at Ynys y Plant, Newtown. Enquiries relating to sites with potential for storage at Mamhilad, Aneurin Bevan UHB, IP5 in Newport and a Welsh Government Building at Newtown have been followed up, none of which have been available for PTHB use. Other 3rd party sites within Powys were put forward for comparison. Although costs, availability, configuration, logistics and security aspects would need further exploration if they are to be considered viable options they are likely to

PTHB Action		Lead	Date for Completion	Status	Update at 30/06/21
					require investment in infrastructure and staff resources to support the management of records. There is potential for the Health Board to secure storage space with Powys County Council Archives in Ddole Road, Llandrindod Wells. There will need to be further exploration of this arrangement to inform any proposal for consideration. Further work is therefore required to develop a comprehensive business case for consideration, with the need for investment likely.
3.8	Develop a business case for the digitisation of active records	Board Secretary with Director of Finance & IT	June 2020		Delayed in-light of COVID-19. It is known that other Health Boards that have commenced digitisation of records have been required to commit significant investment and resource to progress this. It is anticipated that the Health Board will need to initially invest in a Project Manager with expertise in this area to support the design of a business case for investment and design a project structure that enables its development and implementation.
4. RETENTION & ARCHIVING					
4.1	Review and update the health board's Records Retention Schedule alongside the Records Management Policy	Board Secretary	February 2020		Records Retention Schedule reviewed and included in the Records Management Framework approved and published December 2020.
4.2	Explore and secure suitable storage spaces (on-site or off-site) for the storage of archived records	Board Secretary with Director of Planning	April 2021		Update as per action 3.7 (active records)

PTHB Action		Lead	Date for Completion	Status	Update at 30/06/21
		and Performance			
4.3	Develop a business case for the digitisation of archived records	Board Secretary with Director of Finance & IT	April 2022		Update as per action 3.8 (active records)
5. INFORMATION SHARING					
5.1	Review Information Sharing Protocols in place for commissioned services	Board Secretary with Director of Planning & Performance	April 2020		The Health Board has approved a Business Justification Case, as a joint case between Powys Teaching Health Board and NWIS to obtain Welsh Government investment to fund a Project to allow NHS Wales patients who are treated in NHS England to have their administrative and clinical data managed and accessible through NHS Wales digital systems. This project will include the need to ensure robust Information Sharing Protocols are in place.

RECOMMENDATIONS:

The Records Management Framework (**Appendix C**) supports the Health Board's commitment to ongoing improvement of its records management functions to ensure that documents and records are managed and controlled effectively.

Documents and Records Manager

Given the legal responsibilities placed on the Health Board to ensure all documents and records are managed effectively and securely; and the further improvements required as set out in the records management improvement plan, the Executive Committee has recently agreed investment in the appointment of a "Documents and Records Manager". This post will replace the Service Improvement Manager role previously established on an interim basis, which has been vacant since January 2021.

The purpose of this role will be to co-ordinate the ongoing design and delivery of a robust Records Management Framework for the organisation, working across all services and disciplines, as well as working as the Health Board's representative on national workstreams and groups such as Health Records Management Advisory Group. The postholder will therefore play a fundamental role in ensuring compliance with all associated best practice, accreditation, standards, policy, procedures and legislation related to records. It will be necessary for the postholder to establish close working relations with clinical services and teams in order that they can discharge their responsibilities effectively and work to ensure that records management is seen as a key aspect of clinical quality governance.

The Documents and Records Manager will be managed within the Board Secretary's function and accountable to the Head of Information Governance.

Project Manager, Digitisation of Records

A significant element of work to be taken forward via the Records Management Improvement Plan is the digitisation of records, both active and archived. This will undoubtedly require additional capacity as well as expertise to support the development of the business case for investment. It is known that other health boards which have progressed digitisation of records have been required to commit substantial capital funding to implement revised systems and ways of working.
The Executive Committee has therefore recently agreed investment in the appointment of an experienced Project Manager to lead the planning and development of the Health Board's approach to digitisation of records.

The project manager will have experience of and an understanding of ICT & Clinical systems in light of the scanning element to digitisation, and this information needing to be available within Clinical Systems or an Electronic

Document Management Solution (EDMS). An EDMS will need system design, release, transition, training and support.

The project manager will be managed within the Digital Programme Team, supported by the Digital Programme Manager and accountable to the Assistant Director of Digital Transformation. Further, the main objective of the role would be to prepare a business case within 10 months for consideration of investment with an implementation plan prepared for thereafter.

It will be fundamental that the Documents and Records Manager and the Project Manager for Digitisation work collaboratively to achieve implementation of the Records Management Improvement Plan.

APPENDICES

A. Internal Audit Review of Records Management
B. Records Management Improvement Plan
C. Records Management Framework

ARA_Item_3.5a_App2 _Records Managemer

ARA_Item_3.5a_App1 __Records Manageme

IGP 014 Records Managment Framewc

Records Management

Internal Audit Report

2019/20

Powys Teaching Health Board

NHS Wales Shared Services Partnership

Audit and Assurance Services

CONTENTS Page

Review reference:	PTHB-1920-17
Report status:	Final
Fieldwork commencement:	1 August 2019
Fieldwork completion:	30 August 2019
Draft report issued:	4 September 2019
Draft report clearance meeting:	19 August 2019, 11 September 2019
Management response received:	1 November 2019
Final report issued:	1 November 2019
Auditors:	Helen Higgs, Head of Internal Audit Osian Lloyd, Deputy Head of Internal Audit Matthew Smith, Senior Auditor
Executive sign off:	Executive Committee
Distribution:	Rani Mallison, Interim Board Secretary Carol Phillips, Information Governance Manager Dr Jeremy Tuck, Assistant Medical Director Jason Crowl, Assistant Director Community Services

	Joy Garfitt, Assistant Director Mental Health and Learning Disabilities Jayne Lawrence, Assistant Director Primary Care Margy Fowler, Assistant Director Therapies and Health Sciences Wayne Tannahill, Assistant Director Estates and Property Andrew Cresswell, Assistant Director Facilities and Support Services Michelle Williams, Head of Information
Committee:	Audit Committee Performance and Resources Committee Experience, Quality and Safety Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors.

ACKNOWLEDGEMENT

NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Please note:

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Service Strategy and Terms of Reference, approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – 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.

1. Introduction and Background

The records management review sought to provide Powys Teaching Health Board (the 'health board') with assurance that operational procedures and practices were compliant with the health board's strategies, policies and procedures for records management, including:

- IGP 005 Destruction of Records Policy & Procedures
- IGP 007 Health Records Management Procedures
- IGP 008 Records Management Policy
- IGP 009 Records Management Strategy

The General Data Protection Regulation (GDPR) is a new legal framework that came into force on May 25 2018 and was designed to modernise laws that protect the personal information of individuals. The introduction of GDPR changed how public sector organisations must handle personal information and increased the need for greater focus on Information Governance (IG) compliance. Internal Audit reviewed compliance with the requirements of the GDPR in 2018/19 (PTHB-1819-16 refers) which reported reasonable assurance. To aid compliance with GDPR, the health board identified objectives and introduced a number of controls in line with their GDPR work programme defined in the 2019-20 Annual Plan.

2. Scope and Objectives

The internal audit assessed the adequacy and effectiveness of the internal controls in operation. Any weaknesses have been brought to the attention of management and advice issued on how particular problems may be resolved and control improved to minimise future occurrence.

The objective of the audit was to assess the adequacy of the arrangements in place for the management of health records, including compliance with policies and procedures. The audit did not review the content or accuracy of health records.

The review sought to provide assurance that:

- roles, responsibilities and arrangements for the creation, storage, management, retention and disposal of records are clearly documented and reflect the GDPR;
- records are securely shared and stored, including the tracking and transportation of information, accessibility / availability and maintenance of records (including archiving and disposal);
- any record management issues have been identified, risk prioritised and reported; and

- sufficient resources are afforded to train staff (including induction training) and that staff overseeing the management of records have sufficient knowledge and experience.

3. Associated Risks

The risks considered in the review were as follows:

- non-compliance with records management policies and procedures;
- poor management of records, including security, storage, accessibility, archiving and disposal; and
- records are lost or stolen resulting in reputational damage and potential financial penalty from the Information Commissioner's Office (ICO).

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with records management is **No** assurance.

RATING	INDICATOR	DEFINITION
No assurance		The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved.

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

					
1	Roles, responsibilities and arrangements for records management	✓			
2	Security and storage of health records, including tracking and transportation, accessibility / availability and maintenance	✓			
3	Records management issues are identified, managed and reported		✓		
4	Sufficient resources, knowledge and experience		✓		

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

Design of System / Control

The findings from the review have highlighted **six** issues that are classified as weakness in the system control/design for records management.

Operation of System/Controls

The findings from the review have highlighted **one** issue that is classified as weakness in the operation of the designed system/control for records management.

6. Summary of Audit Findings

An effective records management system is critical in the provision of care to patients and staff and to assist in the efficient running of the organisation. However, our audit has identified significant issues regarding the adequacy of the arrangements in place. The majority of the findings are consistent with those raised in previous audits, dating as far back as 2012, including a no assurance audit report in 2015/16. Our follow up review in 2017/18 noted progress with the responding action plan. We advised Audit

committee in September 2017 that work had been carried out by the Information Governance Team to address the recommendations made in the 2015/16 audit report, however, further work was needed to address key areas.

During our current review, we identified a number of areas where poor practices continued to be in operation including in respect of identification and tracking, storage and security of records. We have also raised issues in relation to a lack of accountability, leadership and coordination. Policies and procedures are out of date and do not reflect current working practices which also vary throughout the health board and there are issues with the operational management of risks relating to records management. The issues highlighted within this report could impact the quality of patient care and lead to penalties being imposed by the ICO (up to €20 million, or 4% of the health board's total budget, whichever is higher, from failure to comply with an ICO enforcement notice, assessment notice or information notice).

While a lot of work has since been undertaken by staff within localities to find local solutions to address some of the concerns around records storage, the two national inquiries into historical child sexual abuse and infected blood have resulted in increased pressure on storage areas as a result of the embargo imposed on the culling of records. Despite this, there has been an apparent lack of urgency at more senior levels to undertake the necessary action required.

The '*Informed Health and Care – A Digital Health and Social Care Strategy for Wales'* and '*A Healthier Wales: our Plan for Health and Social care*' documents outline the vision for the future use of digital technology to support patient care.

The long term strategy for the digitalisation of records nationally will assist in solving many of the issues identified. However, this will require capital outlay, resource and a considerable amount of time. In the interim alternative solutions should be sought locally to manage the risk.

A paper presented by the Medical Director to the Executive Committee in June 2019 on 'Digitalisation of Medical Records' for the health board, outlined a proposal to implement intelligence tracking for active and archived records. This exercise needs to be undertaken in advance of progressing the digitalisation of records agenda. The paper stated: '*Until recently, the health board tracked medical records manually and there is little intelligence available on the volumes of medical records in circulation or those stored in archive areas. In August 2018, the Information Services Department began implementing the Intelligence Tracking module of the Welsh Patient Administration System (WPAS). This allows volumes of*

medical records to be identified and tracked electronically to a named location.'

The paper estimates that the health board has 1.1 million volumes of active and archive health records. However, in the absence of information on the number held it is difficult to manage records effectively.

Our audit identified multiple record management systems in place, however, this is not unique to the health board. Primarily, the Myrddin patient administration system is used to track records. Testing confirmed that multiple processes are being followed, with a lack of documented procedures. The 'Digitalisation of Medical Records' paper brought by the Medical Director requested resources and funding of c£360k for intelligence tracking over a 2 year period. The Executive Committee discussed the paper and agreed that there was a need to look further into the logistics and implementation aspects of this proposal, including the project management support required to take this work forward.

7. Detailed Audit findings

In this section, we summarise the findings from our audit fieldwork. The detailed findings are reported in the Management Action Plan (Appendix A).

Objective 1: Roles, responsibilities and arrangements for the creation, storage, management, retention and disposal of records are clearly documented and reflect the GDPR

Our audit found a lack of accountability, leadership and coordination in respect of records management. The health board does not have a Head of Health Records position, records management is instead overseen by the individual heads of services, placing additional pressure on the workforce to find solutions to challenges faced and issues encountered.

The 2018-19 internal audit review of GDPR, which assessed the health board's arrangements to prepare for the regulation, identified that a process for populating its information asset register (IAR) had been developed, and guidance for this process had been provided to staff. Our current audit identified that the IAR continues to be a work in progress and is not yet completed. However, we recognise that this is a dynamic document and as such, the IAR will never be 'completed' instead, identifying, entering and reviewing assets will be a continual process which will be required for compliance with the GDPR.

While the health board has adopted the All Wales Information Governance Policy, all health board policies relevant to records management are overdue for review but are extant. During our site visits we held discussions with staff across various departments, including Patient Services (North and

South), Women & Children's Services, Information, Information Governance, Transport and Estates. The above mentioned policies and procedures include sections on roles and responsibilities from the Chief Executive Officer to the local operational level, including the Caldicott Guardian, Senior Information Risk Owner (SIRO) and Data Protection Officer (DPO). However, we were informed of an inconsistent approach and working practices being applied to records management, some of which are not in accordance with health board policies.

We identified multiple record management systems in place. Primarily, the Myrddin patient administration system is used to track records. Testing confirmed that multiple processes are being followed, with a lack of documented procedures. Health records are kept in multiple formats, including electronically in various patient administration systems and in hard copy. The latter also involves multiple paper files in different formats where separate records are typically kept for each patient contact. There is a lack of robust information on the volumes of health records held, their current location and age. Furthermore, the flow of information between the Information Governance (IG) Team and the Localities, Directorates and Heads of Service is disjointed. For example, we were informed by the IG team that there have been instances where they have not been notified of records management incidents and breaches. The recent formation of the quarterly records management group (sub-group of Information Governance Champions Group) in March 2019 should assist in addressing these issues and to support the records management agenda.

We identified two high priority issues, which we consider require prompt management action. See findings 1 and 2 in Appendix A.

Objective 2: Records are securely shared and stored, including the tracking of information, accessibility / availability and maintenance of records (including archiving and disposal)

Identification and Tracking of Records

There is currently no central inventory of records that provides the exact location of the records held. This is in line with the paper presented to the Executive Committee in June 2019.

We understand that not all 'live' health records held within the local hospitals have been uploaded into the electronic tracking system, only those records that have been requested by hospitals, clinics etc. During our review, we were provided with a report from the Information Department that indicated 4,566 non-mental health records were noted as not having been received within 14 days, which in effect means that they were 'still in transit'. There is a risk that a number of these records are potentially lost

or missing which could result in patient harm where clinicians do not have access to a complete health record, impacting on their ability to make the most accurate clinical assessments. In addition, during our site visits, we selected a sample of ten health records held at Brecon War Memorial (BWM) Hospital and identified two instances where they were incorrectly recorded as being held in a different location per the electronic tracking system. There is also a lack of a standardised signatory process for the collection and delivery of health records, aside from when case notes are transferred to the clinical coders for updating as there is a defined pro-forma signatory sheet.

