Delivery and Performance Committee

Tue 19 December 2023, 10:00 - 12:30

Agenda

10:00 - 10:00
0 min

1. PRELIMINARY MATTERS

1.1. Welcome and Apologies

Chair

1.2. Declarations of Interest

All

1.3. Minutes from the previous meeting held on 17 October 2023

Chair

D&P_1.3_Unconfirmed Minutes DP_17 October 23.pdf (12 pages)

1.4. Committee Action Log

Chair

D&P_1.4_Action Log December 2023.pdf (2 pages)

10:00 - 10:00
0 min

2. ITEMS FOR ASSURANCE

2.1. Finance Performance Report Month 08

Attached *Deputy Chief Executive / Director of Finance, Information and IT*

D&P_2.1_Financial Performance Report Mth 08.pdf (17 pages)

2.2. Integrated Performance Report Month 07

Attached *Director of Performance and Commissioning*

D&P_2.2_IPR Cover Sheet_PTHB_D&P_Final.pdf (6 pages)
D&P_2.2a_IPR_23-24_Month 7_Final.pdf (52 pages)

2.3. Deep Dive - Emergency Access

Attached *Director of Performance and Commissioning*

D&P_2.3 Deep Dive Emergency Access & MIU action log update Dec 2023.pdf (15 pages)

2.4. Information Governance Monitoring Report

To follow *Deputy Chief Executive / Director of Finance, Information and IT*

2.5. Information Governance Toolkit

Attached *Deputy Chief Executive / Director of Finance, Information and IT*

D&P_2.5_IG Toolkit Out turn Report 2022-2023.pdf (5 pages)
D&P_2.5a_Information Governance Toolkit Improvement plan 2023-24.pdf (8 pages)

2.6. Capital Programme Delivery

To follow *Associate Director of Capital, Estates and Property*

2.7. Primary Care Services - General Dental Services (GDS)

Attached *Deputy Chief Executive / Director of Finance, Information and IT*

- D&P_2.7_GDS CAF 2223.pdf (13 pages)
- D&P_2.7b_Appendix 2 - Mitigation Measures 22-23.pdf (4 pages)
- D&P_2.7d_ GDS CAF Dashboard summary 2022-23 App4.pdf (2 pages)

2.8. Digital First Monitoring Report (Cross Border Pathways)

Attached *Deputy Chief Executive / Director of Finance, Information and IT*

- D&P_2.8_Cross Border Pathways Digital First Progress update Dec 2023.pdf (10 pages)
- D&P_2.8a_Digital First Monitoring Report Appendix 1.pdf (1 pages)
- D&P_2.8b_Powys Cross Border Delivery Plan - December 23 review.pdf (5 pages)

2.9. IT Infrastructure and Asset Management (update against audit report and progress)

Attached *Deputy Chief Executive / Director of Finance, Information and IT*

- D&P_2.9_ Infrastrucutre and Asset Audit.pdf (4 pages)
- D&P_2.9a_EC_Infrastructure Audit Management Update Nov 2023.pdf (8 pages)

2.10. Food Hygiene Rating

Attached *Director of Therapies and Health Sciences*

- D&P_2.10_Bronllys Catering Food Hygiene Inspection Report.pdf (12 pages)

10:00 - 10:00
0 min

3. ITEMS FOR DISCUSSION

There are no items for discussion

10:00 - 10:00
0 min

4. ESCALATED ITEMS

4.1. Records Management Improvement Plan and Update (Action D&P/23/11)

Attached *Deputy Chief Executive / Director of Finance, Information and IT*

- D&P_4.1_Records Management Improvement Plan Update.pdf (8 pages)
- D&P_4.1a_Records Management Improvement Plan Appendix 1.pdf (1 pages)
- D&P_4.1b_Records Management_Final Internal Audit Report Appendix 2.pdf (38 pages)

4.2. Organisational Escalation and Intervention Status

Information *Director of Corporate Governance*

Oral

10:00 - 10:00
0 min

5. ITEMS FOR INFORMATION

10:00 - 10:00
0 min

6. OTHER MATTERS

6.1. Committee Risk Register

Oral *Director of Corporate Governance*

6.2. Committee Work Programme

Attached *Director of Corporate Governance*

D&P_6.2_D&P Work Programme December 2023.pdf (1 pages)

6.3. Items to be Brought to the Attention of the Board and/or Other Committees

Oral *Chair*

6.4. Any Other Business

Oral *Chair*

6.5. Date of Next Meeting: 29 February at 10:00 via Microsoft Teams

6.6. Confidential Items

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

6.7. Financial Sustainanility

Oral *Chair*

6.8. Minutes of the previous In-Committee meeting held on the 17 October

Chair

POWYS TEACHING HEALTH BOARD
DELIVERY & PERFORMANCE COMMITTEE

UNCONFIRMED

MINUTES OF THE MEETING HELD ON TUESDAY 17 OCTOBER 2023 VIA MICROSOFT TEAMS

Present:

Ronnie Alexander	Independent Member (Chair)
Robert Lewis	Independent Member (General)
Kirsty Williams	Independent Member (PTHB Vice-Chair)
Cathie Poynton	Independent Member (Trade Union)

In Attendance:

Pete Hopgood	Director of Finance, Information and IT
Steve Elliot	Special Advisor (Finance)
Stephen Powell	Director of Planning, Performance and Commissioning
Debra Wood-Lawson	Director of Workforce and Organisational Development
Joy Garfitt	Director of Operations/Director of Community and Mental Health
Lucie Cornish	Assistant Director of Therapies and Health Sciences
Elizabeth Patterson	Interim Head of Corporate Governance

Observers:

Carl Cooper	Powys Teaching Health Board Chair

Apologies for Absence:

Hayley Thomas	Chief Executive
Bethan Hopkins	Audit Wales
Helen Bushell	Director Of Corporate Governance
Claire Madsen	Director of Therapies and Health Sciences
Mark Taylor	Independent Member (Capital and Estates)

Committee Support:

Belinda Mills	Corporate Governance Officer

D&P/23/54	**WELCOME AND APOLOGIES FOR ABSENCE** The Committee Chair welcomed everyone to the meeting. Apologies for absence were noted as recorded above. The Chair welcomed Steve Elliot as the new Special Advisor (Finance) to the Committee. Steve has been appointed by PTHB to provide additional support to both this Committee and to the Audit Risk and Assurance Committee.
D&P/23/55	**DECLARATIONS OF INTERESTS** No interests were declared in addition to those already declared in the published register.
D&P/23/56	**MINUTES OF THE DELIVERY AND PERFORMANCE COMMITTEE ON 31 AUGUST 2023** The minutes of the previous meeting held on 31 August 2023 were AGREED as a true and accurate record subject to the following amendments: The Chair highlighted that there has been a formatting error had occurred whereby the wrong job titles had been assigned against some staff Members in the minutes. The Interim Head of Corporate Governance undertook to ensure this was corrected. The following matters were raised: *Can the start date for Transnasal Endoscopy be confirmed?* The Director of Planning, Performance and Commissioning confirmed that Transnasal Endoscopy had been planned to go live in October 2023, however, it will now go live in December 2023. *What is the position with regard to the Dermatology GP with an extended role who was due to start in July 2023?* The Assistant Director of Commissioning confirmed that the Dermatology GP with the extended role is in post. The readiness assessment was agreed by the Medical Director on the 5 October 2023. The Commissioning meeting to confirm the external governance arrangements from the consultant in Swansea is scheduled for 17 November 2023 and the revised start date for the service is the 30 November 2023. *Can an update be provided in relation to the Asthma Specialist post?* The Assistant Director of Therapies and Health Sciences confirmed that the post has been recruited to and an appointment had been made. A start date was awaited but it was anticipated that the person will be in post by the end of December 2023.

D&P/23/57	**COMMITTEE ACTION LOG** The Action Log recorded updates with the following information provided during the meeting: **PTHB/22/105, D&P/23/11, ARA/22/104a** - The Director of Finance, Information and IT clarified that these three actions are not at risk, as they had been deferred to a future meeting due to the volume of business on the agenda. The Committee were asked to agree the revised dates. The Chair noted the number of substantial items that were consequently scheduled for consideration at the next meeting and observed that Committee meetings appeared to be on a cycle of heavier and lighter content. He expressed a wish that a more equal distribution of items be scheduled. The Director of Finance, Information and IT suggested a meeting with the Director of Corporate Governance to examine the work programme. **Action: Director of Corporate Governance** The Committee RECEIVED the Action Log updates and AGREED the revised dates.
ITEMS FOR ASSURANCE	
D&P/23/58	**INTEGRATED PERFORMANCE REPORT (IPR) MONTH 04** The Director of Planning, Performance and Commissioning presented the report providing the Committee with the latest available performance update against the 2023/24 NHS Wales Performance Framework. The IPR for Month 4 highlights areas of escalation and exception. Detailed slides on compliant measures will be included bi-annually. Attention was drawn to the following areas: • PTHB provided planned care was showing signs of stress with a decrease in provision of in-reach sessions; • for commissioned services all targets for planned care failed in England and Wales, although access remains inequitable as recovery in England is at a faster pace than in Wales; • no commissioned provider is meeting targets for cancer care. Future reports will include the actual number of days before patients were treated; • compliance against the NHS Delivery Framework was shared along with a month by month exception and escalation measure guide;

	• of the nine Ministerial Targets set, the Health Board, at month 4, are not achieving five for which remedial action plans have been developed. It is expected Therapies and Diagnostics will return to compliance, however, there is lower confidence that planned care will return to compliance due to the difficulties in backfilling planned care in-reach sessions; and • the PTHB team will be working with all commissioned providers to get a detailed finance and performance forecast for the remainder of the financial year. *What are the effects of finance and budgets of other Health Boards going forward, and how does this affect the ability of other Health Boards to maintain the current rate of tackling the backlog? What mechanisms are used to pick up those changes and how are they communicated to enable an assessment of impact?* The Director of Planning, Performance and Commissioning explained that this was picked up immediately through routine monitoring and if it becomes a wider issue it was escalated to the Clinical Quality Performance Review meetings with the provider, and if necessary, this would be escalated to an Executive to Executive meeting. *In relation to in-reach cancellations, can assurance be provided regarding the reasons and concerns for those cancellations, and that commissioned services are not cancelling in-reach services to protect their own priorities?* The Director of Planning, Performance and Commissioning advised that routine cancellations do occur with six weeks' notice and occasionally urgent cancellations happened. It was recognised that some acute providers have extremely long waiting lists (which will include Powys patients) and there is a need to prioritise services. *It appears that primary care is not very prominent in the report. This reflects the plan submitted which did not contain detailed targets for this service and it is therefore difficult to gain assurance on performance.* The Director of Planning, Performance and Commissioning agreed this was an area that needed further consideration in relation to data availability and reporting mechanisms to provide the necessary oversight. The Director of Finance, Information and IT noted there were capacity constraints across the Health Board and cautioned that if additional reporting was found to be necessary, it was likely to be at the expense of the provision of an existing activity. It would be necessary to ascertain the relative importance of requests.