It is also unknown how many duplicate copies of a health record exist. Whilst the recent introduction of the electronic tracking system has led to improvements, we were informed through discussions with staff that it has also identified more duplicate health records are in existence than expected.

During our fieldwork we were informed of a number of practices being applied that are not in accordance with policy. In addition, whilst we were provided with examples of Information Sharing Protocols between the health board and other NHS organisations, we were informed that Wye Valley NHS Trust are utilising digital health records which creates an issue for the health board as it cannot access these records. This could lead to services being cancelled.

The health board's integrated performance report for quarter 4 2018/19 highlights that the project to fully implement the Welsh Community Care Information System (WCCIS) system, a web based software program that allows frontline carers, therapists, mental health workers and community nurses the ability to co-ordinate patient cases through a shared electronic record of care with the aim of improving treatment, across Powys is running significantly behind schedule. Furthermore, while the health board's rurality poses connectivity issues, the number of outages recently reported in relation to WCCIS, some of which have been known to last for days at a time, creates a serious cause for concern for staff as it prevents them from accessing the system and maintaining accurate and up-to-date records.

Security

During the 2015/16 records management audit we raised a high priority finding in regards to security where we identified a number of areas where poor practices were found to be in operation. We noted progress was being made in this area during the follow up audit undertaken in 2017/18, where a rolling programme of 'spot checks' had commenced which included a review of security, highlighting that arrangements could be improved. However, the health board still did not have an up to date record of all storage sites and areas for records which have been risk assessed for matters of security, protection, age, access and responsibility.

Similar findings were identified during the current year audit. We were unable to confirm whether the spot checks have been undertaken since the previous follow up audit, although we understand from review of the health board's IPR for quarter 4 2018/19 that a programme of audits has been agreed for 2019/20. The separate finding raised within this report on the identification and tracking of records has also highlighted security issues regarding confidential sacks and the destruction of records, again reflecting findings from previews audit reviews.

Storage

During the 2015/16 records management audit we raised a high priority finding in regards to storage where testing identified that at each site, storage space across the health board was at a premium.

Typically, records were stored within redundant rooms, some of which were not fit for purpose, corridors, stairs and rooms that were in use occasionally for other purposes were also utilised. We noted progress was being made in this area during the follow up audit undertaken in 2017/18 where the Property and Accommodation Group had been formed and tasked with managing property matters for the health board. One of the early issues brought to the attention of the group was the significant number of requests from departments for extra storage space for archive records, and a piece of work was undertaken to assess the current storage along with options and opportunities. It was also noted that the records stores were often unsuitable in terms of the environment in which they are kept, the security of the space and the appropriateness of the shelving.

Similar findings were identified during the current year audit where storage space for records remains a significant issue. This has been exacerbated by the current embargo on the culling of records initiated by the Welsh Government due to ongoing national inquiries. While we note that the Executive Committee approved the proposal presented at its July meeting to ease accommodation pressures in Newtown, the identification of additional storage space for health records is typically left to the services, placing additional pressure on them to find solutions.

During our site visits, we identified two filing cabinets on a corridor that were unlocked and contained staff records. We also identified that 'live' BWM Hospital health records are now being stored in the old crèche archive site at Bronllys Hospital. We understand that the records have been transferred due to BWM Hospital being at full capacity, which we were informed is also the case elsewhere, and despite concerns around the suitability of the crèche being raised previously on numerous occasions. The building was condemned by the Fire Safety Officer in November 2018, we are aware of other sites that are unsuitable / pose fire safety risks from

review of Executive Committee papers, and the list of necessary works identified to attain both regulatory and legislative compliance have not yet been undertaken.

We identified four high priority issues, which we consider requires prompt management action. See findings 3, 4 and 5 in Appendix A.

Objective 3: Any record management issues have been identified, risk prioritised and reported

Assurance against IG related incidents are reported to sub-board committee level. Incidents are categorised by GDPR Principle definition and include those that originated in GP Practices and other health boards. IG related incidents recorded on Datix from 1 September to 19 December 2018 totalled 45 and involved missing records, personal identifiable information (PII) being sent to the wrong recipient or misdirected mail and the loss / security of PII. The health board determined that none of the incidents investigated during this period have been reported to the ICO by the Board Secretary in their role as the health board's SIRO. A further 96 IG related incidents were reported between 1 January to 31 August 2019, of which five were determined as reportable to the ICO. However only one of the five incidents were reported within the 72 hour requirement under GDPR. Improvements are required to evidence the thought process and rationale for determining whether or not an incident is reportable to the ICO. We note that assurance oversight over IG incidents has not been reported since January 2019, following the restructure of the Committees of the health board.

The Information Governance Risk Register was last presented to the Information, Management, Technology and Governance Committee (IMTG) in January 2019. The Committee Risk Dashboard presented at the meeting was that of July 2018. The risk register has not been reported since to the Performance and Resources Committee. Whilst the health board's Corporate Risk Register at March 2019 contained risk CRR3*: 'the health board breaches IG Standards and legislative requirements, such as the General Data Protection Regulation'*, this had been reduced from 'Major (16)' to 'Moderate' with a score of (12). Given the number of significant findings raised within this report, including their potential impact on the quality of patient care and the associated penalties that could be imposed by the ICO, we recommend the health board reviews this assessment. Review of the March 2019 meeting of the Records Management Group identified that the Group has agreed to develop a Records Management Group risk register. The health board is working to improve this area, following limited assurance internal audit reports being issued in both 2017/18 and 2018/19, including the recent formation of the Risk Assurance

Group and the roll-out of risk management training which commenced in April 2019.

We identified one high priority issue which we consider requires prompt management action. See finding 6 in Appendix A.

Objective 4: There are sufficient resources afforded to train staff (including induction training)

The health board's integrated performance report (IPR) for quarter 4 2018/19 notes that '*the GDPR compliant IG e-learning toolkit has been mandated and implemented for all staff which has resulted in a drop in compliance.*' The toolkit was approved by the Information Governance Management and Advisory Group (IGMAG) and must be completed by all staff.' The aims and objectives are stated as follows:

- *understand how Information Governance is organised in Wales;*
- *recognise principles of information governance and how they apply in every day working environments, including identifying where to gain access to local policies, procedures and further information;*
- *understand the fundamentals of Data Protection, Duty of Confidentiality and the Caldicot Principles;*
- *identify your organisations responsibilities under the Freedom of Information Act 2000 and the Environmental Information Regulations 2004;*
- *demonstrate principles of good record keeping, including data quality;*
- *recognise, within the context of your role, how you can apply and maintain information security guidelines; and*
- *understand the circumstances in which information may be used and how access must be appropriately authorised.*

We were provided with the Statutory and Mandatory training compliance report from the Directorate of Workforce and Organisational Development for July 2019. This showed an 89% compliance rate for IG training, above the 85% target set by Welsh Government.

In addition, classroom training is offered by the IG team, including on health records. During our site visits, many of the heads of the individual services have been in their roles for many years, and whilst that provides good experience in the day-to-day operations involved with records management, they all expressed concern in the lack of provision of specific records management training. The need for training is supported by the findings raised within this report. See finding 2 in Appendix A.

8. Summary of Recommendations

The audit findings and recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**6**	**-**	**-**	**6**

Finding 1 Accountability, leadership and coordination of records management (Design)	Risk
Our audit found a lack of accountability, leadership and coordination in respect of records management. The health board does not have a Head of Health Records position, records management is instead overseen by the individual heads of services, placing additional pressure on the workforce to find solutions to challenges faced and issues encountered. The lack of a coordinated approach has led to inconsistent working practices being applied, some of which are not in accordance with health board policies (refer to the identification and tracking of records finding for examples). We identified multiple record management systems in place. Primarily, the Myrddin patient administration system is used to track records. Testing confirmed that multiple processes are being followed, with a lack of documented procedures. Health records are kept in multiple formats, including electronically in various patient administration systems and in hard copy. The latter also involves multiple paper files in different formats where separate records are typically kept for each patient contact. There is a lack of robust information on the volumes of health records held, their current location and age. Furthermore, the flow of information between the Information Governance (IG) Team and the Localities, Directorates and Heads of Service is disjointed. For example, we were informed by the IG team that there have been instances where they have not been notified of records management incidents and breaches. The recent formation of the quarterly records management group (sub-group of Information Governance Champions Group) in March 2019 should assist in addressing these issues and to support the records management agenda. The terms of reference for the group includes the following *'a working group overseeing the following elements for implementation of Records Management within the tHB:* • *Any review of current arrangements for the management of records (clinical) across the Health Board.* • *Promoting consistency and standardisation of all documents in use* • *Develop, monitor and update the Health Board's Records Management Strategy and Policy and associated procedures.'*	There is an increased risk to the health board of a lack of certainty concerning roles and responsibilities leading to non-compliance with GDPR.

The group also receives the Chair's report from the National Health Records Managers Advisory Group which looks at key records management issues within NHS Wales. The 2018-19 internal audit review of GDPR, which assessed the health board's arrangements to prepare for the regulation, identified that a process for populating its information asset register (IAR) had been developed, and guidance for this process had been provided to staff. Our current audit identified that the IAR continues to be a work in progress and is not yet completed. However, we recognise that this is a dynamic document and as such, the IAR will never be 'completed' instead, identifying, entering and reviewing assets will be a continual process which will be required for compliance with the GDPR. Information Asset Owners (IAO) should be responsible for ensuring that all information held by their directorate/service area is used and managed effectively, efficiently, securely, responsibly and legally, regardless of format. To do this, IAOs responsibility needs to be formally assigned and they need to know what information is held, the legal basis for processing it and who it is shared with. The previous Internal Audit review of GDPR also recommended that the health board ensure that the Information Governance team be supported and adequately resourced to deliver the improvements and enhancements set out in its GDPR action plan. We understand that the health board is still looking to recruit to support the requirements of the IG and records management agendas. In addition, the previous internal review of GDPR also recommended that, in order to ensure accountability and demonstrate compliance to the GDPR, the DPO responsibility should be formally assigned with the job description of the appointed officer updated accordingly. We understand that the organisation has assigned the responsibility of the DPO to the Information Governance Manager. However, the job description has not been updated accordingly.	
Recommendation 1	**Priority level**
The health board should strengthen its leadership arrangements and the coordination of its approach to enable effective records management.	**High**

Individual roles and responsibilities should be reviewed, defined and documented accordingly, either within the most appropriate policy or a separate roles and responsibility document.	
Management Response 1	**Responsible Officer/ Deadline**
The Audit, Risk & Assurance Committee has approved an Improvement Plan to ensure compliance with legislative and regulatory requirements in respect of records management. This internal audit recommendation will be achieved by the implementation of the following actions from the Improvement Plan:	

PTHB Action	Lead	Timescale for completion
Review and update the Health Board's Records Management Policy and supporting Procedures to ensure clarity on roles, responsibilities and the framework for operation in the organisation	Board Secretary	To be approved February 2020

Finding 2 Strategies, Policies and Procedures (Design)	Risk
We inspected the health boards intranet site and identified the following policies in relation to records management: • IGP 009 Records Management Strategy 2014-16: *'sets out an overarching framework for integrating current records management initiatives, as well as recommending new ones. It defines a strategy for improving the quality, availability and effective use of records in the Health Board and provides a strategic framework for all records management activities.'* 'This *Policy was reviewed by the IG Team, in conjunction with the Board Secretary, in July 2017. Due to work being taken forward nationally to re-establish an All-Wales Health Records Managers Group and review the Records Management Policy an extension was applied until May 2018.*' • IGP 008 Records Management Policy: *'sets out the framework to ensure that records are managed and controlled effectively, and at best value, commensurate with legal, operational and information needs.'* *'This Policy was reviewed by the IG Team, in conjunction with the Board Secretary, in July 2017. Due to work being taken forward nationally to re-establish an All-Wales Health Records Managers Group and review the Records Management Policy an extension was applied until May 2018.'* • IGP 005 Policy and Procedure for the Destruction of Records*: 'Defines the Retention & Disposal Periods for Health and Corporate records and highlights requirements to select records for permanent preservation. This will support the confidentiality, integrity and availability of all information held and/or used by the health board.'*	Processes and procedures are not adequately defined, resulting in exposing the health board to the risk of data breaches and associated financial penalties.

'This Policy was reviewed by the IG Team, in conjunction with the Board Secretary, in July 2017. Due to work being taken forward nationally to review policies in readiness for the introduction of the GDPR an extension was applied until May 2018.' • IGP007 Health Records Procedure: '*Aimed at staff involved with the handling of patient health records and how they should undertake key tasks in the course of their day to day duties.'* *'PTHB acknowledge that this document is past the review date. A review is currently in progress therefore an extension has been applied to April 2018.'* Our review of the minutes from the March meeting of the Records Management Group identified actions '*to review the Records Management policy/procedure schedule and advise the IG Team of any further records management procedures required for development by 19 April 2019. All to prioritise their development according to need/risk'* and for '*Group members to provide comments on the Health Records Procedure*.' During our site visits we held discussions with staff across various departments, including Patient Services (North and South), Women & Children's Services, Information, Information Governance, Transport and Estates. The above mentioned policies and procedures include sections on roles and responsibilities from the Chief Executive Officer to the local operational level, including the Caldicott Guardian, SIRO and DPO. However, we were informed of an inconsistent approach and working practices being applied to records management. As noted above, we identified multiple record management systems and processes in place. Primarily, with a lack of documented procedures. Health records are kept in multiple formats, including electronically in various patient administration systems and in hard copy. Paper records are essentially identified as 'live' or 'archived' where there are multiple paper files in different formats where separate records are typically kept for each patient contact.	