	Regarding the fragility of the in-reach service, and whilst there are a number of reasons for cancellation, can it be confirmed that the Health Board are not paying for any services cancelled, and is the Health Board confident that we are not responsible for any cancellations? The Director of Planning, Performance and Commissioning explained that payments for the English contracts were based on a cost per session this year, so if sessions are cancelled, payments are not made. The funds are reused for the further sessions and the Health Board have negotiated the same agreement with all but one other Health Board in Wales for the first time this year. The Director of Planning, Performance and Commissioning advised that the team had worked on preparing the environment and testing the infrastructure for in-reach services and no issues had been identified with the mobilisation of the contract or delivery of those sessions. *What are the consequences of not meeting five of the nine Ministerial Priorities. What does it mean for the enhanced monitoring the Health Board is under and how will the Health Board respond to that situation?* The Director of Planning, Performance and Commissioning noted that the Health Board was not currently achieving five of the nine Ministerial Priorities. The Therapies priority would shortly be met. However, there was some ambiguity in some of the Ministerial measures. *One of the new Ministerial Priorities includes drug and alcohol treatment and the percentage of people completing their drug and alcohol treatment. It appears from the report that the service was commissioned in 2022 on the basis of harm reduction, yet this is given as a mitigation for not meeting the 2022/23 Ministerial Target for completion of drug and alcohol treatment. It is not clear how this could be an appropriate mitigation.* The Director of Operations, Community and Mental Health explained there is tension between the Ministerial Priority which was focused on abstinence and NICE guidance and research which focuses on harm reduction. It may be the case that the Ministerial Priority will change slightly to reflect this. *What confidence do you have that 'therapies will be back on track'?* The Director of Planning, Performance and Commissioning explained as part of the Integrated Performance Framework a remedial action plan has been developed where the performance team worked with the operational managers to understand why a service is not delivering its target, and what steps can be taken to improve performance. With therapies

	there had been a number of staff vacancies and some sickness, and the team are now fully staffed. This capacity will enable the service to return performance back to compliance. The Assistant Director of Therapies and Health Sciences added that there was a remedial action plan with clearly defined actions. There had been illness within a number of services and now these staff have returned to work the trajectory looks more positive. The professional manager was also supporting a comprehensive assessment of workload management and demand capacity planning. The trajectory was improving, and recovery was visible. *In relation to patients waiting up to six years for an intervention can you clarify the specialities that relates to?* The Director of Planning, Performance and Commissioning confirmed that no Powys residents have been waiting for six years, but there are residents across Wales in other Health Boards who have waited this long. However, there are Powys patients waiting more than four years and key pressure points across Wales are in surgical specialties such as orthopaedics, especially for elective care requiring an overnight stay, joint replacement, general surgery, ophthalmology and breast surgery. Most surgical specialties have difficulty reducing waiting times, especially for patients who need to stay overnight. Progress has been made using the use of day case to improve waiting times. *Is there any remedy that one can foresee in relation to these specialities?* The Director of Planning, Performance and Commissioning explained that it was complicated with priority given to treat extreme long waiters, however, Getting It Right First Time (GIRFT) was seen as a key programme to improve the efficiency and effectiveness of current resources. The Committee: • DISCUSSED and NOTED the content of the report. • CONSIDERED any areas for further discussion or action. • Took ASSURANCE that the Health Board has appropriate systems in place to monitor performance and respond to relevant issues.
D&P/23/59	**FINANCE PERFORMANCE REPORT MONTH 06** The Director of Finance, Information and IT presented the report which provided an update on the September 2023 (Month 06) Financial Position, including progress with savings delivery. At month 06, there was a £17.240m over-spend against the planned deficit of £16.737m giving the Health

	Board an operational overspend of £0.503m. Attention was drawn to the following areas: • Key areas of pressure include agency spend supporting the high number of vacancies and pressures in commissioned services, although there could be a financially improved position due to recent strikes; • Continuing Health Care remains an area of concern; • The Health Board continue to hold the forecast deficit of £33.5m despite the overspend at Month 6 of £0.5m based on the ability to manage risk and opportunities. To meet this every budget holder will need to be focussed on delivering the actions within the plan and reduce expenditure where at all possible; • The savings target is covered by green and amber schemes. It is essential the amber schemes are turned green as soon as possible; and • The financial challenges will remain for the foreseeable future. *Noting the increase in the commissioning costs and other costs, do you see these costs continuing to increase over the next couple of years and will that increase be incorporated in the baseline going forward, or do you think in terms of commissioning the position will stabilise due to a lack of additional staff to tackle the backlog?* The Director of Finance, Information and IT explained that it was important to understand the financial position, what the cost drivers are, whether they are related to activity and demand, inflation or any other factors and to be clear on what the ask is in the financial plan for the future. *In relation to variable pay which is a major risk across Wales, but one that this Health Board particularly struggles with, what level of confidence do the Executives have that the position can be improved?* The Director of Workforce and OD explained that the agency reduction plan was in place but will take time to have an effect. To supplement the plan a long term strategy to grow our own has been developed in order to increase the number of substantive staff therefore reducing the reliance on agency and off-contract agency (off which the latter is the bigger cost). Last year two overseas nurses joined the Health Board and this year nine overseas nurses have been recruited. There is a plan to bring in an additional four overseas nurses in April 2024 and when overseas nurses pass their Objective Structured Clinical Examination (OSCE) this will help end the use of off-contract agency staff. In September 2023 22 aspiring nurses were recruited to support healthcare. They have received their pin numbers and will contribute 30 hours as healthcare support workers. This will eliminate agency costs for healthcare support staff. Many agency workers have

	registered with the bank, and Wage Stream has recently been implemented which allows all agency workers to promptly access pay. The Director of Operations, Community and Mental Health added that a fortnightly meeting was held with the project team to review data to manage agency spend and assured the Committee that every single agency shift is scrutinised, and everything possible is done to contain agency spend. *What is the degree of confidence that the mid-year overspend of £0.5m will be brought back into balance rather than increasing to a year end overspend of £1m, and what is your confidence that the savings target which at mid-year is £0.5m off track will be met?* The Director of Finance, Information and IT explained that in relation to savings it is an area of close scrutiny, actions are tracked and will be tracked for the rest of the year. The overall level of confidence is on behalf of the organisation and relates to all budget holders to commit to reduce spend wherever possible. In addition, there are some potential areas of slippage against expenditure plans which will assist the organisation in delivering to plan. The Director of Planning, Performance and Commissioning outlined some of the actions which were being taken in the Commissioning area to accurately forecast spend to assist in budgetary control. The Committee: • DISCUSSED and NOTED the Month 06 2023/24 financial position. • DISCUSSED and NOTED the 2023/24 financial forecast deficit position.
D&P/23/60	**PRIMARY CARE OUT OF HOURS ASSURANCE REPORT** The Director of Finance, Information and IT presented the item in relation to Out of Hours (OOH) Service provision for Powys patients during 2022/2023. Attention was drawn to the following points: • Shropdoc are the main service providers apart from in Ystradgynlais where the service is provided by Swansea Bay UHB; • The quality of service and level of cover provide by Shropdoc is remains good whilst Swansea Bay UHB have been unable to fill their shifts at Ystradgynlais; *Can assurance be provided in relation to the contract with Shropdoc that the procurement process for a future contract is undertaken within an appropriate timeframe?*

	The Director of Finance, Information and IT confirmed this was under consideration. The team are monitoring for any potential changes to legislation from Welsh Government in terms of public procurement, as that will have an impact on how future procurement is undertaken. If procurement rules are changed to a similar model that is used in England, it will not be necessary to undertake a tender process. If procurement rules remain as present it will be necessary to undertake a tender process. *Given Swansea Bay UHB have been unable to fulfil their contracted shifts at Ystradgynlais, what approach is being taken to ensure the situation is regularised and the residents of Ystradgynlais receive the contracted service?* The Director of Finance, Information and IT highlighted that this had been a longstanding issue and Powys patients living in that area are attending at Morriston or Neath OOH if they need face to face contact. The contract with Swansea Bay UHB remains unsigned and both parties are discussing OOH provision as part of a wider discussion which includes District Nursing and Community Services. The Director of Finance, Information and IT offered a further update in terms of OOH in Ystradgynlais. **Action: Director of Finance, Information and IT** The Committee: • RECEIVE the update provided and take ASSURANCE that the OOH Commissioning Assurance Framework monitoring process provides effective assurance to PTHB on OOH contract management
D&P/23/61	**IT INFRASTRUCTURE AND ASSET MANAGEMENT (UPDATE AGAINST AUDIT REPORT AND PROGRESS)** The Director of Finance, Information and IT presented the item which provided the updates against actions from the Infrastructure and Asset Audit recommendations. It was noted that a number of recommendations and action areas had been identified and that internal audit will be undertaking a follow up review audit of this area shortly. It was noted that the majority of actions were now complete. There is some ongoing work in relation to the telephony upgrade. Work to reduce the risk associated with old network devices had been completed, however, a physical

	audit would be undertaken to ensure all digital assets are recorded. Two areas are noted as overdue as follows: • fire and water detection and potential of dedicated power supply to the Bronllys room, fire suppression at Brecon, and air conditioning at Brecon, and • the network should be split into Vlans, and firewalls should be deployed. The team are working with the Associate Director of Estates and Property on these actions. *In relation to the two areas which have been identified as not complete, are you concerned about that in any way?* The Director of Finance, Information, and IT stated there are reasons why progress had not been timely and assured the Committee that if these continue to be an issue it will become a highlighted risk. If this is the case, it will be brought to the next meeting of the Committee. **Action: Director of Finance, Information and IT** The Committee RECEIVED the report taking ASSURANCE against progress.
ITEMS FOR DISCUSSION	
There were no items for inclusion within this section	
ESCALATED ITEMS	
There were no items for inclusion within this section	
ITEMS FOR INFORMATION	
There were no items for inclusion within this section	
OTHER MATTERS	
D&P/23/62	**COMMITTEE WORK PROGRAMME** The Committee RECEIVED the Committee Work Programme for information.
D&P/23/63	**ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND OTHER COMMITTEES** The Delivery and Performance Committee will bring to the Board the financial position as an ongoing escalated item.
D&P/23/64	**ANY OTHER URGENT BUSINESS** It was noted that there was a first meeting held by Welsh Government in relation to escalation and intervention status and the team were working through the process in relation to the terms of reference and the key performance metrics. There would be a monthly meeting in the form of an IQPD