Additionally, many of the heads of the individual services have been in their roles for many years and whilst that provides good experience in the day-to-day operations involved with records management, they all expressed concern in the lack of provision of specific records management training.	
Recommendation 2	**Priority level**
In order to ensure correct and up to date policies and procedures are accessible to all staff, policies and procedures need to be reviewed and updated to reflect current legislation, All Wales guidance and current working practices. Once updated and approved, the policies and procedures should be communicated to staff. The health board should consider rolling out training / workshops to remind staff of the agreed procedures and practices to ensure consistent application.	**High**
Management Response 2	**Responsible Officer/ Deadline**
The Audit, Risk & Assurance Committee has approved an Improvement Plan to ensure compliance with legislative and regulatory requirements in respect of records management. This internal audit recommendation will be achieved by the implementation of the following actions from the Improvement Plan:	

PTHB Action	Lead	Timescale for completion
Review and update the Health Board's Records Management Policy and supporting Procedures to ensure clarity on roles, responsibilities and the framework for operation in the organisation	Board Secretary	To be approved February 2020

Publish the updated Policy and Procedures, raising awareness across the organisation	Board Secretary	March 2020
Introduce a programme of records management training for clinicians and staff, including management of identified risks	Board Secretary	April 2020 onwards

Finding 3 Identification and Tracking of Records (Design)	Risk
There is currently no central inventory of records that provides the exact location of the records held. This is in line with the paper presented by the Medical Director to the Executive Committee in June 2019 on 'Digitalisation of Medical Records' which stated: '*Until recently, PTHB tracked medical records manually and there is little intelligence available on the volumes of medical records in circulation or those stored in archive areas. In August 2018, the Information Services Department began implementing the Intelligence Tracking module of the Welsh Patient Administration System (WPAS). This allows volumes of medical records to be identified and tracked electronically to a named location… In the absence of information on the total number of medical records held it is difficult to manage records effectively… PTHB does not have robust data to inform the impact of the national embargo on culling records or the future digitalisation of records.*' We understand that not all 'live' health records held within the local hospitals have been uploaded into the electronic tracking system, only those records that have been requested by hospitals, clinics etc. During our review, we were provided with a report from the Information Department that indicated 4,566 non-mental health records were noted as not having been received within 14 days, which in effect means that they were 'still in transit'. There is a risk that a number of these records are potentially lost or missing. In addition, during our site visits, we selected a sample of ten health records held at Brecon War Memorial Hospital and identified two instances where they were incorrectly recorded as being held in a different location per the electronic tracking system. There is also a lack of a standardised signatory process for the collection and delivery of health records, aside from when case notes are transferred to the clinical coders for updating as there is a defined pro-forma signatory sheet. It is also unknown how many duplicate copies of a health record exist. Whilst the recent introduction of the electronic tracking system has led to improvements, we were informed through discussions with staff that it has also identified more duplicate health records are in	If records are incomplete, for example in transit / are kept in multiple paper files in different formats and have not been coded, or cannot be accessed due to system outages then there is a risk that clinicians may not have access to the complete health record which impacts on their ability to make the most accurate clinical assessments possible. In this circumstance, a clinical decision based on incomplete history may result in patient harm. Data protection is compromised, resulting in exposing the health board to the risk of data breaches and associated financial penalties.

existence than expected. In addition, inconsistent operating procedures are being applied following the introduction of the electronic tracking service system, particularly in respect of the report running functions used to monitor the health boards compliance with the Welsh Government's clinical coding target of 95% within a 4 week period. During our fieldwork we were informed of a number of practices being applied that are not in accordance with policy: • despite this being defined as a 'last resort' when sharing data, there are still occasions whereby health records are still 'faxed' instead of being scanned and sent digitally via encrypted pdf or file sharing portal; • at present, notes are being transferred outside the health board in their original form, which is against health board policy; • inconsistent practices being applied in relation to the packaging and labelling of health records being transferred; • tracer cards / manual log books are still being completed by members of staff, who are also using the electronic system to track records. This is a duplication of effort which we understand is to ensure that, if computer systems go down, the records last known location would be known; • confidential waste sacks not auditable during different parts of the process and at risk of breaching GDPR legislation where there have been instances where waste bags are regularly left open and / or unattended in public areas. This issue was raised previously in the 2015/16 and 2017/18 records management internal audit reports, although we understand that the arrangements are currently under review as per minutes of the March 2019 records management group; and • a lack of evidence to demonstrate the process regarding the destruction of health records, noting the current national embargo on culling records.	

In addition, whilst we were provided with examples of Information Sharing Protocols between the health board and other NHS organisations, we were informed that Wye Valley NHS Trust are utilising digital health records which creates an issue for the health board as it cannot access these records. This could lead to services being cancelled. The health board's integrated performance report for quarter 4 2018/19 highlights that the project to fully implement the WCCIS system, a web based software program that allows frontline carers, therapists, mental health workers and community nurses the ability to co-ordinate patient cases through a shared electronic record of care with the aim of improving treatment, across Powys is running significantly behind schedule. Furthermore, while the health board's rurality poses connectivity issues, the number of outages recently reported in relation to WCCIS, some of which have been known to last for days at a time, creates a serious cause for concern for staff as it prevents them from accessing the system and maintaining accurate and up-to-date records. This issue was included within the report published by the National Assembly for Wales Public Accounts Committee in November 2018 titled '*The Informatics Systems in NHS Wales*'. The lack of a mobile functionality also hampers the practitioner's ability to work flexibly as they always have to return to base to record visits, with inputting into multiple systems impacting on practitioners' time and there is risk of patients missing appointments. There has been a greater call on resource from the Information Department which will be ongoing that had not been envisaged. Whilst the intent of the WCCIS was to remove the need for two databases held separately by health boards and local authorities, we have been informed that a common issue is the creation of duplicate electronic records, including some without a record of an individual's NHS number (a unique identifier and vital for quality assurance). Both scenarios result in additional administrative work for the health board to merge the two records or identify the NHS number.	

Recommendation 3	Priority level
The health board should ensure records are tracked adequately and that all staff are aware of these processes. Processes should be fully documented and consistent across the health board, to aid staff in their responsibilities. In line with recommendation 1, local procedures should be developed, but aligned to the policies regarding records management and tracking. Practices should be consistent from one site to another. The health board should strengthen the current processes for the transport of health records through the introduction of standard packaging and labelling requirements along with a standard signatory system for collection and delivery. The health board should investigate the access issues to Wye Valley NHS Trust's digital records, including the extent this applies to other NHS organisations, and revisit the information sharing protocol to ensure a better flow of patient information. The health board should ensure robust business continuity arrangements are in place to minimise the impact of system outages, WCCIS in particular, and work with the local authority to ensure the effective implementation of the integrated system, including the merging of multiple records and removal of duplicate records to create one single record.	**High**
Management Response 3	**Responsible Officer/ Deadline**
The Audit, Risk & Assurance Committee has approved an Improvement Plan to ensure compliance with legislative and regulatory requirements in respect of records management. This internal audit recommendation will be achieved by the implementation of the following actions from the Improvement Plan:	

PTHB Action	Lead	Timescale for completion
Review and update procedures and guidance to support effective tracking of records	Board Secretary with Director of Finance & IT	March 2020
Ensure adequate Business Continuity Planning arrangements are in place relating to records management	Board Secretary with Executive Directors	April 2020
Review and update arrangements for the retrieval and transportation of records, ensuring consistency in approach across the organisation	Board Secretary with Director of Workforce & OD	March 2020
Develop a business case for the digitisation of active records	Board Secretary with Director of Finance and IT	June 2020
Review Information Sharing Protocols in place for commissioned services	Board Secretary with Director of Planning & Performance	April 2020 (as part of LTA negotiations)

Finding 4 Security of Records (Design)	Risk
During the 2015/16 records management audit we raised a high priority finding in regards to security where we identified a number of areas where poor practices were found to be in operation. We noted progress was being made in this area during the follow up audit undertaken in 2017/18, where a rolling programme of 'spot checks' had commenced which include a review of security, highlighting that arrangements could be improved. However, the health board still did not have an up to date record of all storage sites and areas for records which have been risk assessed for matters of security, protection, age, access and responsibility. Similar findings were identified during the current year audit. We were unable to confirm whether the spot checks have been undertaken since the previous follow up audit, although we understand from review of the health board's IPR for quarter 4 2018/19 that a programme of audits has been agreed for 2019/20. The separate finding raised within this report on the identification and tracking of records has also highlighted security issues regarding confidential sacks and the destruction of records, again reflecting findings from previous audit reviews. Our visit to Brecon War Memorial (BWM) Hospital found that records were generally being stored appropriately, including on suitable shelving within locked cupboards in rooms that could only be entered via access codes on the doors. Records are stored sequentially via their unique identifier. However, our separate finding on storage has also identified security issues which could lead to unauthorised access, theft and damage to health records.	The risks to the health board include loss of confidential and personal records resulting in regulatory censure or financial penalties, breaches of security, reputational loss and financial loss. Poor storage of personal records may result in an increased risk of insufficient medical information available to hand to assist with a patient's immediate needs.

Recommendation 4	Priority level
The health board should identify all storage sites and areas for records and risk assess each site accordingly, for matters of security, protection, age, access and responsibility. Following on from above, the health board should ensure that the security of records is maintained and that the points raised in this report are addressed, where weaknesses are identified.	**High**
Management Response 4	**Responsible Officer/ Deadline**
The Audit, Risk & Assurance Committee has approved an Improvement Plan to ensure compliance with legislative and regulatory requirements in respect of records management. This internal audit recommendation will be achieved by the implementation of the following actions from the Improvement Plan:	

PTHB Action	Lead	Timescale for completion
Explore and secure suitable storage spaces (on-site or off-site) for the storage of active records	Board Secretary with Director of Planning and Performance	April 2020
Explore and secure suitable storage spaces (on-site or off-site) for the storage of archived records	Board Secretary with Director of Planning and Performance	April 2021

Finding 5 Storage of Records (Design)	Risk
During the 2015/16 records management audit we raised a high priority finding in regards to storage where testing identified, that at each site, storage space across the health board was at a premium. A paper was presented to Executive Committee in July 2019 noting the accommodation pressures and outlining proposals to resolve the lack of storage space for health records, in particular from across the North locality. The paper states that *'the challenge and risks presented by record storage across the North locality has been escalated to Corporate Health & Safety on three occasions; 20th October 2017, 15th February 2018 and most recently on 20th July 2018… Staff are regularly advised that they must review their records storage with a view to archiving records to minimise the impact they have on space utilisation.'* Typically, records were stored within redundant rooms, some of which were not fit for purpose, corridors, stairs and rooms that were in use occasionally for other purposes were also utilised. We noted progress was being made in this area during the follow up audit undertaken in 2017/18 where the Property and Accommodation Group had been formed and tasked with managing property matters for the health board. One of the early issues brought to the attention of the group was the significant number of requests from departments for extra storage space for archive records, and a piece of work was undertaken to assess the current storage along with options and opportunities. It was also noted that the records stores were often unsuitable in terms of the environment in which they are kept, the security of the space and the appropriateness of the shelving, highlighting that they could constitute both a fire risk and risk to floor loadings in some of the older premises. Similar findings were identified during the current year audit where storage space for records remains a significant issue. This has been exacerbated by the current embargo on the culling of records initiated by the Welsh Government due to ongoing national inquiries, placing additional pressure on the services to find solutions. There is currently no centralised storage facility for archived material. While we note that the Executive Committee approved the proposal presented at its July meeting to ease accommodation pressures in Newtown, the	The risk to the Health Board is that records are not maintained appropriately and securely and are in breach of the GDPR. The lack of available space means that individual service areas regularly find inappropriate alternative accommodation for their own records, leading to an increased health and safety risk. As the volume of records increases, it will become increasingly more difficult to securely store records and retrieve them in a timely manner.

identification of additional storage areas on-site is typically left to the heads of services and the process for a 'change of use' is time consuming, requiring input from a number of Directorates including the service, estates, facilities and information governance as well as the Property and Accommodation Group. The current audit again found records were being stored in rooms that were not fit for purpose, corridors and stairs. Rooms that were in use occasionally for other purposes were also utilised. During our site visits, we identified two filing cabinets on a corridor that were unlocked and contained staff records. We were informed by management that these were removed and stored securely in a locked office as an interim measure whilst the appropriate archiving is arranged. We also identified that 'live' BWM Hospital health records are now being stored in the old crèche archive site at Bronllys Hospital. We understand that the records have been transferred due to BWM Hospital being at full capacity, which we were informed is also the case elsewhere, and despite concerns around the suitability of the crèche being raised previously on numerous occasions. The building was condemned by the Fire Safety Officer in November 2018, we are aware of other sites that are unsuitable / pose fire safety risks from review of Executive Committee papers, and the list of necessary works identified to attain both regulatory and legislative compliance have not yet been undertaken. Our visit at the site noted that records were easily accessible and were alongside various items of old equipment which had been discarded. The room is in a poor state of upkeep with plants growing through the windows, cobwebs, smell of damp and rat / mice droppings. Curtains are also hanging out of the window which could easily be reached from outside the building and set on fire.	

Recommendation 5	Priority level
Whilst recognising that capital expenditure is required to address this risk, a plan should be compiled for identifying adequate facilities for the storage of records throughout the health board.	High
Management Response 5	**Responsible Officer/ Deadline**
The Audit, Risk & Assurance Committee has approved an Improvement Plan to ensure compliance with legislative and regulatory requirements in respect of records management. This internal audit recommendation will be achieved by the implementation of the following actions from the Improvement Plan:	

PTHB Action	Lead	Timescale for completion
Explore and secure suitable storage spaces (on-site or off-site) for the storage of active records	Board Secretary with Director of Planning and Performance	April 2020
Explore and secure suitable storage spaces (on-site or off-site) for the storage of archived records	Board Secretary with Director of Planning and Performance	April 2021

Finding 6 Risk Management (Operation)	Risk
Assurance against Information Governance related incidents are reported to sub-board committee level, categorised by GDPR Principle definition. For example, IG related incidents recorded on Datix from 1 September to 19 December 2018 totalled 45 and were reported to the Information, Management, Technology and Governance Committee (IMTG) meeting held on 10 January 2019. The incidents include those that originated in GP Practices and other health boards and involved missing records, personal identifiable information (PII) being sent to the wrong recipient or misdirected mail and the loss / security of PII. The health board determined that none of the incidents investigated during this period have been reported to the ICO by the Board Secretary in their role as the health board's SIRO. A further 96 IG related incidents were reported between 1 January to 31 August 2019, of which five were determined as reportable to the ICO. However only one of the five incidents were reported within the 72 hour requirement under GDPR. We also note that the datix records were often incomplete, where details of investigations undertaken had not been populated nor the thought process and rationale for determining whether or not an incident is reportable to the ICO. We note that assurance oversight over IG incidents has not been reported since January 2019, following the restructure of the Committees of the health board. The Information Governance Risk Register was last presented to the IMTG Committee in January 2019. The Committee Risk Dashboard presented at the meeting was that of July 2018. The risk register has not been reported since to the Performance and Resources Committee. The following risks were rated 'major' with a score of 16 on the current register: • CRR3 - The health board breaches IG Standards and legislative requirements, such as the General Data Protection Regulation. • CRR4 - ICT systems are not robust or stable enough to support safe, effective and up to date care.	The risk to the health board is that risks are being ignored or insufficient progress is completed, which increases the chance of financial loss, reputational damage and enforcement action by the ICO.