	(Integrated Quality, Performance and Delivery) and the Executive team are working through the governance arrangements. . It was a constructive and helpful meeting, the details of which will be reported to the Board
D&P/23/65	**DATE OF THE NEXT MEETING** The date of the next meeting is scheduled on 19 December 2023 at 10:00 via Microsoft Teams.
D&P IC/23/66	The following resolution was passed: Representatives of the press and other members of the public shall be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

Present:

Ronnie Alexander	Independent Member (Chair)
Cathie Poynton	Independent Member
Rhobert Lewis	Independent member
Kirsty Williams	Independent Member (PTHB Vice-Chair)

In Attendance:

Pete Hopgood	Director of Finance, Information and IT
Steve Powell	Director of Performance and Commissioning
Debra Wood-Lawson	Director of Workforce and Organisational Development
Joy Garfitt	Director of Operational/Director of Community and Mental Health
Lucie Cornish	Assistant Director Therapies and Health Sciences
Steve Elliot	Special Advisor (Finance)
Liz Patterson	Interim Head of Corporate Governance

Observer:

Carl Cooper	PTHB Chair

Apologies for Absence:

Mark Taylor	Independent Member
Helen Bushell	Director of Corporate Governance
Hayley Thomas	Interim Chief Executive
Claire Madsen	Director of Therapies and Health Sciences
Joy Garfitt	Director of Operational/Director of Community and Mental Health

Committee Support:

Belinda Mills	Corporate Governance Officer

D&P IC/23/67	**MINUTES OF IN-COMMITTEE 31 AUGUST 2023** The minutes of the In-Committee meeting held on 31 August 2023 were AGREED as an accurate and true record.
D&P IC/23/68	**FINANCIAL SUSTAINABILITY** Rationale for item being held in private: Information relating to the financial and business affairs of the organisation that were confidential but would be released, either partially or fully, into the public domain in the future. The Director of Finance, Information and IT provided the Committee with a verbal update in relation to financial sustainability. The Committee NOTED the update on financial sustainability.

Belinda Mills
RAG Status:

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

Delivery and Performance Committee

Meeting Date	Item Reference	Lead	Meeting Item Title	Details of Action	Update on Progress	Original target date	Revised Target Date	RAG status
OPEN ACTIONS FOR REVIEW								
21-Jul-23	ARA/23/028	Director of Planning, Performance and Commissioning / Director of Operations	External Audit Report	Audit Wales - Orthopaedic Services in Wales - tackling the backlog to be considered in Delivery and Performance Committee	**Update at 10.10.2023 -** This has been added to the D&P work programme - for Dec 23 D&P meeting. **Update at 18.12.23** - udpate will be provided during the meeting on 19.12.23	Dec-23		On track
31-Aug-23	D&P/23/43	Assistant Director of Support Services	Health and Safety Assurance Assurance Update	To examine the two falls from height and to ascertain if there was any learning that clould be gained.	**10.10.23 update:** 1. A member of staff at Welshpool stumbled and fell while descending the stair case, no defects highlighted, possibly due to rushing to the face fit testing we were delivering at the time – lesson to be learnt, do not rush on stair cases. 2. The second was in Brecon again related to a fall on a stair case - further investigation is on going. **Update at 10.10.2023:** This remains an open action at request of Committee 10 October 2023. Update scheduled for Dec meeting. **Update at 18.12.23** - update will be provided during the meeting on 19.12.23	Oct-23	Dec-23	On track
25th January 2023	PTHB/22/105	DFIT	Integrated Performance Report	A report on the learning from the Adastra Cyber issues to be taken to the Delivery and Performance Committee in August 2023.	Action transferred from Board Action log. **Update at 31.08. 2023** - Item on the Agenda for 31st August 2023. item deferred due to length of Agenda new time scales required to committee **Update at 10.10.23** – The key learning and actions report has now been scheduled for the December 2023 meeting.	Aug-23	Dec-23	On track
OPEN ACTIONS - IN PROGRESS BUT NOT YET DUE (NONE)								
ACTIONS RECOMMENDED FOR CLOSURE (MEETING 19/12/2023)								
28th February 2023	D&P/22/73a	MD	Care Home Staff Training	Data regarding care home staff training on safely lifting fallen patients would be shared when more was available but early indications (one month of data) showed a reduction in falls, and no falls related conveyances from those care homes that took part in the project.	Data to be reviewed and shared with Committee members at the next D&P Committee in August 2023. **Update at 31.08.23** A total of 21 homes and 157 Care Home staff attended falls familiarisation sessions across Powys. 11 homes had declined or had not been able to attend the sessions during the pilot period (often due to staffing issues due to sickness including COVID-19). For November 2022 to April 2023, the data shows there were 25% less attended incidents for Falls in the homes which attended familiarisation sessions (57) versus those care homes that did not (76). Overall, there has been a 10% reduction in falls calls for homes Powys over the past 3 months (March – May 2023). WAST has agreed to review the data quarterly so that impact of the project can continue to be monitored. An AHP Falls Lead has been appointed and is now in post. The Multifactorial Falls Assessment App (MFA) has been developed and is now ready for testing. It is hoped that this will improve screening and referral of those at risk of fall allowing us to implement more preventative measures. **Update at 10.10.2023:** This remains an open action at request of Committee 31 August 2023. **Update at 19.12.2023**: The number of Care Homes who have not participated in the Powys provided falls familiarisation training now stands at 7. They all belong to one of the larger Care Home Groups and have been contacted to ascertain how their Homes approach Falls Prevention Training. An update will be provided orally at Committee.	Aug-23		Completed

Patterson,Liz
15/12/2023 15:27:50

27th June 2023	D&P/23/19	DFIT	Action Log (Cross Border Informaton Flow)	In partnership with DHCW, working with cross border secondary care commissioned health orgs to improve access to information and flow via the All Wales applications.	**Update at 31.08. 2023** - This will come in December 2023 along with the Digitial Strategic Framework update **Update at 10.10.2023** - Cross Border update report to be provided December 2023 as planned. **Update at 19.12.2023:** Information provided within Item 2.8 (Digital First).	Dec-23		Completed
27th June 2023	D&P/23/18	DP&C	Integrated Performance Report	To provide an indication of trend analysis and direction of the development to extend MIUs and seek comparators of good practice against other Health Boards.	**Update at 31.08.23** - the proposal to extend MIUs is being considered as part of the Accelerated Sustainable Model work. The design report for this exercise will be available for the October meeting. **Update at 10.10.23** – to be provided in the meeting. **Update at 19.12.2023:** Included in Item 2.2 for December 2023 meeting	Oct-23		Completed
31-Aug-23	D&P/23/39	DP&C	Integrated Performance Report (Month 3)	A deep Dive on WAST to fully understand the reasons for poor performances.	**10.10.2023 update**:This has started and will be available for the next meeting. **Update at 19.12.2023:** Included in Item 2.3 for December 2023 meeting	Dec-23		Completed
27-Sep-23	PTHB/23/074	DPC	Board Minutes of meeting 25 July 2023	Breakdown by age of waiting list for cochlear implants to be taken to D&P Committee	**Update at 19.12.2023** Update to Board 29.11.2023: This has been transferred to the Delivery and Performance Committee for the Committee to be updated at their December 2023 meeting. **Update at 19.12.2023:** Information provided in slide emailedto the Committee.	Dec-23		Completed
25-Jul-23	PTHB/23/054	DFIT	Financial Performance 2023/24 Month 03	Montoring of the Primary Care Prescribing to be undertaken in the Delivery and Performance Committee	**Update at 10.10.2023 -** this has been added to the D&P work programme - for Dec 23 D&P meeting **Update as of 19.12.2023:** A comparison of the period April – Sept 23 against April – Sept 22 shows a 2.7% increase in items but a 12.9% increase in cost. Price concessions continue to be a big issue – as an example, we've spent £120k more on lipid modification drugs this year, compared to the same period last year and 90% of growth is linked to atorvastatin (12.5% increase in items but 123% increase in cost die to price concessions). Other things that drive costs are implementation of national guidelines e.g. resulting in increased use of more expensive drugs in diabetes etc. The cause of the increase in costs is therefore multi-factorial.	Dec-23		Completed
2nd May 2023	D&P/23/11	DFIT	Records Mangement Improvement Plan	To include futher detail regarding specfic evidece to support assessment of 100% completion against the action plan. A further mid year report would be expected in August 2023	**Update at 31.08. 2023 -** Action deferred to October 2023 meeting due to prioritisation of August 2023 agenda **Update at 10.10.23** – The records management update will be provided at December 2023 D&P as per reporting schedule business cycle. Update at 19.12.23 - item on agenda for December meeting	Aug-23	Dec-23	Completed
31-Jan-23	ARA/22/104a	Director of Finance and IT	A review of financial delegations in relation to capital projects/developments *(Machynlleth Hospital Development)*	This issue arises due to the fact that the day to day approval levels for an AD are relatively low when they act as a Project Director on a major capital project. This specific scheme is the largest PTHB has implemented to date. Approvals were required in a live project decision making. The approvals were all ratified by the SRO but for future projects learning will be applied to ensure the PD is able to sign off timely expenditure in a live project and this will be followed up and embedded by future SROs and wider appropriate colleagues when establishing project governance.	Item transferred from ARAC to D&P Committee. **12.06.2023 Update:** A report to be presented to Committee in August in terms of the Capital Procedures re authorisation of capital payments and orders with reference to the current limits and potential changes to improve the current processes. **Update at 31.08. 2023** - A revised authorisation proces has been developed. It is planned to take it to the next Innovative Environments Group for endorsement. It will need Board approval as an update to the Scheme of Delegation, so will come to D&P Committee in October for consideration ahead of that. **Update at 10.10.2023:**This will now come to the December D&P meeting. **Update at 19.12.23** - Board agreed revised authorisation limits for capital projects at its meeting on 29 November 2023	Aug-23	Dec-23	Completed
17-Oct-23	D&P/23/61	DFIT	IT Infrastructure and Asset Management update against Internal Audit Report	If the two overdue items continue to be an issue they will be brought back to Committee	**Update at 19.12.2023** - an agenda item to the December 2023 meeting	Dec-23		Completed

Powys THB Finance Department
Financial Performance Report
Delivery and Performance Committee

Period 08 (November 2023)
FY 2023/24

Date Meeting: 19th December 2023

Introduction

Subject:	FINANCIAL PERFORMANCE REPORT FOR MONTH 8 OF FY 2023/24
Approved & Presented by:	Pete Hopgood, Director of Finance
Prepared by:	Hywel Pullen, Deputy Director of Finance
Other Committees and meetings considered at:	Executive Committee

PURPOSE:

This paper provides an update on the November 2023 (Month 08) Financial Position, including progress with savings delivery.

RECOMMENDATION:

The Committee is asked to receive the financial report and take assurance that the organisation has effective financial monitoring and reporting mechanisms in place.

The Committee is asked to consider and discuss the revised financial forecast for 2023/24 and underlying deficit.

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 2023/24

Revenue			
Financial KPIs : To ensure that net operating costs do not exceed the revenue resource limit set by WG	**Revised Plan £'000**	**Actual £'000**	**Trend**
Reported in-month financial position – (deficit)/surplus	-630	-633	↑
Reported Year To Date financial position – (deficit)/surplus	-9,481	-9,771	↑
Year end – (deficit)/surplus	-12,000	-12,000	↓

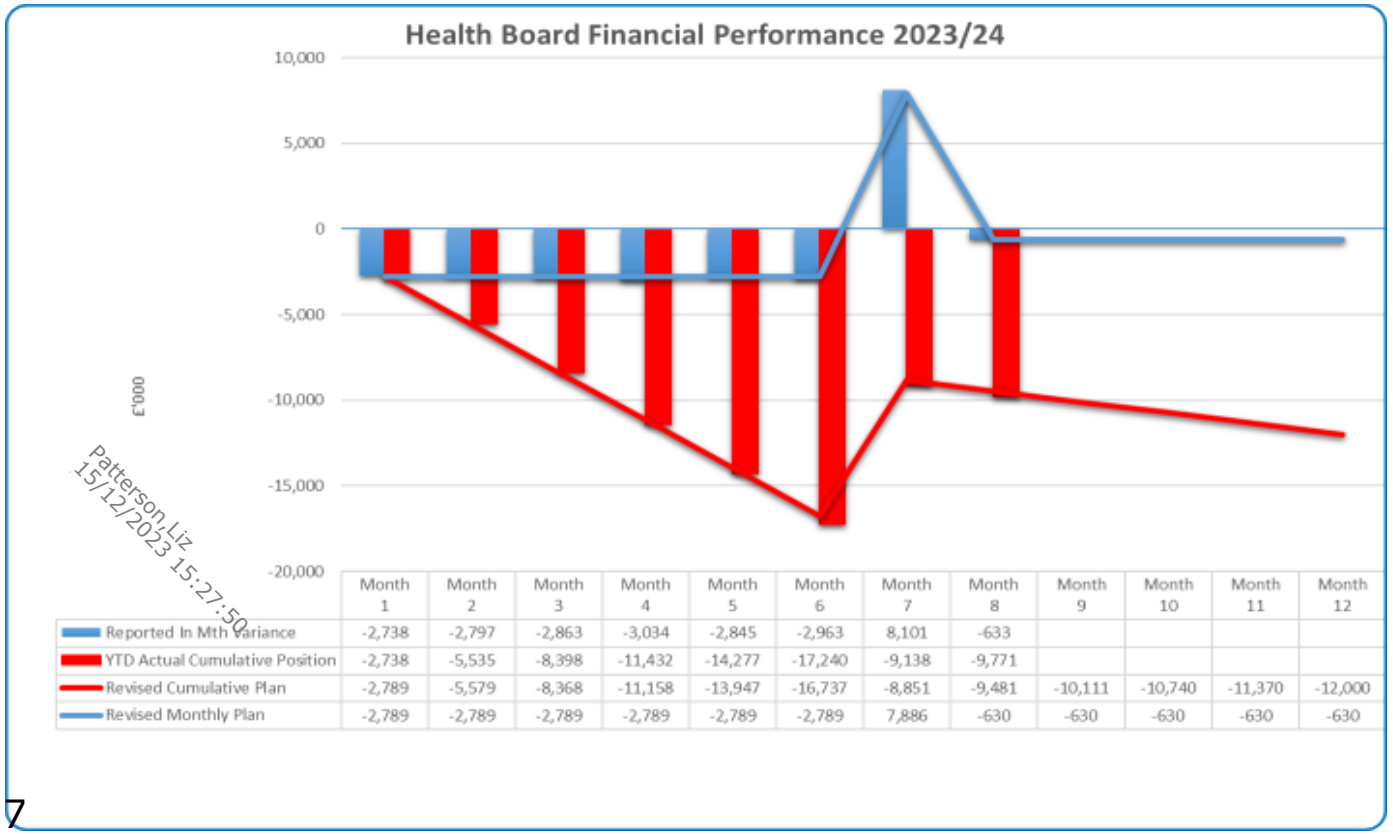
Capital		
	Value £'000	**Trend**
Capital Resource Limit	3,941	↑
Reported Year to Date expenditure	1,244	→
Reported year end – (deficit)/surplus – Forecast	0	→

In November, following the provision of £18.300m additional funding from WG, the Board agreed to revise the 2023/24 Financial Plan to the £12.000m deficit target control total given by WG.

At month 8, there is a £9.771m overspend against the revised planned deficit of £9.481m giving the Health Board a year-to-date operational overspend of £290k.

At this stage, the Health Board is forecasting that it will achieve the £12.000m deficit control total.

The capital resource limit for 2023/24 is £3.941m. To date £1.244m has been spent.



	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Reported In Mth Variance	-2,738	-2,797	-2,863	-3,034	-2,845	-2,963	8,101	-633				
YTD Actual Cumulative Position	-2,738	-5,535	-8,398	-11,432	-14,277	-17,240	-9,138	-9,771				
Revised Cumulative Plan	-2,789	-5,579	-8,368	-11,158	-13,947	-16,737	-8,851	-9,481	-10,111	-10,740	-11,370	-12,000
Revised Monthly Plan	-2,789	-2,789	-2,789	-2,789	-2,789	-2,789	7,886	-630	-630	-630	-630	-630

DAY FIVE – Flash

- Agency expenditure of £1.045m in October, an increase of £192k on last month and highest monthly level to date. **This is of serious concern, given the Health Board is planning for it to reduce.**
- Overspend on commissioning budget, due to increased emergency activity and cost at providers; plus, transformational savings yet to be found by the organisation.
- A key component of the revised financial plan has been achieved with the receipt of VAT rebates this month.
- CHC has remained constant in month 8, a net decrease of 1 package of care, giving a total of 311 clients.

Revenue Variance Position 2023/24

Overall Summary of Variances £'000s

	Budget YTD	Actual YTD	Operational Variance YTD
01 - Revenue Resource Limit	(269,865)	(269,865)	0
02 - Capital Donations	(87)	(87)	0
03 - Other Income	(5,070)	(5,583)	(512)
Total Income	**(275,022)**	**(275,534)**	**(512)**
05 - Primary Care - (excluding Drugs)	29,416	28,918	(498)
06 - Primary care - Drugs & Appliances	23,561	23,727	166
07 - Provided services -Pay	71,055	72,791	1,736
08 - Provided Services - Non Pay	16,635	14,418	(2,217)
09 - Secondary care - Drugs	1,001	936	(66)
10 - Healthcare Services - Other NHS Bodies	108,918	110,609	1,691
12 - Continuing Care and FNC	19,297	19,485	188
13 - Other Private & Voluntary Sector	2,519	2,288	(231)
14 - Joint Financing & Other	6,294	6,327	33
15 - DEL Depreciation etc	3,313	3,313	0
16 - AME Depreciation etc	2,494	2,494	0
18 - Profit\Loss Disposal of Assets	0	0	0
Total Costs	**284,503**	**285,305**	**802**
Reported Position	**9,481**	**9,771**	**290**

At Month 08, there is a £9.771m overspend against the revised planned deficit of £9.481m giving the Health Board a year-to-date operational overspend of £290k.