It was also noted at the meeting that: '*it is recommended that risk IG01 - Inappropriate and ineffective management of patient, staff and corporate records be de-escalated from 12 to 6 in light of the controls and mitigating actions put in place.*' Furthermore, whilst the health board's Corporate Risk Register at March 2019 contained risk CRR3, this had been reduced from 'major (16)' to 'moderate' with a score of (12). Given the number of significant findings raised within this report, including their potential impact on the quality of patient care and the associated penalties that could be imposed by the ICO, we recommend the health board reviews this assessment. In addition, review of the March 2019 meeting of the Records Management Group identified that the Group has agreed to develop a Records Management Group risk register. The health board is working to improve this area, following limited assurance internal audit reports being issued in both 2017/18 and 2018/19, including the recent formation of the Risk Assurance Group and the roll-out of risk management training which commenced in April 2019.	
Recommendation 6	**Priority level**
Where the decision is taken to not refer an incident to the ICO, this should be documented to demonstrate that an assessment has been undertaken and to evidence the rationale for not notifying. Advice on notifications should be sought where appropriate. A review of the risks relating to records management should be undertaken. The results of this review should be reported and monitored at the appropriate health board forums on an ongoing basis. Individuals with responsibilities in relation to records management should attend the risk management training being rolled out across the health board to improve the identification, management and mitigation of risks.	**High**

Management Response 6	Responsible Officer/ Deadline
The Audit, Risk & Assurance Committee has approved an Improvement Plan to ensure compliance with legislative and regulatory requirements in respect of records management. This internal audit recommendation will be achieved by the implementation of the following actions from the Improvement Plan:	

PTHB Action	Lead	Timescale for completion
Introduce of a programme of records management training for clinicians and staff, including management of identified risks	Board Secretary	April 2020 onwards
Ensure that risks associated with records management, including those arising from the Internal Audit review, are identified and recorded managed in-line with the Risk Management Framework	Board Secretary/ Head of Risk & Assurance	November 2019
Review arrangements for the reporting and management of information governance related breaches and incidents	Board Secretary	January 2020

Audit Assurance Ratings

 **Substantial Assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

 **Reasonable Assurance** - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

 **Limited Assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

 **No Assurance** - The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved.

Prioritisation of Recommendations

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

** Unless a more appropriate timescale is identified/agreed at the assignment.*

Confidentiality

This report is supplied on the understanding that it is for the sole use of the persons to whom it is addressed and for the purposes set out herein. No persons other than those to whom it is addressed may rely on it for any purposes whatsoever. Copies may be made available to the addressee's other advisers provided it is clearly understood by the recipients that we accept no responsibility to them in respect thereof. The report must not be made available or copied in whole or in part to any other person without our express written permission.

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Audit

The audit was undertaken using a risk-based auditing methodology. An evaluation was undertaken in relation to priority areas established after discussion and agreement with the Health Board. Following interviews with relevant personnel and a review of key documents, files and computer data, an evaluation was made against applicable policies procedures and regulatory requirements and guidance as appropriate.

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems. These include the possibility of poor judgement in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

Where a control objective has not been achieved, or where it is viewed that improvements to the current internal control systems can be attained, recommendations have been made that if implemented, should ensure that the control objectives are realised/ strengthened in future.

A basic aim is to provide proactive advice, identifying good practice and any systems weaknesses for management consideration.

Responsibilities

Responsibilities of management and internal auditors:

It is management's responsibility to develop and maintain sound systems of risk management, internal control and governance and for the prevention and detection of irregularities and fraud. Internal audit work should not be seen as a substitute for management's responsibilities for the design and operation of these systems.

We plan our work so that we have a reasonable expectation of detecting significant control weaknesses and, if detected, we may carry out additional work directed towards identification of fraud or other irregularities. However, internal audit procedures alone, even when carried out with due professional care, cannot ensure fraud will be detected. The organisation's Local Counter Fraud Officer should provide support for these processes.

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RECORDS MANAGEMENT IMPROVEMENT PLAN

Audit, Risk & Assurance Committee

11 November 2019

Internal Audit Review – August 2019

1	Roles, responsibilities and arrangements for records management	✓			
2	Security and storage of health records, including tracking and transportation, accessibility / availability and maintenance	✓			
3	Records management issues are identified, managed and reported		✓		
4	Sufficient resources, knowledge and experience		✓		

RATING	INDICATOR	DEFINITION
No assurance		The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved.

Priority	H	M	L	Total
Number of recommendations	**6**	**-**	**-**	**6**

Legal and Regulatory Framework

- Under the terms of the **Public Record Act 1958** all records created in the Health Board are regarded as public records. The act imposes a statutory duty on the Health Board to make arrangements for the safe keeping and eventual disposal of records.

- As a Public Authority subject to the **Freedom of Information Act** the Health Board has a duty to follow the Code of Practice for Records Management published by the Lord Chancellor in accordance with ***section 46*** of the FOIA. The code provides guidance to public authorities on keeping, managing and destroying records.

Legal and Regulatory Framework

- The **Data Protection Act** sets in law how personal and sensitive information may be processed and largely influences the way we handle care records.

- The **Records Management Code of Practice for Health and Social Care 2016** provides records management guidance for NHS and Social Care organisations based on current legal requirements and professional best practice.

Governance & Accountability

FREEDOM OF INFORMATION ACT: CODE OF PRACTICE FOR RECORDS MANAGEMENT
Have in place organisational arrangements that support records management – this includes the recognition of records management as a core corporate function, the allocation of clearly defined roles and responsibilities, and the provision of appropriate training.

PTHB Action	Internal Audit Recommendation	Lead	Timescale for completion
Review and update the Health Board's Records Management Policy and supporting Procedures to ensure clarity on roles, responsibilities and the framework for operation in the organisation	• R1: Clarify Leadership, Roles & Responsibilities • R2: Update policies and procedures	Board Secretary	To be approved February 2020
Publish the updated Policy and Procedures, raising awareness across the organisation	• R2: Update policies and procedures to be communicated	Board Secretary	March 2020
Introduce of a programme of records management training for clinicians and staff, including management of identified risks	• R2: Update policies and procedures to be rolled out across the organisation with training • R6: Records management training to include a focus on risk identification	Board Secretary	April 2020 onwards
Ensure that risks associated with records management, including those arising from the Internal Audit review, are identified and recorded managed in-line with the Risk Management Framework	• R6: Risks to records management to be assessed & monitored • R6: Records management training to include a focus on risk identification	Board Secretary/ Head of Risk & Assurance	November 2019

Records Management Framework

FREEDOM OF INFORMATION ACT: CODE OF PRACTICE FOR RECORDS MANAGEMENT
Have in place a records management policy covering information security, records retention, destruction and archive policies, and data protection (including data sharing) policies.

PTHB Action	Internal Audit Recommendation	Lead	Timescale for completion
Review and update the Health Board's Records Management Policy and supporting Procedures to ensure clarity on roles, responsibilities and the framework for operation in the organisation	• R1: Clarify Leadership, Roles & Responsibilities • R2: Update policies and procedures	Board Secretary	To be approved February 2020
Ensure those policies related to the Records Management Policy are up-to-date and embedded across the health board		Board Secretary & Policy Owners	March 2020
Review and update arrangements for Access to Information Requests, e.g. Subject Access Requests, ensuring clarity on roles and responsibilities		Board Secretary & Executive Directors	April 2020
Review arrangements for the reporting and management of information governance related breaches and incidents	• R6: All Breaches and Incidents to be assessed for referral to ICO with evidence for rationale	Board Secretary	January 2020

Storage, Security & Retrieval (1)

FREEDOM OF INFORMATION ACT: CODE OF PRACTICE FOR RECORDS MANAGEMENT

- Know what records are held, where they are and ensure that they remain useable.
- Have in place systems that enable records to be stored and retrieved as necessary.
- Ensure that records are stored securely and that access to them is controlled

PTHB Action	Internal Audit Recommendation	Lead	Timescale for completion
Undertake a scoping exercise to assess the location, status and identity of all records in the organisation, informing the ongoing development of the Information Asset Register		Board Secretary with Executive Directors	March 2020
Review and update procedures and guidance to support effective tracking of records	• R3: Establish adequate processes and local arrangements to support tracking	Board Secretary with Director of Finance & IT	March 2020
Develop a business case for the further role out of Intelligence Tracking across all provided services		Director of Finance & IT	April 2020
Ensure adequate Business Continuity Planning arrangements are in place relating to records management	• R3: Business Continuity, especially WCCIS	Board Secretary with Executive Directors	April 2020

Storage, Security & Retrieval (2)

FREEDOM OF INFORMATION ACT: CODE OF PRACTICE FOR RECORDS MANAGEMENT
- Know what records are held, where they are and ensure that they remain useable.
- Have in place systems that enable records to be stored and retrieved as necessary.
- Ensure that records are stored securely and that access to them is controlled

PTHB Action	Internal Audit Recommendation	Lead	Timescale for completion
Review and update arrangements for the retrieval and transportation of records, ensuring consistency in approach across the organisation	• R3: Establish standard packaging, labelling and signatory system for collection and delivery of records	Board Secretary with Director of Workforce & OD	March 2020
Review and update the Information Security Policy with awareness raising across the organisation		Board Secretary with Director of Finance & IT	February 2020
Explore and secure suitable storage spaces (on-site or off-site) for the storage of active records	• R4: Identify all storage sites and areas for records, considering security, protection, age, access and responsibilities • R5: Identify adequate facilities for the storage of records	Board Secretary with Director of Planning and Performance	April 2020
Develop a business case for the digitisation of active records	• R3: Merging of multiple records and removal of duplicate records to create one single record	Board Secretary with Director of Finance and IT	June 2020

Retention & Archiving

FREEDOM OF INFORMATION ACT: CODE OF PRACTICE FOR RECORDS MANAGEMENT

- Retain the records needed for business, regulatory, legal and accountability purposes.
- Define how long records should be kept for, and dispose of them when no longer needed

PTHB Action	Internal Audit Recommendation	Lead	Timescale for completion
Review and update the health board's Records Retention Schedule alongside the Records Management Policy		Board Secretary	To be approved February 2020
Explore and secure suitable storage spaces (on-site or off-site) for the storage of archived records	• R4: Identify all storage sites and areas for records, considering security, protection, age, access and responsibilities • R5: Identify adequate facilities for the storage of records	Board Secretary with Director of Planning and Performance	April 2021
Develop a business case for the digitisation of archived records		Board Secretary with Director of Finance and IT	April 2022

Information Sharing

FREEDOM OF INFORMATION ACT: CODE OF PRACTICE FOR RECORDS MANAGEMENT
Ensure that records shared with other bodies or held on their behalf are managed in accordance with the code.

PTHB Action	Internal Audit Recommendation	Lead	Timescale for completion
Review Information Sharing Protocols in place for commissioned services	• R3: Review arrangements with Wye Valley Trust, including ISPs	Board Secretary with Director of Planning & Performance	April 2020 (as part of LTA negotiations)

RECORDS MANAGEMENT FRAMEWORK

Document Number:	IGP 014	Classification	Corporate

Version No:	Approved by:	Date of Approval:	Date of Issue:	Review Date:
V1.0	Executive Committee	16/12/20	22/1/2021	22/1/2023

Brief Summary of Document:	This document aims to set out the components that provide the foundation and organisational arrangements for supporting records management processes in Powys Teaching Health Board (PTHB).
Scope:	This framework applies to Board members, all employees of the health board; agency staff; contractors brought in to undertake work on behalf of the health board, for example capital and estates works; students; locums; volunteers; individuals employed on honorary contracts; and other third parties engaged in PTHB business. It applies to all activities of the health board, including those related to the commissioning of services. Managers at all levels within the health board must take an active lead to ensure that records are managed effectively and to support the development of a records management aware culture within the health board.
To be read in conjunction with:	• Information Governance policies and procedures http://nww.powysthb.wales.nhs.uk/searchresultssql/?q=igp
Owning Committee	Executive Committee with assurance provided to the Board via Performance and Resources Committee and/or Experience, Quality & Safety Committee.

Document Owner:	Board Secretary	Document Author:	Service Improvement Manager – Records

			Management

Reviews and updates		
Version no:	Summary of Amendments:	Date Approved:
0.1	This document, when approved, will supersede the IGP 009 Records Management Strategy and IGP 008 Records Management Policy documents. Procedure guides should be reviewed/developed in support.	March 20
0.2	Comments from Board Secretary	August 20
0.3	Comments following consultation	November 20

CONTENTS

1. Introduction

Records Management is the process by which the health board manages all aspects of records whether internally or externally generated and in any format or media type, from their creation through their lifecycle to their eventual disposal.

Powys Teaching Health Board, 'the health board', is committed to a systematic and planned approach to the secure and effective management of all records within the organisation, particularly patients' records. It takes its responsibility towards patient confidentiality seriously. Records should always be held in an environment which affords an appropriate level of security to the sensitivity of the records held and should only be accessed on a need to know basis.

The health board's records are its corporate memory, providing evidence of actions and decisions and represent a valuable asset to support daily functions and operations. Records support policy formation and managerial decision-making, protect the interests of the health board and the rights of patients, staff and members of the public. They support consistency, continuity, efficiency and productivity and help deliver services and patient care in consistent and equitable ways. Health records are contemporaneous and form the basis for the organisation's accountability for clinical care. The health board retains legal responsibility for the information held by its records management systems until their disposal i.e. they are destroyed or if they are of archival value, transferred to a Place of Deposit.

The Records Management Framework supports the health board's commitment to ongoing improvement of its records management functions to ensure that records are managed and controlled effectively. The health board must ensure that records management policies and procedures exist that are fully compliant with legislation, standards and government policy, including (but not limited to):

- Access to Health Records Act 1990;
- Access to Medical Reports Act 1988;
- BS 10008 Evidential Weight and Legal Admissibility of Electronic Information;
- Caldicott Principles;
- Computer Misuse Act 1990;
- Common Law Duty of Confidentiality;
- Data Protection Act 2018;
- Freedom of Information Act 2000 (section 46 Code of Practice - Records Management);

- General Data Protection Regulation 2016;
- Government of Wales Act 2006;
- Health and Care Standards (3.5 Record Keeping);
- Human Rights Act 2000;
- Information Sharing Protocols (Wales Accord on the Sharing of Personal Information);
- NHS Confidentiality Code of Practice;
- Powys THB ICT and Information Governance Policy and Procedures;
- Records Management Code of Practice for Health and Social Care 2016 (supersedes 2006 Department of Health Record Management: NHS Code of Practice);
- Welsh Health Circulars (in particular, WHC 2000 071 For the Record – Managing Records in NHS Trusts and Health Authorities);
- Welsh IG Toolkit for Health Boards and Trusts, and;
- other legislation and guidance referenced within the NHS: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/200702/NHS_Information_Governance_Guidance_on_Legal_and_Professional_Obligations.pdf

The health board is committed to developing a records management culture that underpins and supports the values and business of the health board. It will ensure its staff are aware of their obligations and trained to achieve best practice in record keeping.

2. Purpose

The purpose of this framework is to enable the health board to set out arrangements for records management and to comply with appropriate legislation, standards, policy, best practice and contractual obligations. This applies to the creation, utilisation, retention and disposal of all records regardless of format, of all types and in all locations where it is used to:

- support patient care and continuity of care;
- support day to day corporate activities which underpin the delivery of care;
- support evidence based practice;
- support epidemiology;
- meet legal and regulatory requirements;
- assist medical and other audits, and;
- to support improvements in clinical effectiveness through research.

3. Scope

This framework applies to Board members, all employees of the health board; agency staff; contractors brought in to undertake work on behalf of the

health board, for example capital and estates works; students; locums; volunteers; individuals employed on honorary contracts and other third parties engaged in the health board's business. Managers at all levels within the health board must take an active lead to ensure that records are managed effectively and to support the development of a records management aware culture within the health board.

Its remit includes management of the health board's records, including records of patients, staff, complaints, corporate records and any other record held in any format including paper and electronic records.

4. Objectives

The Framework seeks to ensure:

- **Records are available when needed** - from which the health board is able to form a reconstruction of activities or events that have taken place.

- **Records can be accessed** - records and the information within them can (within the legal time constraints) be located and displayed in a way consistent with its initial use, and that the current version is identified where multiple versions exist.

- **Records can be interpreted** - the context of the record can be interpreted, who created or added to the record and when, it is legible, during which business process and how the record is related to other records.

- **Records can be trusted** - the quality of the information held within the record reliably represents the information that was actually used in, or created by, the business process, and its integrity and authenticity can be demonstrated.

- **Records can be maintained through time** - the qualities of availability, accessibility, interpretation and trustworthiness can be maintained for as long as the record is needed, perhaps permanently, despite changes of format. To ensure that records are held in a robust format which remains readable for as long as records are required.

- **Records are secure** - from unauthorised or inadvertent alteration or erasure, that access and disclosure are properly controlled, records are stored safely and securely and audit trails will track all use and changes.

- **Records are retained and disposed of appropriately** - using consistent and documented retention and disposal procedures, which

include provision for appraisal and the permanent preservation of records with archival value in accordance with legal requirements.

- **Staff are trained** - so that all staff are made aware of their professional codes of conduct and responsibilities for record keeping and records management.

- **Records are shared appropriately**- where records are shared both externally and internally appropriate protocols will be put in place in order to safeguard any confidential and sensitive information from inappropriate access.

- **Records are compliant with legislation and standards** – to ensure the legality and quality of records are maintained.

5. Roles and Responsibilities

5.1 Controller

The Chief Executive Officer (CEO) has overall accountability for ensuring that records management operates legally within the health board. The CEO may delegate responsibility for management and organisation of the health records services to the Caldicott Guardian and/or another Director who will be responsible for ensuring that appropriate mechanisms are in place to support service delivery and continuity. Records management is key to this as it will ensure appropriate and accurate information is available as required.

5.2 Caldicott Guardian

The health board's Medical Director is the Caldicott Guardian and has responsibility for reflecting patients' interest regarding the use of patient identifiable information:

- ensuring the health board is fulfilling all legal obligations in managing patients' health records;
- agreeing and reviewing internal protocols governing the protection and use of patient identifiable information by health board staff;
- agreeing and reviewing protocols governing the disclosure of patient information across organisational boundaries e.g. with social services and other partner organisations, contributing to the local provision of care (WASPI); and
- representing confidentiality requirements and issues to the Board, advising on annual improvement plans and agreeing and presenting outcome reports.

5.2 Senior Information Risk Owner (SIRO)

The health board's Executive Director of Finance, Information & IT Services is the SIRO and is responsible for:

- fostering a culture for protecting and using data;
- provides a focal point for managing information, risk and incidents;
- is concerned with the management of all information assets; and
- acts as an advocate for information risk on the Board and provides written advice on the content of their annual governance statement in regard to information risk.

5.3 Designated Officer

The designated officer, the Board Secretary, has professional responsibility for the overall development and maintenance of records management practices within the organisation and for ensuring that related policies and procedures conform to the latest legislation and standards on data protection, confidentiality and health records practice. This officer is accountable for ensuring that the release of all patient clinical information for data subject access and provision of records for medico-legal purposes is in accordance with legislation.

5.4 Data Protection Officer (DPO)

The data protection expert is the Information Governance Manager. They are responsible for monitoring the organisation's compliance, informing and advising the organisation on its data protection obligations and acting as a contact for data subjects and the Information Commissioner's Office.

5.5 Service Improvement Manager

The Service Improvement Manager for Records Management is a temporary role appointed to address the recommendations within the 2019 Internal Audit of Records Management. They will address the requirements through the Records Management Improvement Plan, approved by the Audit, Risk and Assurance Committee.

5.6 Information Asset Owners (IAO)

The Information Asset Owner is the senior/responsible individual involved in the running of the relevant service or department and are identified through the Information Asset Register (IAR). The IAO does not need to be the creator or the primary user of the asset, but they must understand its value to the organisation. They will:

- lead and foster a culture that values, protects and uses information/ records for the public good;
- know what information/records the asset holds, what enters and leaves it, and why;

- know who has access to the information/records and why, and ensure their use of the asset is monitored;
- understand and address risks to the asset and provide assurance to the SIRO;
- ensure the asset is fully used for the public good, including responding to requests;
- maintain a record of the information asset on the health board's Information Asset Register http://7a7ehsrvsql0005/Information/systems/assetregister/assetlookup.asp
- be accountable for ensuring information and records are processed in accordance with the legal basis as outlined in the health board's Privacy Notice http://www.powysthb.wales.nhs.uk/page/80765 , and;
- lead the investigation into records related incidents.

5.7 Staff Responsibility for Record Keeping

All NHS employees are responsible for any records which they create or use. This responsibility is established and defined by the law (Public Records Act 1958 amended in 1967 and Section 146 of the Government of Wales Act 2006). Furthermore, as an employee of the NHS, any records created by an employee are public records.

Clinical staff are accountable for their individual practice under their professional standards. All health board staff, whether clinical or administrative, who create, receive and use records have records management responsibilities. All staff must ensure that they keep appropriate records of their work and manage those records in keeping with this policy and with any guidance subsequently produced.

Everyone working for or within the NHS who records, handles, stores or otherwise comes across patient information has a personal common law duty of confidence to patients and to his or her employer. The duty of confidence continues even after the death of the patient or after the employee or contractor has left the NHS.

Breach of this policy will mean that the health board is not safeguarding information entrusted to it, which could render them liable to prosecution. It is essential that staff with responsibility for records management complies with the policy or they may be subject to disciplinary procedures.

5.8 Information Commissioner's Office (ICO)

The ICO is the UK's independent body set up to uphold information rights in the public interest. Their role includes regulating key pieces of legislation including the GDPR, DPA 2018 and Freedom of Information Act 2000.

6. Legal and Professional Obligations

The principal legislation governing the management of records is Section 46 of the *Freedom of Information Act 2000* (FOIA). This directs organisations covered by the Act to have records management systems which will help them to perform their statutory function. The FOIA was designed to create transparency in Government and allow any citizen to know about the provision of public services through the right to submit a request for information. This right is only as good as the ability of those organisations to supply information through good records management programmes. Those with responsibility for records management are recommended to adhere to a code of practice issued under Section 46 of the FOIA https://ico.org.uk/media/for-organisations/documents/1624142/section-46-code-of-practice-records-management-foia-and-eir.pdf

The *General Data Protection Regulation* (GDPR) sets out in law seven key principles for how personal and sensitive (special category) personal information may be processed:

1. Lawfulness, fairness and transparency.
2. Purpose limitation.
3. Data minimisation.
4. Accuracy.
5. Storage limitation.
6. Integrity and confidentiality (security).
7. Accountability.

However, the GDPR does not cover everything that is needed to have a workable data protection regime so the UK implemented the Data Protection Act 2018 in order to fill the gaps that have (intentionally) been left in GDPR to give each EU member state some leeway in implementation. The DPA therefore sits alongside the GDPR when considering data protection duties. This arrangement continues despite the UK's withdrawal from the European Union and until further advice is issued by the ICO.

The FOIA and the DPA have records management codes of practice that recommend the systems and policies that must be in place to comply with the law. Other legislation requires information to be held as proof of an activity against the eventuality of a claim. Refer to the ICO's website and guidance documents for further information https://ico.org.uk/.

The *Caldicott principles* outline seven areas that all health and social care staff are expected to adhere to in addition to the DPA. These principles are:

1. Justify the purpose(s).
2. Don't use personal confidential data unless it is absolutely necessary.

3. Use the minimum necessary personal confidential data.
4. Access to personal confidential data should be on a strict need-to-know basis.
5. Everyone with access to personal confidential data should be aware of their responsibilities.
6. Comply with the law.
7. The duty to share information can be as important as the duty to protect patient confidentiality.

For staff working in health and social care, there are a number of record keeping codes that are associated with certain professional bodies which must be adhered to as part of respective professions. The Academy of Medical Royal Colleges (AoMRC) *generic medical record keeping standards* (hosted by the Royal College of Physicians) were prepared for use in the NHS in a primarily acute setting, but the standard is useful to be considered in all settings. The AoMRC note that a medical record, whether paper or electronic, must adhere to the following standards:

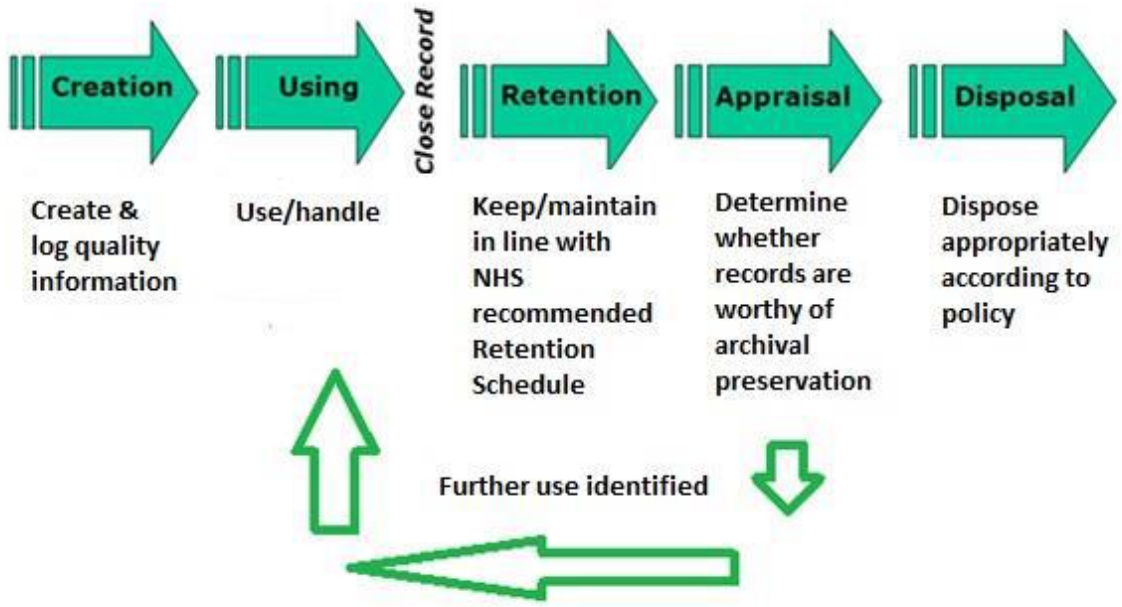
Standard Number	Description
1	The patient's complete medical record should be available at all times during their stay in hospital
2	Every page in the medical record should include the patient's name, identification number (must include NHS number, may include local ID) and location in the hospital
3	The contents of the medical record should have a standardised structure and layout
4	Documentation within the medical record should reflect the continuum of patient care and should be viewable in chronological order
5	Data recorded or communicated on admission, handover and discharge should be recorded using a standardised proforma
6	Every entry in the medical record should be dated, timed (24 hour clock), legible and signed by the person making the entry. The name and designation of the person making the entry should be legibly printed against their signature. Deletions and alterations should be countersigned, dated and timed

7	Entries to the medical record should be made as soon as possible after the event to be documented (for example change in clinical state, ward round, investigation) and before the relevant staff member goes off duty. If there is a delay, the time of the event and the delay should be recorded
8	Every entry in a medical record should identify the most senior healthcare professional present (who is responsible for decision making) at the time the entry is made
9	On each occasion a transfer of care occurs, the consultant responsible for the patient's care will change the name of the responsible consultant and the date and time of the agreed transfer of care
10	An entry should be made in the medical record whenever a patient is seen by a doctor. When there is no entry in the hospital record for more than four (4) days for acute medical care or seven (7) days for long-stay continuing care, the next entry should explain why
11	The discharge record/discharge summary should be commenced at the time a patient is admitted to hospital
12	Advanced Decisions to Refuse Treatment, Consent, and Cardiopulmonary Resuscitation decisions must be clearly recorded in the medical record. In circumstances where the patient is not the decision maker, that person should be identified e.g. Lasting Power of Attorney

7. The Records Management Life Cycle

The records management life cycle describes the life of a record from its creation/receipt through the period of its 'active' use, then into a period of 'inactive' retention (such as closed files which may still be referred to occasionally) and finally either confidential disposal or archival preservation.

The Records/Information Lifecycle:



Published by the Information Governance Alliance – July 2016

The key components of records management are:

- record creation;
- record keeping;
- record maintenance;
- access and disclosure;
- sharing;
- security and storage;
- closure and transfer;
- appraisal/audit;
- archiving; and
- disposal.

Staff members must not alter, deface, block, erase, destroy or conceal records with the intention of preventing disclosure under a request relating to the FOIA 2000 or the GDPR/DPA 2018.

Staff members are expected to manage records about individuals in accordance with this policy irrespective of their race, disability, gender, age, sexual orientation, religion or belief, or socio-economic status.

A Data Protection Impact Assessment (DPIA) is 'a tool to help identify and minimise the data protection risks to the rights and freedoms of natural persons resulting from the processing of personal data'. A DPIA should be considered at the outset of implementing new or changes to records

management systems to ensure they are fit for purpose and compliant with data protection legislation.

7.1 Creation

- A comprehensive health record should be created and maintained for every patient attending health services to provide an up to date and chronological account of the patient's care.
- Patient demographic data for each registration should be recorded on the master patient index of the patient administration or departmental system. The minimum patient demographic data should include: surname, forename, sex, date of birth, home address, postcode, NHS and or Patient Administration System (PAS)/departmental number.
- The organisation should use the NHS number as a partial validation tool.
- Where there is more than one local identifier or case record per patient, a system is in place to ensure that the existence of all other health records is known.
- The paper health record has a standard case record folder constructed of robust material which can withstand handling and transport and has secure anchorage points to protect against loss or damage to documentation.
- There is a designated area within the health record for health professionals to record actual or suspected clinical alerts or risk factors.
- There is a locally agreed format for the filing of the information in the health record which facilitates ease of access to all clinical information. Clear instructions regarding the order of filing is contained within the folder.
- Machine generated reports and recordings such as CTG, ECG and laboratory reports are stored securely within the case note folder.
- All electronic systems are password protected and passwords are changed at regular intervals. An audit trail of access, amendments or updates is available and reports can be taken from the system.