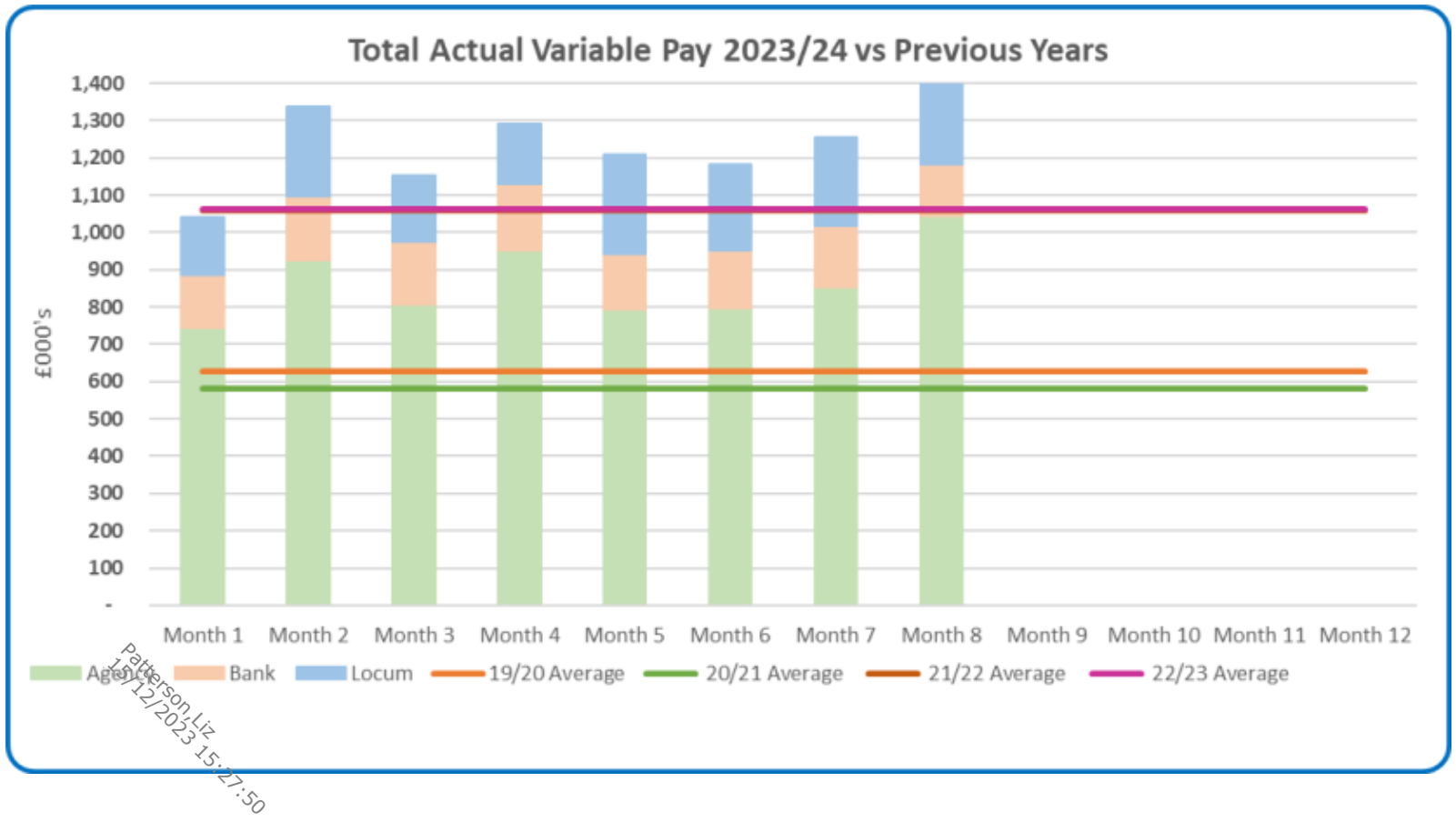
The most significant adverse variances are on:

- pay budgets at £1.736m - driven by the use of agency, from both on and off contract suppliers, which is running at a much higher rate in April to November than it was for the equivalent months last year; and
- commissioned healthcare services at £1.691m - combination of two factors:
  - Costs of emergency activity greater than had been planned for; and
  - Transformational savings, which are intended to reduce expenditure on commissioned healthcare services are having less financial impact.

The underspend on non-pay budgets is due to accountancy gains and VAT rebates.

Health Board Agency Spend

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



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

Performance and Actions

- The Month 08 YTD pay is showing an overspend of £1.736m against the year-to-date plan. The current level of vacancies is 255 (11%) against the HB's budgetary establishment, mainly in MH and Community services.
- The chart opposite on variable pay demonstrates high levels of variable pay in the first 8 months of 2023/24 compared to the average value from each of the last 4 financial years. **The growth is particularly stark within our Mental Health services.**
- Powys appears to be an outlier within NHS Wales as agency spend was 11.0% of total pay in Month 07, against the Wales average of 4.6%.
- The HB's Variable Pay Reduction group is implementing its action plan.

Risks

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

Commissioning and Contracting

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

Status Update

At Month 08 overspend of £1.691m on year-to-date budget of £108.918m. This is £0.968m on transformational savings not achieved and increased expenditure with English providers. LTAs for 2023/24 are in the process of being agreed with our providers in England.

Commissioning Forecast 2023/24

Commissioning	2021-22 Outturn (£'000)	2022-23 Outturn (£'000)	2023-24 Forecast (£'000)
Welsh Providers	38,536	38,772	40,801
English Providers	61,013	65,033	69,436
WHSSC / EASC	44,608	48,694	50,122
Other NHS Providers	4,374	4,501	4,627
Mental Health (LTAs Only)	742	851	904
Total	**149,274**	**157,851**	**165,890**

Risks

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

2023/24 forecast is less certain due to pace of recovery by providers.

- 2023/24 inflation included in forecast; Welsh Health Boards 1.5% to cover non-pay / English providers 3.4%.
- 2023/24 Welsh Health Boards based on DoFs financial flows agreement (2019/20 activity baseline with 5% tolerance levels).
- A review of activity information has identified a trend of increased emergency presentations, which is under investigation. Providers ability to deliver both core and recovery activity is variable and will be closely monitored.
- To date, the HB has experienced 4,353 days of delayed discharges as a result of Social Care availability. At the daily full cost of a community hospital bed, this equates to a cost of £2.566m to date.

Prescribing

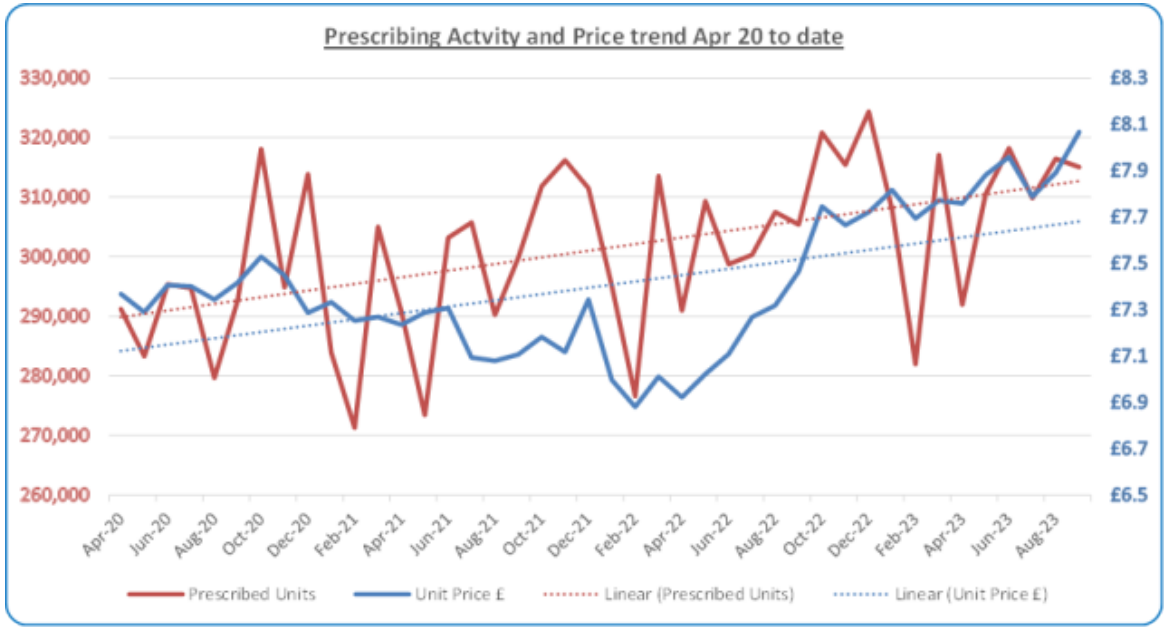
We are focused on this because:
The costs of prescribing have risen significantly since April 2022. This has been driven by both price inflation and increased prescribing activity.
Current adverse variance of £1.4m against the prescribing budget of £28.8m pa, will have a material impact on the Health Board's financial obligations.

Status Update

At Month 08 forecast overspend of £1.428m on 2023/24 budget of £28.8m. Prescribing costs are reported 2 months in arrears.

- YTD costs, M1-M6, are £1.799m higher than M1-6 in 2022-23 (12.2%).
- Unit price increase year on year of 9.5% to M6 23-24, driven by NCSO/price concessions.
- Prescribing activity steady year on year increase of 2.8%.

Prescribing cost increases	19-20	20-21	21-22	22-23	23-24 (f'cast)
		£k	£k	£k	£k
Prescribing Budget	23,142	22,320	23,182	24,694	28,831
Prescribing Annual costs	24,867	25,953	25,610	27,469	30,259
Yr on Yr % increase/decrease		4.4%	-1.3%	7.3%	10.2%
Yr on Yr increase £ Total		**1,086**	**-344**	**1,859**	**2,790**
Yr on Yr increase £ Growth		-109	475	655	758
Yr on Yr increase £ Inflation		1,196	-819	1,204	2,032



Risks & Challenges

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

Medicines Mgt savings performance and actions

- Medicines Mgt savings scheme forecasting £1.3m against prescribing budget plus £0.3m of rebates.
- Guidance & support is given to Primary Care including, decision support software, monthly KPI reporting, practice visits, shared formulary and prescribing guidelines, audit, shared care agreements.
- Active involvement in NHS Wales pharmacy and finance fora.

CHC Forecast 2023/24

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

Area	19/20 Year end Position £'000	20/21 Year end Position £'000	21/22 Year end Position £'000	22/23 Year end Position £'000	23/24 Budget £'000	23/24 Forecast £'000	Growth 2022/23 to 2023/24 Forecast £'000
Children	267	151	157	296	324	303	7
Learning Disabilities	957	1,568	1,639	2,461	2,580	3,343	883
Mental Health	7,344	7,801	10,611	13,949	16,487	15,500	1,551
Mid Locality	981	925	1,635	1,882	1,560	2,198	316
North Locality	1,365	1,537	2,098	2,646	2,907	3,479	833
South Locality	1,495	1,958	1,853	1,904	2,068	1,862	(42)
Grand Total	**12,410**	**13,941**	**17,994**	**23,138**	**25,927**	**26,686**	**3,547**
Number of active clients	**236**	**252**	**294**	**307**	**324**	**311**	**4**

D2RA				**696**	**648**	**327**	**(369)**
FNC	**2,218**	**2,095**	**1,960**	**2,131**	**2,370**	**2,320**	**189**
Total	**14,628**	**16,035**	**19,954**	**25,966**	**28,945**	**29,333**	**3,367**

Risks

The HB has seen a significant increase in the complexity and number of patients requiring CHC, there is a risk the growth continues in 2023/24 above that planned for.

Performance and Action

The 2023/24 financial plan had provision for CHC inflation and growth.

As at month 8, there is an overspend of £0.188m on year-to-date budget of £19.297m against Continuing Care and FNC. The number of CHC packages has reduced by 1 from 312 to 311 in November.

D2RA is the cost associated with discharging patients direct into nursing homes to facilitate flow from DGHs, prior to full CHC assessment.

Across Wales, at Month 07, the forecast is for a 16.2% increase in costs in 2023/24 compared to 2022/23, with Powys currently showing 9.5% increase.