7.2 Management

- Maintaining the health record is vital to patient care. The health records service should have well defined procedures and systems in operation for the ongoing management of the health record from initiation to final disposal in accordance with legislation;
- Whenever possible, separate areas are maintained for current ('active')and non-current ('archive') health records within the organisation;
- There are documented procedures for the safe storage and retrieval of health records;
- There are documented procedures for the tracking of records within the organisation and audit and reporting is used to highlight any issues that arise as a result of non compliance;

- There is a documented procedure for the splitting of fat folders and cross referencing of the volumes. Closed volumes are suitably labelled.
- There is a documented procedure relating to the management and return of the patient held record when an episode of care is complete.
- There are agreed processes and identified staff responsible for the filing of loose documentation. Each person who uses and adds to the record has the responsibility to maintain the record and file any information into the appropriate section and format. This is part of the overall record keeping standards of the organisation.
- Health records staff will routinely split large folders or provide a new folder if the outer cover is not of a good standard.
- There are documented procedures for the transportation of health records both within and outside of the Health Board.
- There are documented procedures for the handling of Subject Access, Access to Health Records and other requests for the disclosure of records with clear responsibility for responding by fully trained, dedicated staff who process requests in accordance with the law;
- There is a set of performance indicators which demonstrate the efficiency of the health records service which include health record availability, incorrectly tracked records, missing records and temporary records.
- Contingencies for records management should exist if the preferred system(s) are unavailable. Business continuity arrangements should be documented.
- It is not necessary to keep duplicate instances of the same record unless it is used in another process and is then part of a new record. If a duplicate is held, it should be marked as a copy to prevent their use as a primary record.
- The management of integrated or joint care records should be supported by an appropriate information sharing agreement to provide clarity and transparency on the standards that all partner organisations must meet.
- Records management related incidents are reported, investigated and escalated as required and any lessons learned are shared.
- An audit of records should be undertaken annually to ensure there is an understanding of the extent of records held on and off-site. This will enable the health board to know what series of records are held by which business areas and that there are named information asset owners managing all records appropriately. This could be linked to the Information Asset Register.
- Staff should ensure that where a manual system has been replaced by an approved electronic system, they only maintain the electronic records.
- Please see **Appendix B** for a list of frequently used administrative and management terms and abbreviations.

7.3 Storage

- Record storage areas should provide a safe working environment with secure storage that allows records to be retrieved as and when required and to protect their confidentiality and integrity. These areas should only be accessible to authorised staff and should conform to agreed standards to protect records from damp, fire, flood and chemical contamination.
- Records storage areas should conform to all current legislation and guidance regarding health and safety.
- Risk assessments are undertaken in line with the Risk Management Framework.
- Racking, where this is in use, is stable and of strong enough construction to support the weight of the records and complies with health and safety regulations.
- There are safety step ladders and stools appropriate to the number of staff employed and to the size of the different storage areas.
- The staff are trained in the manual handling procedures associated with the library areas.
- Equipment within the department conforms to the appropriate legislation and equipment checks are conducted when necessary.
- Access to the libraries is restricted to authorised personnel. The keys/access codes/swipes to areas that are locked are made available to staff to facilitate the retrieval of records during the out-of-hours service.
- The records areas should be capable of accommodating the current needs and annual growth of records.
- Health records must be stored securely when in clinical areas, offices and arrangements made within these areas to allow retrieval of records when required.
- Requests for additional records storage should be submitted to the Property and Accommodation Group managed by the Estates & Property Department.

7.4 Archiving and Disposal of Records

- It is a requirement that all of the health board's records are maintained for a minimum period of time for clinical, legal, operational, research and safety reasons. The length of time for retaining records depends on the record type.
- The health board has adopted the minimum retention periods as set out in the retention and destruction schedule in accordance with the legislation. Please refer to **Appendix C**.
- The Public Records Act 1958 (PRA) makes special provision for Welsh public records: under the Government of Wales Act 2006, they are not subject to the PRA but are to be treated as if they were until an order has been made transferring responsibility for them to Welsh Ministers.

- There are documented procedures on the appraisal of records to determine whether records that have reached their minimum retention should be destroyed, retained for a longer period as they are still in use, or are worthy of archival preservation and transferred to a Place of Deposit. A record should be maintained of disposal activity.
- Publication on the health board's website does not fulfil the requirement for a record to be retained – the responsibility lies with the record holder.
- The method of destruction should ensure that confidentiality is maintained at all times – please refer to the organisation's Waste Policy which sets out confidential waste requirements.
- If personal data is held for longer than necessary it may breach principle five of the DPA.

*****STAFF ARE REMINDED OF THE CURRENT STATUS OF THE TWO NATIONAL INQUIRIES (INFECTED BLOOD & HISTORICAL CHILD SEXUAL ABUSE) WHICH HAVE PLACED AN EMBARGO ON THE CULLING OF RELATED RECORDS FOR THE FORSEEABLE FUTURE. IN ADDITION, THE NATIONAL ARCHIVES HAVE ADVISED THAT RECORDS RELATING TO THE COVID-19 PANDEMIC SHOULD ALSO BE RETAINED INDEFINITELY PENDING A NATIONAL INQUIRY*****

The health board's guidance in support of the records management processes is available on the staff intranet
http://nww.powysthb.wales.nhs.uk/information-governance-policies-and-guid

8. Audit and Monitoring

Compliance with this framework will be monitored by reporting progress against:

- the 'Health and Care Standards (3.5 Record Keeping)';
- the 'Welsh IG Toolkit for Health Boards and Trusts' – Section 5: Records Management Procedures;
- the 'Records Management Improvement Plan'. This Plan outlines the organisation's response to the 2019 Internal Audit of Records Management in which six key recommendations were identified for improvement;
- agreed key performance indicators;
- risks, incidents and learning, and;
- the annual audit programme.

The health board will ensure the application of records management procedures is regularly monitored against agreed indicators and action taken to improve standards as necessary.

9. Records Management Training

Effective records management involves staff at all levels. Training and guidance enables staff to understand and implement policies, and facilitates the efficient implementation of good record keeping practices.

All staff, whether clinical or administrative, must be appropriately trained so that they are fully aware of their personal responsibilities in respect of record keeping and records management and that they are competent to carry out their designated duties. No patient or client records or systems should be handled or used until training has been completed within the induction period.

Information Governance e-learning training is a mandatory requirement for all staff. This should be completed every two years and is available on ESR.

Training should include the use of electronic records systems and should be delivered through generic and/or organisation-wide training programmes which can be department or context specific. These should be complemented by organisational policies and procedures and guidance documentation.

APPENDIX A – Glossary of Terms

Glossary of terms	
Term	**Definition**
Appraisal	The process of reviewing records when they have reached their minimum retention period - deciding whether to retain for a longer period, destroy or transfer to a Place of Deposit. Actions should be documented.
Contemporaneous	With reference to completion of entries in the patient record is defined that they are to be made 'as soon as possible' if the relevant clinical records management system can be accessed but definitely by the end of the shift. If this is not possible for any reason, the entry should be completed at the earliest opportunity to ensure high quality care and patient safety, and includes an entry about the length of delay, mitigation as to risk to the patient caused by the delay (if any) and a full explanation of the circumstances.
Data Quality	Data Quality refers to the procedures and processes in place to ensure that data is accurate, up to date, free from duplication (for example, where two or more different records exist for the same individual), and free from confusion (where different parts of an individual's records are held in different places, and possibly in different formats).
Health Records	A health record is everything (paper or electronic) that contains information which has been created or gathered as a result of any aspect of the delivery of patient care. It is defined in the Data Protection Act (DPA) 2018 as 'consists of information relating to the physical or mental health or condition of an individual, and has been made by or on behalf of a health professional in connection with the care of that individual'.
Information Asset Owner (IAO)	The Information Asset Owner is the senior responsible individual involved in the running of the service/department. Their role is to understand what information is held, what is added and what is removed, how information is moved and who has access and why. As a result, they are able to understand and address the

	risks to the information and ensure that information is fully used within the law. They provide a written judgement of the security and use of their asset annually to support the audit process.
Information Asset Register (IAR)	In order to comply with the accountability principle under the GDPR the health board needs to know what personal data it holds, where it came from and who it is shared with. Documenting an information asset audit will help us maintain records of processing activities and identify risks to processing. The IAR is a log of information assets and enables us to understand what information we hold in order to protect it and process it in accordance with legislation.
Place of Deposit	A Place of Deposit is a record office which has been approved by The National Archives (TNA) for the deposit of public records in accordance with the Public Records Act 1958. Powys Archives in Llandrindod Wells serves as the official repository for the records of the county of Powys and includes PTHB records which have been identified as requiring transfer to the Archives following appraisal.
Records	Records are defined as 'recorded information, in any form, created or received and maintained by the Health Board in the transaction of its business or conduct of affairs and kept as evidence of such activity'. This includes but is not limited to: • Patient health records e.g manual patient casenotes or the digital clinical record such as those held in the Welsh Community Care Information System (WCCIS) • Registers or databases containing patient-related information • Administrative records (including human resources, estates, financial and accounting, litigation, health & safety, infection control etc) • Minutes of meetings and reports • Records associated with clinical supervision, training, compliments, incidents and complaint handling • Diaries • Patient proformas • Photographs, slides and other images • Xray and imaging reports, output and images • Mircroform (e.g. fiche/film) • Removable media and its content e.g. data sticks, CDs, cassettes • Computer database and all other electronic records • Digital records • Email • Material intended for short term or transitory use,

	including notes, notebooks and spare copies of documents • Text messages (both outgoing from the NHS and incoming responses from patients) • Scanned documents
Records Management	Records Management is a discipline which utilises administrative systems to direct and control the creation, control, distribution, filing, retention, storage and disposal of records, in a way that is administratively and legally sound, whilst at the same time serving the operational needs of the Health Board and preserving an appropriate historical record.
WASPI	Wales Accord for the Sharing of Personal Information (WASPI) is a framework that supports the exchange of personal information between partner organisations which can be made up from public sector, voluntary sector and private and independent organisations: http://www.waspi.org/home. Information Sharing Protocols (ISPs) should be developed to support the regular, reciprocal sharing of information.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

APPENDIX B – Administrative and Management Terms

Administrative and Management Terms	
A&E	Accident and Emergency – also known as Emergency Department
ACU	Acute Cardiac Unit
APC	Admitted Patient Care
CAMHS	Child and Adolescent Mental Health Services
CaNISC	Cancer Network Information System Cymru
CBT	Cognitive Behavioural Therapy
CCT	Community Care Team (Adult Services)
CDU	Clinical Decisions Unit
CHIRP	Cancer Histopathology reporting
CLDT	Community Learning Disability Team
CMATs	Clinical MSK and Treatment Service
COPD	Chronic Obstructive Pulmonary Disease
CP	Child Protection
CPA	Care Programme Approach
CMHT	Community Mental Health Team
DNA	Did not attend
DoB	Date of Birth
ED	Emergency Department/A&E
E-Pex	Mental Health IT System
ELP	Essential Lifestyle Planning
EHR	Electronic Health Record
EPR	Electronic Patient Record
FU /FUWL	Follow up /Follow Up Waiting List
GP	General Practitioner
GPOOH	GP Out of Hours Service
H@N	Hospital at Night Service
HDU	High Dependency Unit
ICA/ICU	Intensive Care Area/Intensive Care Unit

IG	Information Governance
LD	Learning Disabilities/Difficulties
MAU	Medical Assessment Unit
MCA	Mental Capacity Act
MDT	Multi-Disciplinary Team
MH	Mental Health
MHA	Mental Health Act
MIU	Minor Injury Unit
MSK	Musculoskeletal Service
MSU	Medium Secure Unit
NoK	Next of Kin
NP	New Patient
OOH	Out of Hours
OPD	Out Patient Department
PICU	Psychiatric Intensive Care Unit
OT	Occupational Therapy/Therapist
SM	Substance Misuse
SW	Social Work (er)
TCI	To Come In
T&O	Trauma & Orthopaedics
RAU	Rapid Assessment Unit
RTT	Referral to Treatment
SAU	Surgical Assessment Unit
WPAS	Welsh Patient Administration System
WPOCT	Welsh Point of Care Testing

COMMON MEDICAL ABBREVIATIONS:

Ax	Assessment
BD	Twice daily
BMI	Body Mass Index
BO	Bowels Open
BNO	Bowels not Open
Ca	Cancer
C/O	Complaining Of
COAG	Coagulation
COBH	Change of Bowel Habit
CVA	Cerebrovascular accident
DNR	Do Not Resuscitate
DNAR	Do Not Attempt Resuscitation
DNACPR	Do Not Attempt Cardio Pulmonary Resuscitation
DVT	Deep Vein Thrombosis
EUA	Examination under anaesthetic

El LSCS	Elective Lower Segment Caesarean Section
EM LSCS	Emergency Lower Segment Caesarean Section
ERPC	Evacuation of Retained Products of Conception
ERCP	Endoscopic Retrograde Cholangiopancreatography
EUS	Endoscopic Ultrasound
FBC	Full Blood Count
FH	Family History/foetal Heart
FM	Foetal Movement
GA	General Anaesthetic
Gest	gestation
Hb	Haemoglobin
HI	Head Injury
H/o	History of
HNPU	Has not Passed Urine
Ht	Height
INR	International Normalised ratio – measure of the time taken for blood to clot (for patients on anti-coagulants)
IOL	Induction of Labour
IVI	Intravenous Infusion
LA	Local Anaesthetic
LMP	Last Menstrual Period
Mane	Morning dose
MI	Myocardial Infarction
MRSA	Methicillin or Multiple Antibiotic Resistant Staphylococcus Aureus
NAD	No abnormality detected
NAI	Non Accidental Injury
NG	Nasogastric
NBM	Nil by Mouth
Nocte	Night dose
NoF	Neck of Femur
NSD	Normal spontaneous delivery
O/E	On Examination
OM	Each morning
ON	Every night
PMH	Past Medical History
PO	Per Orem (Orally)
POP	Plaster of Paris
PR	Per rectum
PU	Passed Urine
PV	Per vagina
PRN	Pro re nata (as required)

QDS	Four times daily
ROM	Range of Movement
RTA	Road Traffic Accident
RX	Treatment
SC	Subcutaneous
SL	Sublingual
SOB	Shortness of Breath
SROM	Spontaneous Rupture of Membranes
SVD	Spontaneous Vertex Delivery
TDS	Three times daily
TOP	Termination of pregnancy
TTH	To take home
Tx	Treatment
U/S	Ultrasound
UTI	Urinary Tract Infection
VTE	Venous Thromboembolism
#	Fracture
+ive / -ive	positive / negative
2/7	Two days
2/52	Two weeks

Common Procedures and Investigations

BP	Blood Pressure
CT scan	Computerised Tomography
CVP	Central Venous Pressure
CXR	Chest X-ray
ECT	Electro Convulsive Therapy
ECG	Electrocardiogram
EEG	Electro-encephalogram
ESR	Erythrocyte Sedimentation Rate
FBC	Full Blood Count
Hb	Haemoglobin
IVP	Intravenous Pyelogram
LFT's	Liver Function Tests
MRI	Magnetic Resonance Imaging
TPN	Total Parenteral Nutrition
TPR	Temperature, Pulse and Respiration
U's and E's	Urea and Electrolytes

SPECIMENS

CSU	Catheter Stream Urine Sample
CSF	Cerebrospinal Fluid
EMU	Each Morning Urine Sample
MSU	Mid-Stream Urine Sample

Latin Abbreviations

a.c. (before food)	=	ante cibum	
b. d.	=	bis die	(twice daily)
o. m.	=	omni mane	(every morning)
o. n.	=	omni nocte	(every night)
p. c.	=	post cibum	(after food)
p. r. n.	=	pro re nata	(when required)
q. d.	=	quater die	(four times daily)
q. d. s.	=	quater die sumendus	(to be taken 4 times daily)
q. q. h.	=	quarta quaque hora	(every four hours)
Stat	=		Immediately
t. d. s.	=	ter die sumendus	(to be taken 3 times daily)
t. i. d.	=	ter in die	(three times daily)

Signs for male and female ♂ ♀

♂ The symbol for a male organism or man.