What the table tells us

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

Health Board 2023/24 Savings Programme

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

Progress against Savings Target

Exec Lead	23/24 Target	Green (£'000)	Amber (£'000)	Green + Amber (£'000)	Red (£'000)	Shortfall on Total Target vs Green & Amber (£'000)	% Achievement on Target vs Green & Amber
Finance	**610**	2,381	535	**2,916**	385	**(2,306)**	478%
Medical	**504**	1,590	9	**1,599**	0	**(1,095)**	317%
Nursing	**21**	21	21	**42**	0	**(21)**	202%
Planning & Performance	**2,570**	943	66	**1,009**	246	**1,561**	39%
Primary & Community Care & MH/LD	**1,464**	250	339	**589**	893	**875**	40%
Therapies Directorate	**211**	269	12	**281**	203	**(70)**	133%
Public Health	**2,089**	2,089	2	**2,091**	0	**(2)**	100%
Workforce & Organisational Development	**17**	34	0	**34**	0	**(17)**	199%
Chief Executive	**14**	44	7	**51**	0	**(37)**	366%
Grand Total	**7,500**	**7,621**	**991**	**8,612**	**1,728**	**(1,112)**	**115%**

Performance and Actions

- The original 2023/24 Financial Plan was a deficit of £33.5m, this was predicated on the Health Board achieving £7.5m savings. The readvised £12.0m 2023/24 financial Plan still requires this as well as £3.2m of mitigating actions.
- As shown in the table £8.6m schemes have been forecast (£7.6m Green and £1.0m Amber), with a further £1.7m Red pipeline ideas.
- The HB is overperforming against savings profiled to date by £980k.
- There are two key actions:
  - Develop increased certainty on amber schemes so that they turn green.
  - Red pipeline opportunities need to be converted into deliverable plans and further opportunities identified.

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

Performance of Schemes

		Green and Amber								RED		
Exec Lead	No of Schemes	Plan to Date	YTD Actual Savings	Variance to Date	Current Year Annual Plan	Current Year Forecast	Forecast Variance	Plan FYE (Recurring Schemes only)	Forecast FYE (Recurring schemes only)	No of Red Schemes	Red Potential 23/24	Red Potential FYE
Finance	9	2,677	2,709	32	610	2,916	2,306	605	566	6	385	453
Medical	8	353	783	429	504	1,599	1,095	687	1,769	0	0	0
Planning & Performance	7	1,691	579	(1,112)	2,570	1,009	(1,561)	2,301	598	1	246	493
Primary & Community Care & MH/LD	23	729	299	(430)	1,464	589	(875)	1,377	650	46	893	1,407
Therapies Directorate	5	60	90	30	211	281	70	59	59	6	203	367
Public Health	4	1,392	1,392	(1)	2,089	2,091	2	2,090	2,089	0	0	0
Workforce & Organisational Developmer	3	11	11	0	17	34	17	16	17	0	0	0
Chief Executive	4	37	37	0	14	51	37	0	0	0	0	0
Nursing	9	12	12	(0)	21	42	21	22	22	0	0	0
Grand Total	72	6,963	5,912	(1,051)	7,500	8,612	1,112	7,157	5,768	59	1,728	2,719

Risks

Timescales and capacity of teams to deliver the schemes. This risk is currently quantified at £138k.

What the tables tells us

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

Summary:

- PTHB submitted a plan with a £33.5m planned deficit for 2023/24. Following the additional allocations of £18.3m in Month 7, at the public Board meeting in November, the Board approved a revised financial plan for 2023/24, which aims to achieve a deficit £12m control total.

- At month 8, PTHB is reporting a £9.771m overspend. This comprises the profiled revised planned deficit £9.481m, with an operational overspend of £0.290m.
  - The £7.5m savings target is profiled into the position. Actions are progressing to deliver a greater value of savings in 2023/24 than the target, but with a reduced recurrent impact.
  - The key operational pressure needing to be addressed is agency expenditure, especially within mental health services.

- The revised revenue forecast for 2023/24 is £12.0m in line with the WG control total.

- The underlying deficit of the Health Board is £21.0m, due to £4.1m of the additional funding being non-recurrent and £1.7m recurrent shortfall on the savings programme.

- The Health Board has a £3.941m capital allocation, which it will manage within.

- Due to the £12.0m revised forecast financial deficit, the THB will require additional cash in the latter part of the year (month 12). Powys THB submitted a formal application for strategic cash support to Welsh Government in November.

Powys THB Finance Department
Financial Performance Report - Appendices

Capital 2023/24

Scheme	Capital Resource Limit	Annual Planned Expenditure	Expenditure to 30th November 2023
WG CRL FUNDING	**£M**	**£M**	**£M**
Discretionary Capital	0.993	0.993	0.737
EFAB Infrastructure	0.406	0.406	0.110
EFAB Fire	0.107	0.107	0.000
EFAB Decarbonisation	0.378	0.378	0.000
Llandrindod Fees	0.236	0.236	0.236
Replacement Roofing, Bronllys Hospital	1.468	1.468	0.161
Telephony Infrastructure upgrades	0.285	0.285	0.000
IFRS16 Leases	0.068	0.068	0.000
Donated assets - Purchase	0.130	0.130	0.000
Donated assets (receipt)	(0.130)	(0.130)	0.000
TOTAL APPROVED FUNDING	**3.941**	**3.941**	**1.244**

Monitoring Return Reported

Embedded below are extracts from the Monthly Monitoring Return submitted to Welsh Government on 13th December 2023.

MMR Narrative

https://
s365.sharepoint.co

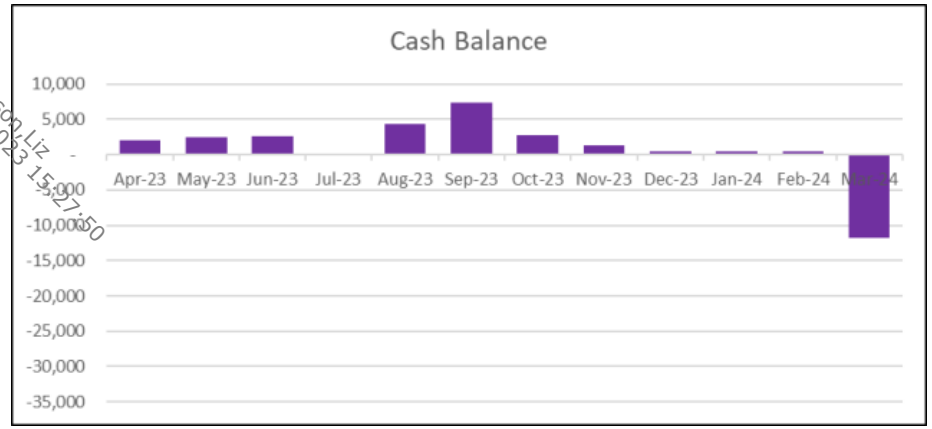
MMR Tables

https://
s365.sharepoint.co

Cash Flow 2023/24

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	**1,268**	**2,011**	**2,438**	**2,598**	**118**	**4,335**	**7,397**	**2,756**	**1,332**	**500**	**500**	**500**
Receipts												
WG Revenue Funding - Cash Limit (excluding NCL) - LHB & SHA	37,680	35,008	41,867	34,714	35,921	35,913	29,385	35,070	35,815	31,022	32,093	19,585
WG Revenue Funding - Non Cash Limited (NCL) - LHB & SHA onl	(130)	(130)	(130)	(130)	(106)	(198)	(237)	(145)	(183)	(130)	(130)	(130)
WG Revenue Funding - Other (e.g. invoices)	6	150	5	58	19	19	1,135	5	21	1,109	1,074	1,514
WG Capital Funding - Cash Limit - LHB & SHA only	0	0	500	0	0	250	176	472	569	731	624	1,024
Income from other Welsh NHS Organisations	1,137	509	489	875	687	363	867	698	600	600	600	600
Sale of Assets	0	0	0	0	0	0	0	0	0	0	0	0
Other	610	612	289	229	549	854	274	675	600	600	600	600
Total Receipts	39,303	36,149	43,020	35,746	37,070	37,201	31,600	36,775	37,422	33,932	34,861	23,193
Payments												
Primary Care Services : General Medical Services	2,722	2,386	3,119	1,998	2,606	2,561	3,003	2,505	3,000	2,871	2,557	2,520
Primary Care Services : Pharmacy Services	904	0	845	0	366	815	0	407	900	0	450	450
Primary Care Services : Prescribed Drugs & Appliances	2,852	0	2,970	0	1,534	2,985	0	1,522	3,000	0	1,500	1,500
Primary Care Services : General Dental Services	307	465	545	628	488	439	585	463	450	450	450	450
Non Cash Limited Payments	81	81	88	85	75	89	96	96	80	80	80	80
Salaries and Wages	8,918	8,647	9,864	9,261	8,715	8,109	8,407	8,506	8,200	8,200	8,200	8,200
Non Pay Expenditure	22,723	24,070	25,201	26,123	19,041	18,979	23,875	24,406	21,901	21,600	21,000	21,189
Capital Payment	53	73	228	131	28	162	275	294	723	731	624	1,154
Other items	0	0	0	0	0	0	0	0	0	0	0	0
Total Payments	38,560	35,722	42,860	38,226	32,853	34,139	36,241	38,199	38,254	33,932	34,861	35,543
NET CASH FLOW IN MONTH	**743**	**427**	**160**	**(2,480)**	**4,217**	**3,062**	**(4,641)**	**(1,424)**	**(832)**	**0**	**0**	**(12,350)**
Balance c/f	**2,011**	**2,438**	**2,598**	**118**	**4,335**	**7,397**	**2,756**	**1,332**	**500**	**500**	**500**	**(11,850)**



Due to the £12m revised forecast financial deficit, the THB will require strategic cash support in the latter part of the year (month 12).

Balance Sheet 2023/24

Appendix 4

	Opening Balance Beginning of Apr-22 £'000	Closing Balance End of Nov-23 £'000	Forecast Closing Balance End of Mar-24 £'000
Tanglible & Intangible Assets	104,855	106,326	106,326
Trade & Other Receivables	18,154	19,138	19,138
Inventories	147	147	147
Cash	1,268	1,332	(11,850)
Total Assets	**124,424**	**126,943**	**113,761**
Trade and other payables	49,845	22,161	44,749
Provisions	15,842	15,750	15,750
Total Liabilities	**65,687**	**37,911**	**60,499**
Total Assets Employed	**58,737**	**89,032**	**53,262**

Financed By			
General Fund	11,604	41,899	6,129
Revaluation Reserve	46,625	46,625	46,625
Total Taxpayers' Equity	**58,229**	**88,524**	**52,754**

2023/24 Financial Plan

Financial Plan submitted to WG on 31 March 2023 with deficit of £33.5m

Core Financial Plan Year 1 2023/24

Financial Plan	(£m)
Underlying deficit	18.6
Inflationary pressures	8.9
Demand/ service growth	7.4
Net effect of allocation adjustments and COVID	6.1
Mitigating actions	(7.5)
TOTAL DEFICIT	**33.5**

The original 2023/24 Financial Plan was a deficit of £33.5m

Range of significant risks to be managed

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

Submission of supplementary papers and associated Minimum Data Set on 31 May 2023 confirmed a deficit financial plan of £33.5m, with increased assurance.

Following the additional allocations of £18.300m in Month 7, at the public Board meeting in November, the Board approved a revised financial plan for 2023/24, which aims to achieve a deficit £12m control total.

2023/24 Financial Plan

Original Financial Plan

£33.5m

Additional Funding

£18.3m

Interim Position @M7

£15.2m

Actions underway

• Slippage WG funding	£1.1m
• 10% schemes	£0.5m
• VAT rebate	£0.4m
• Dental contract under performance	£0.4m

£2.4m

£12.8m

Stretch

• Commissioned services –	£0.4m
• Agency expenditure –	£0.4m
• Continuing Healthcare –	£0.1m
• Further underspends on WG funding streams –	£0.2m

£0.8m

£12.0m

Revised Financial Plan

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 2.1

Delivery and Performance Committee	**Date of Meeting: 19 December 2023**
Subject:	**Powys Teaching Health Board Integrated Performance Report** **Position as at October (Month 7) 2023/24**
Presented by:	Executive Director of Planning and Performance
Approved by:	Executive Director of Planning and Performance Assistant Director of Performance and Commissioning
Prepared by:	Head of Performance Administrative Officer, Integrated Performance
Other Committees and meetings considered at:	N/A, will be considered at Executive Committee on 20 December 2023

PURPOSE:

This Integrated Performance Report (IPR) provides an update on the latest available performance position for Powys Teaching Health Board against the NHS Wales Performance Framework up until the end of October 2023 (month 7).

RECOMMENDATION(S):

The Delivery and Performance Committee are asked to:

- **DISCUSS** and NOTE the content of this report;
- **CONSIDER** any areas for further discussion or action;
- Take **ASSURANCE** that the Health Board has appropriate systems in place to monitor performance and respond to relevant issues.

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 Executive Committee with the latest available performance update against the 2023/24 NHS Wales Performance Framework.

The month 7 position provided within the report remains in new format (which focuses on metrics in escalation/exception).

Summary of health board performance for month 7 (October 2023)

This report provides the Executive Committee with the latest available performance update against the new 2023/24 NHS Wales Performance Framework. The IPR format for Month 7 highlights areas of escalation and exception as a priority. To note detailed slides on compliant measures will only be included bi-annually.

At the end of October 2023 (Month 7) the health board has a significantly challenged position for planned care where key ministerial target trajectories (submitted by the health board) are not being achieved. As a provider of planned care key fragility remains in high demand specialties resulting in longer waits, these specialties include but are not limited to General Surgery, Urology, Orthopaedics, and Ophthalmology. Key reasons for the health boards challenges include an especially fragile in-reach service provision, reliance on commissioned service providers for complex diagnostics (delaying pathways), resource requirement for private insource (which would reduce waiting times), and the health boards reliance on fragile NHS in-reach. Further challenge includes staff vacancies (high turnover) and reliance on agency staff to cover a fragile workforce across the large geographical and rural area of Powys.

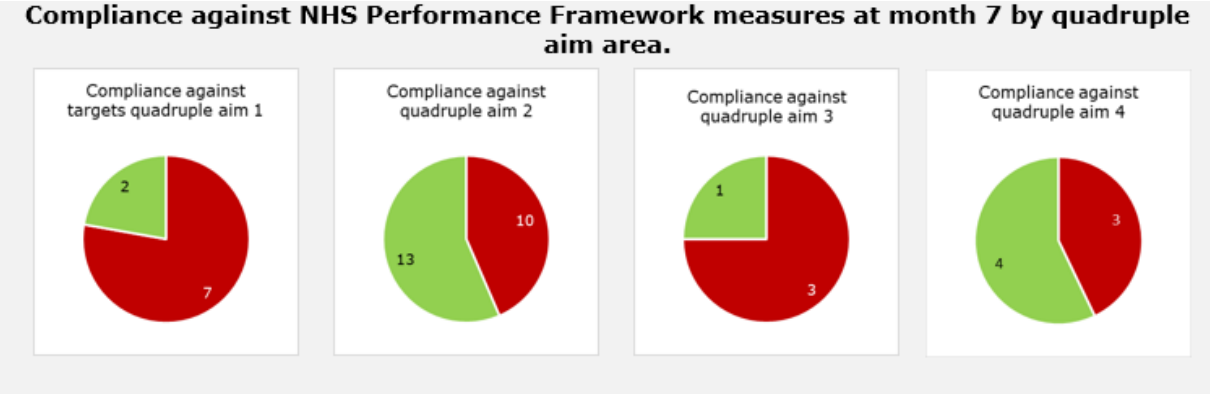
Positive elements for the provider include key clinical recruitment strengthening the day case and endoscopy units in Brecon and Llandrindod, review of processes with the aim to improve efficiencies and outcomes. Rollout of new diagnostics in endoscopy (sponge capsule) which has already had very positive feedback from staff, and patients. More capacity but limited by resource constraints from insource with a confirmed start in November resulting in reduced long waiters and improved urgent waits in key specialties. Progress against remedial action plans, for example Therapies service who are escalated have seen improvement in-line with plan reducing breaching pathways.

Powys residents in commissioned services see ongoing challenges especially linked to equity of access with shorter RTT waits in England than Wales. There is general improvement across the acute care providers and very long waits are reducing. As a national priority cancer pathways and care remain challenging with significant variation by tumour site and geographical provider area with challenge linked to key themes e.g., diagnostic and reporting delays, physical staffing capacity due to sickness or vacancies, and finally patients choosing to delay their pathways (which are not excluded from pathway breach reporting).

For emergency care Welsh Ambulance performance times remain poor with 46.9% of calls meeting the 8-minute target. For emergency department access Powys minor injuries units continue to perform well with no patients waiting over 12hrs and 99.9% compliance on the 4hr target. However, A&E units in England continue to report challenging performance with extreme system flow pressure remaining. The position of residents accessing Welsh A&E units is slightly better with 61.6% being seen within 4hrs in October. And to support the flow of emergency departments in Wales and England the health board continues to maximise repatriation of patients to improve acute flows and reduce the number of admissions with preventative support.

<u>Quadruple aim compliance</u>

Compliance against quadruple aims remains challenging with aim 2, and 4 reporting a positive percentage of measures achieved.



Escalation & Exception

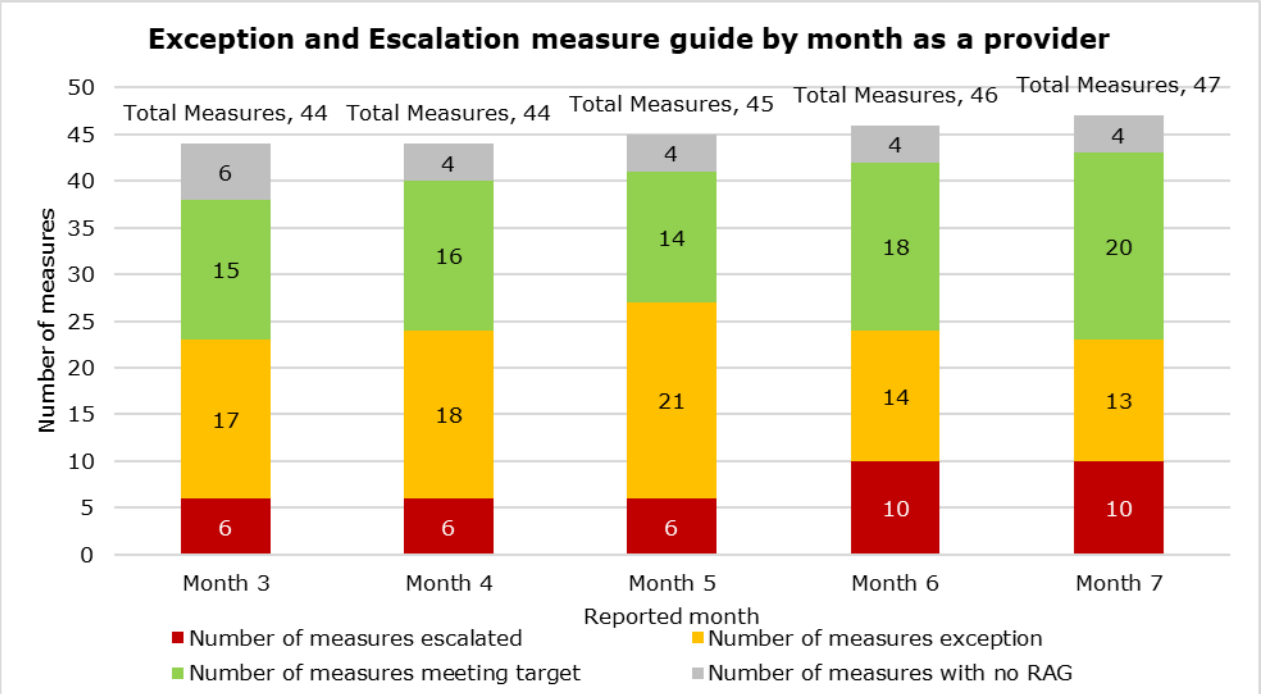
As part of the Integrated Performance Framework (IPF), process measures are now highlighted as escalations *(when a performance matter does not meet target and hits criteria for a higher level for resolution, decision-making, or further action)* or exception *(Referring to a deviation or departure from the normal or expected course of action).*

In Month 7 (October) 47 quantitative measures as a provider are reportable of the 53 total in the NHS Performance Framework, with 10 of the measures escalated:

- Percentage of patients offered an index colonoscopy within 4 weeks of booking specialist screening appointment.
- Mental Health adult interventions.
- Patients waiting for diagnostics beyond 8 weeks.
- Percentage of children waiting under 14 weeks for a therapy.
- Patients waiting longer than 14 weeks for a therapy.
- Number of patients waiting over 52 weeks for a new outpatient appointment.
- Number of patients waiting more than 36 weeks for a new outpatient appointment.
- Patient follow-up (FUP) pathways delayed 100% and over.
- Number of patients waiting more than 52 weeks for treatment.
- Mental Health adult CTP compliance.