♀ The symbol for a female organism or woman

APPENDIX C – Retention Schedule for Health & Corporate Records

This Appendix sets out the retention period for different types of records.

The following information is important to ensure the retention schedule is used correctly. The retention periods listed in this retention schedule must always be considered the minimum period. With justification a retention period can be extended, for the majority of cases, up to 20 years.

Retention periods begin when the record ceases to be operational. This is usually at point of discharge from care, when the record is no longer required for current on-going business, or the patient/service user has died. There are some exceptions to this rule, whereby the retention begins from the date the record is created (for Corporate Records, such as policies, the retention may start from the date of publication). These are marked with an asterisk (*) in the schedule.

If a record comes back into use during its retention period, then the retention period will reset and begin again from the end of the second period of use. This may mean that records will look as if they are being kept for longer than the retention times stated here, or even maximum periods as suggested by law, but this is acceptable where retention periods reset due to use.

The actions following review as set out in the schedule are as follows:

Review and destroy if no longer required – Destroy refers to the confidential and secure destruction of the record with proof of destruction.

Review and dispose of if no longer required – Dispose of refers to the secure destruction of a record OR the transferral to the appointed Place of Deposit (PoD) for permanent preservation. A certificate of transfer will be provided as proof of transfer (and can act as evidence of disposal).

Review and consider transfer to PoD – This refers to records that are more likely to be transferred to the PoD, subject to their agreement.

Review and transfer to PoD – This refers to records that should be transferred to the PoD. It is very important that any health and care records are reviewed before they are destroyed. This review should take into account:

• Serious incidents which will require records to be retained for up to 20 years as set out in the schedule

• Use of the record during the retention period which could extend its retention

• Potential for long-term archival preservation. This may particularly be the case where the records relate to rare conditions such as Creutzfeldt-Jakob Disease records or innovative treatments e.g. new cancer treatments.

Record Type	Retention Start	Retention period	Action at end of retention period	Notes
1) CARE RECORDS WITH STANDARD RETENTION PERIODS				
Adult health records not covered by any other section in this schedule	Discharge or patient last seen	8 years	Review and if no longer needed destroy	Basic health and social care retention period - check for any other involvements that could extend the retention. All must be reviewed prior to destruction taking into account any serious incident retentions. This includes medical illustration records such as X-rays and scans as well as video and other formats.
Adult social care records	End of care or client last seen	8 years	Review and if no longer needed destroy	

Record Type	Retention Start	Retention period	Action at end of retention period	Notes
Children's records including midwifery, health visiting and school nursing	Discharge or patient last seen	25th or 26th birthday (see Notes)	Review and if no longer needed destroy	Basic health and social care retention requirement is to retain until 25th birthday or if the patient was 17 at the conclusion of the treatment, until their 26th birthday. Check for any other involvements that could extend the retention. All must be reviewed prior to destruction taking into account any serious incident retentions. This includes medical illustration records such as X-rays and scans as well as video and other formats.
Electronic Patient Records System	See Notes	See Notes	Destroy	Where the electronic system has the capacity to destroy records in line with the retention schedule, and where a metadata stub can remain demonstrating that a record has been destroyed, then the code should be followed in the same way for electronic records as for paper records with a log being kept of the records destroyed. If the system does not have this capacity, then once the records have reached the end of their retention periods they should be inaccessible to users of the system and upon decommissioning, the system (along with audit trails) should be retained for the retention period of the last entry related to the schedule.
General Dental Services records	Discharge or patient last seen	10 Years	Review and if no longer needed destroy	

Record Type	Retention Start	Retention period	Action at end of retention period	Notes
GP Patient records	Death of Patient	10 years after death see Notes for exceptions	Review and if no longer needed destroy	If a new provider requests the records, these are transferred to the new provider to continue care. If no request to transfer: 1. Where the patient does not come back to the practice and the records are not transferred to a new provider the record must be retained for 100 years unless it is known that they have emigrated 2. Where a patient is known to have emigrated, records may be reviewed and destroyed after 10 years 3. If the patient comes back within the 100 years, the retention reverts to 10 years after death.
Integrated Records – all organisations contribute to the same single instance of the record		Retain for period of longest specialty	Review and consider transfer to PoD	The retention time will vary depending upon which type of health and care settings have contributed to the record. Areas that use this model must have a way of identifying the longest retention period applicable to the record.

Record Type	Retention Start	Retention period	Action at end of retention period	Notes
Integrated records – all organisations contribute to the same record, but keep a level of separation		Retain for relevant specialty period	Review and consider transfer to PoD	This is where all organisations contribute into the same record system but have their own area to contribute to and the system still shows a contemporaneous view of the patient record.
Integrated records – all organisations keep their own records, but enable them to be viewed by other organisations		Retain for relevant specialty period	Review and consider transfer to PoD	This is the most likely model currently in use. Organisations keep their own records on their patients/service users but can grant *view only* access to other organisations, to help them provide health and care to patients/service users.

Record Type	Retention Start	Retention period	Action at end of retention period	Notes
Mental Health records	Discharge or patient last seen	20 years or 8 years after the patient has died	Review and if no longer needed destroy	Covers records made where the person has been cared for under the Mental Health Act 1983 as amended by the Mental Health Act 2007. This includes psychology records. Retention solely for any persons who have been sectioned under the Mental Health Act 1983 must be considerably longer than 20 years where the case may be ongoing. Very mild forms of adult mental health treated in a community setting where a full recovery is made may consider treating as an adult records and keep for 8 years after discharge. All must be reviewed prior to destruction taking into account any serious incident retentions.
Obstetric records, maternity records and antenatal and post natal records	Discharge or patient last seen	25 years	Review and if no longer needed destroy	For the purposes of record keeping these records are to be considered as much a record of the child as that of the mother.

Record Type	Retention Start	Retention period	Action at end of retention period	Notes
2) *CARE RECORDS WITH NON-STANDARD RETENTION PERIODS*				
Cancer/ Oncology - the oncology records of any patient	Diagnosis of Cancer	30 Years or 8 years after the patient has died	Review and consider transfer to a Place of Deposit	For the purposes of clinical care the diagnosis records of any cancer must be retained in case of future reoccurrence. Where the oncology records are in a main patient file the entire file must be retained. Retention is applicable to primary acute patient record of the cancer diagnosis and treatment only. If this is part of a wider patient record then the entire record may be retained. Any oncology records must be reviewed prior to destruction taking into account any potential long term research value which may require consent or anonymisation of the record.
Contraception, sexual health, Family Planning and Genito-Urinary Medicine (GUM)	Discharge or patient last seen	8 or 10 years (see Notes)	Review and if no longer needed destroy	Basic retention requirement is 8 years unless there is an implant or device inserted, in which case it is 10 years. All must be reviewed prior to destruction taking into account any serious incident retentions. If this is a record of a child, treat as a child record as above.

Record Type	Retention Start	Retention period	Action at end of retention period	Notes
HFEA records of treatment provided in licenced treatment centres		3, 10, 30, or 50 years	Review and if no longer needed destroy	Retention periods are set out in the HFEA guidance at:http://www.hfea.gov.uk/docs/General_directions_0012.pdf
Medical record of a patient with Creutzfeldt-Jakob Disease (CJD)	Diagnosis	30 Years or 8 years after the patient has died	Review and consider transfer to a Place of Deposit	For the purposes of clinical care the diagnosis records of CJD must be retained. Where the CJD records are in a main patient file the entire file must be retained. All must be reviewed prior to destruction taking into account any serious incident retentions.
Record of long term illness or an illness that may reoccur	Discharge or patient last seen	30 Years or 8 years after the patient has died	Review and if no longer needed destroy	Necessary for continuity of clinical care. The primary record of the illness and course of treatment must be kept of a patient where the illness may reoccur or is a life long illness.

Record Type	Retention Start	Retention period	Action at end of retention period	Notes
3) PHARMACY				
Information relating to controlled drugs	Creation	See Notes	Review and if no longer needed destroy	NHS England and NHS BSA guidance for controlled drugs can be found at: http://www.nhsbsa.nhs.uk/PrescriptionServices/1120.aspx and https://www.england.nhs.uk/wp-content/uploads/2013/11/som-cont-drugs.pdf The Medicines, Ethics and Practice (MEP) guidance can be found at the link (subscription required) http://www.rpharms.com/support/mep.asp#new Guidance from NHS England is that locally held controlled drugs information should be retained for 7 years. NHS BSA will hold primary data for 20 years and then review.NHS East and South East Specialist Pharmacy Services have prepared pharmacy records guidance including a specialised retention schedule for pharmacy. Please see:http://www.medicinesresources.nhs.uk/en/Communities/NHS/SPS-E-and-SE-England/Reports-Bulletins/Retention-of-pharmacy-records/

Record Type	Retention Start	Retention period	Action at end of retention period	Notes
Pharmacy prescription records *see also Controlled Drugs*	Discharge or patient last seen	2 Years	Review and if no longer needed destroy	See also 'Controlled Drugs'. There will also be an entry in the patient record and a record held by the NHS Business Services Authority. NHS East and South East Specialist Pharmacy Services have prepared pharmacy records guidance including a specialised retention schedule for pharmacy. Please see: http://www.medicinesresources.nhs.uk/en/Communities/NHS/SPS-E-and-SE-England/Reports-Bulletins/Retention-of-pharmacy-records/
4) PATHOLOGY				
Pathology Reports/Information about Specimens and samples	Specimen or sample is destroyed	See Notes	Review and consider transfer to a Place of Deposit	This Code is concerned with the information about a specimen or sample. The length of storage of the clinical material will drive the length of time the information about it is to be kept. For more details please see: https://www.rcpath.org/resourceLibrary/the-retention-and-storage-of-pathological-records-and-specimens--5th-edition-.html. Retention of samples for clinical purposes can be for as long as there is a clinical need to hold the specimen or sample. Reports should be stored on the patient file. It is common for pathologists to hold duplicate reports. For clinical purposes this is 8 years after the patient is discharged for an adult or until a child's 25th birthday whichever is the longer. . After 20 years for adult records there must be an appraisal as to the historical importance

Record Type	Retention Start	Retention period	Action at end of retention period	Notes
				of the information and a decision made as to whether they should be destroyed of kept for archival value.
5) EVENT & TRANSACTION RECORDS				
Blood bank register	Creation	30 Years minimum	Review and consider transfer to a Place of Deposit	
Clinical Audit	Creation	5 years	Review and if no longer needed destroy	
Chaplaincy records	Creation	2 years	Review and consider transfer to a Place of Deposit	See also Corporate Retention

Record Type	Retention Start	Retention period	Action at end of retention period	Notes
Clinical Diaries	End of the year to which they relate	2 years	Review and if no longer needed destroy	Diaries of clinical activity & visits must be written up and transferred to the main patient file. If the information is not transferred the diary must be kept for 8 years.
Clinical Protocols	Creation	25 years	Review and consider transfer to a Place of Deposit	Clinical protocols may have archival value. They may also be routinely captured in clinical governance meetings which may form part of the permanent record (see Corporate Records).
Datasets released by HSCIC under a data sharing agreement	Date specified in the data sharing agreement	Delete with immediate effect	Delete according to HSCIC instruction	http://www.hscic.gov.uk/media/15729/DARS-Data-Sharing-Agreement/pdf/Data_Sharing_Agreement_2015v2%28restricted_editing%29.pdf

Record Type	Retention Start	Retention period	Action at end of retention period	Notes
Destruction Certificates or Electronic Metadata destruction stub or record of clinical information held on destroyed physical media	Destruction of record or information	20 Years	Review and consider transfer to a Place of Deposit	Destruction certificates created by public bodies are not covered by an instrument of retention and if a Place of Deposit or the National Archives do not class them as a record of archival importance they are to be destroyed after 20 years.
Equipment maintenance logs	Decommissioning of the equipment	11 years	Review and consider transfer to a Place of Deposit	
General Ophthalmic Services patient records related to NHS financial transactions	Discharge or patient last seen	6 Years	Review and if no longer needed destroy	

Record Type	Retention Start	Retention period	Action at end of retention period	Notes
GP temporary resident forms	After treatment	2 years	Review and if no longer needed destroy	Assumes a copy sent to responsible GP for inclusion in the primary care record
Inspection of equipment records	Decommissioning of equipment	11 Years	Review and if no longer needed destroy	
Notifiable disease book	Creation	6 years	Review and if no longer needed destroy	
Operating theatre records	End of year to which they relate	10 Years	Review and consider transfer to a Place of Deposit	If transferred to a place of deposit the duty of confidence continues to apply and can only be used for research if the patient has consented or the record is anonymised.

Record Type	Retention Start	Retention period	Action at end of retention period	Notes
Patient Property Books	End of the year to which they relate	2 years	Review and if no longer needed destroy	
Referrals not accepted	Date of rejection.	2 years as an ephemeral record	Review and if no longer needed destroy	The rejected referral to the service should also be kept on the originating service file.
Requests for funding for care not accepted	Date of rejection	2 years as an ephemeral record	Review and if no longer needed destroy	
Screening, including cervical screening, information where no cancer/illness detected is detected	Creation	10 years	Review and if no longer needed destroy	Where cancer is detected see 2 Cancer / Oncology. For child screening treat as a child health record and retain until 25th birthday or 10 years after the child has been screened whichever is the longer.

Record Type	Retention Start	Retention period	Action at end of retention period	Notes
Smoking cessation	Closure of 12 week quit period	2 years	Review and if no longer needed destroy	
Transplantation Records	Creation	30 Years	Review and consider transfer to a Place of Deposit	See guidance at: https://www.hta.gov.uk/codes-practice
Ward handover sheet	Date of handover	2 years	Review and if no longer needed destroy	This retention relates to the ward. The individual sheets held by staff must be destroyed confidentially at the end of the shift.
6) TELEPHONY SYSTEMS & SERVICES (999 phone numbers,111 phone numbers, ambulance, out of hours, single point of contact call centres).				

Record Type	Retention Start	Retention period	Action at end of retention period	Notes
Recorded conversation which may later be needed for clinical negligence purpose	Creation	3 Years	Review and if no longer needed destroy	The period of time cited by the NHS Litigation Authority is 3 years
Recorded conversation which forms part of the health record	Creation	Store as a health record	Review and if no longer needed destroy	It is advisable to transfer any relevant information into the main record through transcription or summarisation. Call handlers may perform this task as part of the call. Where it is not possible to transfer clinical information from the recording to the record the recording must be considered as part of the record and be retained accordingly.
The telephony systems record (not recorded conversations)	Creation	1 year	Review and if no longer needed destroy	This is the absolute minimum specified to meet the NHS contractual requirement.

Record Type	Retention Start	Retention period	Action at end of retention period	Notes
7) BIRTHS, DEATHS & ADOPTION RECORDS				
Birth Notification to Child Health	Receipt by Child health department	25 years	Review and if no longer needed destroy	Treat as a part of the child's health record if not already stored within health record such as the health visiting record.
Birth Registers	Creation	2 years	Review and actively consider transfer to a Place of Deposit	Where registers of all the births that have taken place in a particular hospital/birth centre exist, these will have archival value and should be retained for 25 years and offered to a Place of Deposit at the end of this retention period. Information is also held in the NHS Number for Babies (NN4B) electronic system and by the Office for National Statistics. Other information about a birth must be recorded in the care record.
Body Release Forms	Creation	2 years	Review and consider transfer to	

Record Type	Retention Start	Retention period	Action at end of retention period	Notes
			a Place of Deposit	
Death - cause of death certificate counterfoil	Creation	2 years	Review and consider transfer to a Place of Deposit	
Death register information sent to General Registry Office on monthly basis	Creation	2 years	Review and consider transfer to a Place of Deposit	A full dataset is available from the Office for National Statistics.
Local Authority Adoption Record (normally held by the Local Authority children's services)	Creation	100 years from the date of the adoption order	Review and consider transfer to a Place of Deposit	The primary record of the adoption process is held by the local authority children's service responsible for the adoption service

Record Type	Retention Start	Retention period	Action at end of retention period	Notes
Mortuary Records of deceased	End of year to which they relate	10 Years	Review and consider transfer to a Place of Deposit	
Mortuary register	Creation	10 Years	Review and consider transfer to a Place of Deposit	
NHS Medicals for Adoption Records	Creation	8 years or 25th birthday	Review and consider transfer to a Place of Deposit	The health reports will feed into the primary record held by Local Authority Children's services. This means that the adoption records held in the NHS relate to reports that are already kept in another file which is kept for 100 years by the appropriate agency and local authority.

Record Type	Retention Start	Retention period	Action at end of retention period	Notes
Post Mortem Records	Creation	10 years	Review and if no longer needed destroy	The primary post mortem file will be maintained by the coroner. The coroner will retain the post mortem file including the report. Local records of post mortem will not need to be kept for the same extended time.

Record Type	Retention Start	Retention period	Action at end of retention period	Notes
8) CLINICAL TRIALS & RESEARCH				
Advanced Medical Therapy Research Master File	Closure of research	30 years	Review and consider transfer to a Place of Deposit	See guidance at: https://www.gov.uk/guidance/advanced-therapy-medicinal-products-regulation-and-licensing For clinical trials record retention please see the MHRC guidance at https://www.gov.uk/guidance/good-clinical-practice-for-clinical-trials
Clinical Trials Master File of a trial authorised under the European portal under Regulation (EU) No 536/2014	Closure of trial	25 years	Review and consider transfer to a Place of Deposit	For details see: http://eur-lex.europa.eu/legal-content/EN/TXT/?uri=uriserv:OJ.L_.2014.158.01.0001.01.ENG
European Commission Authorisation (certificate or letter) to enable	Closure of trial	15 years	Review and consider transfer to a Place of Deposit	http://ec.europa.eu/health/files/eudralex/vol-2/a/vol2a_chap1_2013-06_en.pdf

Record Type	Retention Start	Retention period	Action at end of retention period	Notes
marketing and sale within the EU member states area				
Research data sets	End of research	Not more than 20 years	Review and consider transfer to a Place of Deposit	http://tools.jiscinfonet.ac.uk/downloads/bcs-rrs/managing-research-records.pdf

Record Type	Retention Start	Retention period	Action at end of retention period	Notes
Research Ethics Committee's documentation for research proposal	End of research	5 years	Review and consider transfer to a Place of Deposit	For details please see:http://www.hra.nhs.uk/resources/research-legislation-and-governance/governance-arrangements-for-research-ethics-committees/ Data must be held for sufficient time to allow any questions about the research to be answered. Depending on the type of research the data may not need to be kept once the purpose has expired. For example data used for passing an academic exam may be destroyed once the exam has been passed and there is no further academic need to hold the data. For more significant research a place of deposit may be interested in holding the research. It is best practice to consider this at the outset of research and orphaned personal data can inadvertently cause a data breach.
Research Ethics Committee's minutes and papers	Year to which they relate	Before 20 years	Review and consider transfer to a Place of Deposit	Committee papers must be transferred to a place of deposit as a public record: http://www.hra.nhs.uk/resources/research-legislation-and-governance/governance-arrangements-for-research-ethics-committees/

Record Type	Retention Start	Retention period	Action at end of retention period	Notes
9) CORPORATE GOVERNANCE				
Board Meetings	Creation	Before 20 years but as soon as practically possible	Transfer to a Place of Deposit	
Board Meetings (Closed Boards)	Creation	May retain for 20 years	Transfer to a Place of Deposit	Although they may contain confidential or sensitive material they are still a public record and must be transferred at 20 years with any FOI exemptions noted or duty of confidence indicated.
Chief Executive records	Creation	May retain for 20 years	Transfer to a Place of Deposit	This may include emails and correspondence where they are not already included in the board papers and they are considered to be of archival interest.
Committees Listed in the Scheme of Delegation or that report into the Board and	Creation	Before 20 years but as soon as practically possible	Transfer to a Place of Deposit	

Record Type	Retention Start	Retention period	Action at end of retention period	Notes
major projects				
Committees/ Groups / Sub-committees not listed in the scheme of delegation	Creation	6 Years	Review and if no longer needed destroy	Includes minor meetings/projects and departmental business meetings
Destruction Certificates or Electronic Metadata destruction stub or record of information held on destroyed physical media	Destruction of record or information	20 Years	Consider Transfer to a Place of Deposit and if no longer needed to destroy	The Public Records Act 1958 limits the holding of records to 20 years unless there is an instrument issued by the Minister with responsibility for administering the Public Records Act 1958. If records are not excluded by such an instrument they must either be transferred to a place of deposit as a public record or destroyed 20 years after the record has been closed.
Incidents (serious)	Date of Incident	20 Years	Review and consider	

Record Type	Retention Start	Retention period	Action at end of retention period	Notes
			transfer to a Place of Deposit	
Incidents (not serious)	Date of Incident	10 Years	Review and if no longer needed destroy	
Non-Clinical Quality Assurance Records	End of year to which the assurance relates	12 years	Review and if no longer needed destroy	
Patient Advice and Liaison Service (PALS) records	Close of financial year	10 years	Review and if no longer needed destroy	
Policies, strategies and operating procedures including business plans	Creation	Life of organisation plus 6 years	Review and consider transfer to a Place of Deposit	

Record Type	Retention Start	Retention period	Action at end of retention period	Notes
10) COMMUNICATIONS				
Intranet site	Creation	6 years	Review and consider transfer to a Place of Deposit	
Patient information leaflets	End of use	6 years	Review and consider transfer to a Place of Deposit	
Press releases and important internal communications	Release Date	6 years	Review and consider transfer to a Place of Deposit	Press releases may form a significant part of the public record of an organisation which may need to be retained
Public consultations	End of consultation	5 years	Review and consider transfer to	

Record Type	Retention Start	Retention period	Action at end of retention period	Notes
			a Place of Deposit	
Website	Creation	6 years	Review and consider transfer to a Place of Deposit	
11) STAFF RECORDS & OCCUPATIONAL HEALTH				
Duty Roster	Close of financial year	6 years	Review and if no longer needed destroy	
Exposure Monitoring information	Monitoring ceases	40 years/5 years from the date of the last entry made in it	Review and if no longer needed destroy	A) Where the record is representative of the personal exposures of identifiable employees, for at least 40 years or B) In any other case, for at least 5 years.

Record Type	Retention Start	Retention period	Action at end of retention period	Notes
Occupational Health Reports	Staff member leaves	Keep until 75th birthday or 6 years after the staff member leaves whichever is sooner	Review and if no longer needed destroy	
Occupational Health Report of Staff member under health surveillance	Staff member leaves	Keep until 75th birthday	Review and if no longer needed destroy	
Occupational Health Report of Staff member under health surveillance where they have been	Staff member leaves	50 years from the date of the last entry or until 75th birthday, whichever	Review and if no longer needed destroy	

Record Type	Retention Start	Retention period	Action at end of retention period	Notes
subject to radiation doses		is longer		
Staff Record	Staff member leaves	Keep until 75th birthday (see Notes)	Create Staff Record Summary then review or destroy the main file.	This includes (but is not limited to) evidence of right to work, security checks and recruitment documentation for the successful candidate including job adverts and application forms. May be destroyed 6 years after the staff member leaves or the 75th birthday, whichever is sooner, if a summary has been made.
Staff Record Summary	6 years after the staff member leaves	75th Birthday	Place of Deposit should be offered for continued retention or Destroy	Please see page 36 for an example of a Staff Record Summary used by an organisation.

Record Type	Retention Start	Retention period	Action at end of retention period	Notes
Timesheets (original record)	Creation	2 years	Review and if no longer needed destroy	
Staff Training records	Creation	See Notes	Review and consider transfer to a Place of Deposit	Records of significant training must be kept until 75th birthday or 6 years after the staff member leaves. It can be difficult to categorise staff training records as significant as this can depend upon the staff member's role. The IGA recommends: 1) Clinical training records - to be retained until 75th birthday or six years after the staff member leaves, whichever is the longer 2) Statutory and mandatory training records - to be kept for ten years after training completed 3) Other training records - keep for six years after training completed.
12) PROCUREMENT				
Contracts sealed or unsealed	End of contract	6 years	Review and if no longer needed destroy	

Record Type	Retention Start	Retention period	Action at end of retention period	Notes
Contracts - financial approval files	End of contract	15 years	Review and if no longer needed destroy	
Contracts - financial approved suppliers documentation	When supplier finishes work	11 years	Review and if no longer needed destroy	
Tenders (successful)	End of contract	6 years	Review and if no longer needed destroy	
Tenders (unsuccessful)	Award of tender	6 years	Review and if no longer needed destroy	
13) ESTATES				

Record Type	Retention Start	Retention period	Action at end of retention period	Notes
Building plans and records of major building work	Completion of work	Lifetime of the building or disposal of asset plus six years	Review and consider transfer to a Place of Deposit	Building plans and records of works are potentially of historical interest and where possible be kept and transferred to a place of deposit
CCTV		See ICO Code of Practice	Review and if no longer needed destroy	ICO Code of Practice: https://ico.org.uk/media/for-organisations/documents/1542/cctv-code-of-practice.pdf The length of retention must be determined by the purpose for which the CCTV has been deployed. The recorded images will only be retained long enough for any incident to come to light (e.g. for a theft to be noticed) and the incident to be investigated.
Equipment monitoring and testing and maintenance work where asbestos is a factor	Completion of monitoring or test	40 years	Review and if no longer needed destroy	

Record Type	Retention Start	Retention period	Action at end of retention period	Notes
Equipment monitoring and testing and maintenance work	Completion of monitoring or test	10 years	Review and if no longer needed destroy	
Inspection reports	End of lifetime of installation	Lifetime of installation	Review	
Leases	Termination of lease	12 years	Review and if no longer needed destroy	
Minor building works	Completion of work	retain for 6 years	Review and if no longer needed destroy	

Record Type	Retention Start	Retention period	Action at end of retention period	Notes
Photographic collections of service locations and events and activities	Close of collection	Retain for not more than 20 years	Consider transfer to a place of deposit	The main reason for maintaining photographic collections is for historical legacy of the running and operation of an organisation. However, photographs may have subsidiary uses for legal enquiries.
Radioactive Waste	Creation	30 years	Review and if no longer needed destroy	
Sterilix Endoscopic Disinfector Daily Water Cycle Test, Purge Test, Nynhydrin Test	Date of test	11 years	Review and if no longer needed destroy	
Surveys	End of lifetime of installation or building	Lifetime of installation or building	Review and consider transfer to	

Record Type	Retention Start	Retention period	Action at end of retention period	Notes
			Place of Deposit	
14) FINANCE				
Accounts	Close of financial year	3 years	Review and if no longer needed destroy	Includes all associated documentation and records for the purpose of audit as agreed by auditors
Benefactions	End of financial year	8 years	Review and consider transfer to Place of Deposit	These may already be in the financial accounts and may be captured in other records/reports or committee papers. Where benefactions endowment trust fund/legacies - permanent retention.
Debtor records cleared	Close of financial year	2 years	Review and if no longer needed destroy	

Record Type	Retention Start	Retention period	Action at end of retention period	Notes
Debtor records not cleared	Close of financial year	6 years	Review and if no longer needed destroy	
Donations	Close of financial year	6 years	Review and if no longer needed destroy	
Expenses	Close of financial year	6 years	Review and if no longer needed destroy	
Final annual accounts report	Creation	Before 20 years	Transfer to place of deposit if not transferred with the board papers	Should be transferred to a place of deposit as soon as practically possible

Record Type	Retention Start	Retention period	Action at end of retention period	Notes
Financial records of transactions	End of financial year	6 Years	Review and if no longer needed destroy	
Petty cash	End of financial year	2 Years	Review and if no longer needed destroy	
Private Finance initiative (PFI) files	End of PFI	Lifetime of PFI	Review and consider transfer to Place of Deposit	
Salaries paid to staff	Close of financial year	10 Years	Review and if no longer needed destroy	

Record Type	Retention Start	Retention period	Action at end of retention period	Notes
Superannuation records	Close of financial year	10 Years	Review and if no longer needed destroy	
15) LEGAL, COMPLAINTS & INFORMATION RIGHTS				
Complaints case file	Closure of incident (see Notes)	10 years	Review and if no longer needed destroy	http://www.nationalarchives.gov.uk/documents/information-management/sched_complaints.pdf The incident is not closed until all subsequent processes have ceased including litigation. The file must not be kept on the patient file. A separate file must always be maintained.
Fraud case files	Case closure	6 years	Review and if no longer needed destroy	

Record Type	Retention Start	Retention period	Action at end of retention period	Notes
Freedom of Information (FOI) requests and responses and any associated correspondence	Closure of FOI request	3 years	Review and if no longer needed destroy	Where redactions have been made it is important to keep a copy of the redacted disclosed documents or if not practical to keep a summary of the redactions.
FOI requests where there has been a subsequent appeal	Closure of appeal	6 years	Review and if no longer needed destroy	
Industrial relations including tribunal case records	Close of financial year	10 Years	Review and consider transfer to a Place of Deposit	Some organisations may record these as part of the staff record but in most cases they will form a distinct separate record either held by the staff member/manager or by the payroll team for processing.
Litigation records	Closure of case	10 years	Review and consider transfer to	

Record Type	Retention Start	Retention period	Action at end of retention period	Notes
			a Place of Deposit	
Patents / trademarks / copyright / intellectual property-	End of lifetime of patent or termination of licence/ action	Lifetime of patent or 6 years from end of licence /action	Review and consider transfer to Place of Deposit	
Software licences	End of lifetime of software	Lifetime of software	Review and if no longer needed destroy	
Subject Access Requests (SAR) and disclosure correspondence	Closure of SAR	3 Years	Review and if no longer needed destroy	

Record Type	Retention Start	Retention period	Action at end of retention period	Notes
Subject access requests where there has been a subsequent appeal	Closure of appeal	6 Years	Review and if no longer needed destroy	