Through the IPF, remedial action plans have been developed to address these escalated measures, those plans with a red RAG rating have currently been unable to identify an estimated recovery time or the plan has high risk of achievement.

This graph below provides the relative performance of the health board against the 2023/24 NHS Performance Framework that is applicable to the provider e.g., no commissioned or local measures are accounted for even if they are listed within the IPR by exception.



Measures with no RAG rating are those with either insufficient data to determine compliance and those where PTHB reports but has no national target as a non-acute provider.

Ministerial Priorities 2023/24

At the end of October, the health board is not meeting six of the challenging set targets to drive performance improvement (33% compliant 3 of 9). Four planned care measures are now not expected to achieve their target as of March 2024. All escalated measures are discussed within the Performance and Engagement group with key service leads and remedial actions plans are in place or under development.

The performance team has included its RAG assessment of year end delivery against the Ministerial Priorities should no further action be taken:

Ministerial Priority Measures			Month											Risk of delivery R.A.G
Measure	Target		Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	
Number of patients referred from primary care (optometry and General Medical Practitioners) into secondary care Ophthalmology services	Improvement trajectory towards a national target of reduction by March 2024	Performance Trajectory	135	135	135	135	135	135	128	120	113	105	98	90	
		Actual	98	97	100	74	53	85	82						
Number of patients waiting more than 52 weeks for a new outpatient appointment	Improvement trajectory towards a national target of zero by June 2023	Performance Trajectory	0	0	0	0	0	0	0	0	0	0	0	0	
		Actual	1	3	4	19	42	60	80						
Number of patients waiting more than 36 weeks for a new outpatient appointment	Improvement trajectory towards a national target of zero by March 2024	Performance Trajectory	35	35	35	30	30	25	20	15	10	5	5	0	
		Actual	67	98	112	126	159	197	257						
Number of patients waiting more than 104 weeks for referral to treatment	Improvement trajectory towards a national target of zero by June 2023	Performance Trajectory	0	0	0	0	0	0	0	0	0	0	0	0	
		Actual	0	0	0	0	0	0	0						
Number of patients waiting more than 52 weeks for referral to treatment	Improvement trajectory towards a national target of zero by March 2025	Performance Trajectory	20	15	10	5	5	0	0	0	0	0	0	0	
		Actual	16	14	14	29	52	75	99						
Number of patients waiting over 8 weeks for a specified diagnostic	Improvement trajectory towards a national target of zero by March 2024	Performance Trajectory	160	160	150	130	120	110	100	80	50	30	15	0	
		Actual	159	160	117	134	152	139	132						
Number of patients waiting over 14 weeks for a specified therapy	Improvement trajectory towards a national target of zero by March 2024	Performance Trajectory	190	190	180	170	120	70	20	0	0	0	0	0	
		Actual	243	273	265	418	511	499	312						
Number of patients waiting for a follow-up outpatient appointment who are delayed by over 100%	Improvement trajectory towards a national target of reduction by March 2024	Performance Trajectory	4,600	2,500	2,000	1,700	1,400	900	400	0	0	0	0	0	
		Actual	4,763	1902	1667	1660	1683	1624	1575						
Number of patients who spend 12 hours or more in all major and minor emergency care facilities from arrival until admission, transfer or discharge	Improvement trajectory towards a national target of zero by March 2024	Performance Trajectory	0	0	0	0	0	0	0	0	0	0	0	0	
		Actual	0	0	0	0	0	0	0						

NEXT STEPS

- Through the IPF, work continues to implement the required process to provide effective challenge, support and scrutiny of both provider and commissioned services, with the aim to improve patient outcomes including regular discussion at directorate performance review meetings.

- The Performance Team continues to work closely with commissioned service providers to understand referral demand, demand and capacity gaps, waiting list profiles at specialist level and model robust performance trajectories within the context of the NHS Wales Planning Framework and Ministerial Targets for 2023/24 for Powys provider, English and Welsh commissioned services.

Powys Teaching Health Board

Integrated Performance Report

Month 7 – Updated 06/12/2023

Select one of the below boxes to navigate to the required section of the report

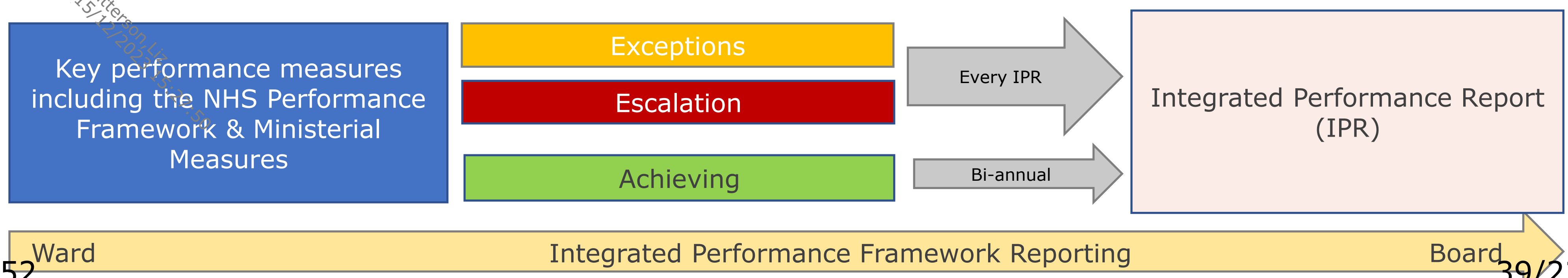
What is the Integrated Performance Report (IPR)

This report is a key part of the health boards Integrated Performance Framework (IPF) designed to drive improvement in health board performance and health outcomes for those patients that Powys is responsible for. The IPR uses key NHS Performance Framework measures which include Ministerial priorities and other timely local measures to provide robust assessment of the health boards success. This process utilises both quantitative and qualitative measurements which are backed by statistical process, business rules, and narrative provided by leads of that service area.

Business rules for reporting within the Integrated Performance Report

The health board business rules are designed to highlight potential challenge and provide clear assurance for the Board and Public stakeholders. The IPR as a function of the IPF will **not** contain information on those metrics that are consistently achieving success (exception of bi-annual full update) but focus on metrics of exception or escalation.

Exception	**Escalation**
Referring to a deviation or departure from the normal or expected course of action, it signifies that a specific condition or event requires attention or further action to address the deviation and ensure corrective measures are taken.	When a performance matter (exception) does not meet target and hits criteria for a higher level for resolution, decision-making, or further action.
Criteria of an exception	Criteria for escalation
Any target failing an NHS Performance target, operational, or local target/trajectory	Any measure that fails a health submitted trajectory as part of the Ministers priorities.
Where SPC methodology reports rule 2, or rule 4 (details on next slide) even if a measure is set target.	Performance recovery failing its Remedial Action Plan (local plan to improve or maintain performance)
Any reportable commissioned metric where performance is not meeting national target	Any significant failure of quality standard e.g. never event or failing accountability conditions.



Using statistical process control (SPC)

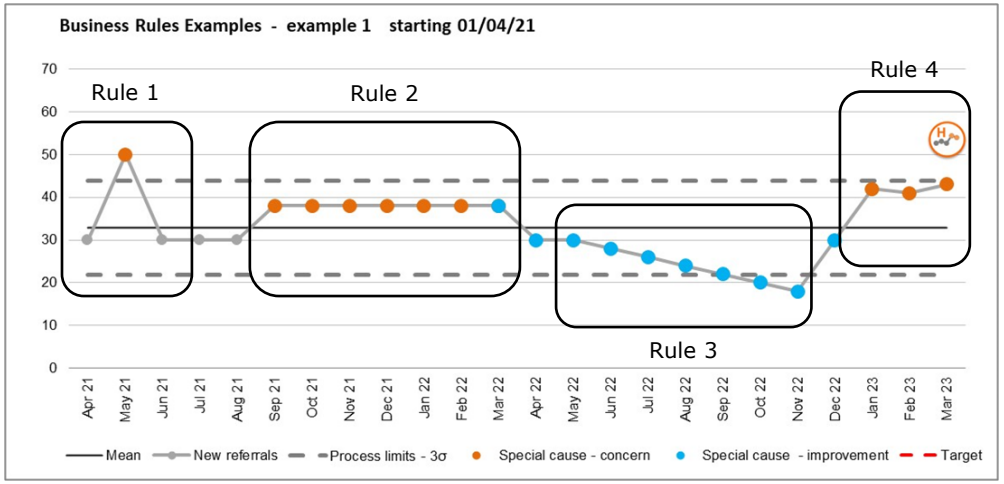
SPC charts are used as an analytical technique to understand data (performance) over time. Using statistical science to underpin data, and using visual representation to understand variation, areas that require appropriate action are simply highlighted. This method is widely used within the NHS to assess whether change has resulted in improvement.

Key facts for SPC

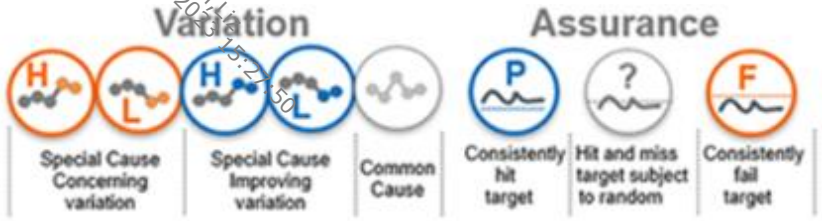
- A minimum of 15-20 data points is needed for this method (24 are used within this document where available).
- 99% of all data points will fall between lower and upper confidence intervals (outside of this should be investigated).
- Two types of trend variation: Special cause (**Concerns** or **Improvement**) and **Common Cause** (no significant change)

Key Rules of SPC

1	Single data point outside of limit (upper or lower) – unexpected (data quality? Isolated event or significant service pressure?)
2	Consecutive points above or below mean (not normally natural) - A run of six or more values showing continuous increase or decrease is a sign that something unusual is happening in the system.
3	Consecutive points increasing/decreasing (trend of at least 6 if monthly, more for shorter time periods e.g., days/weeks) showing special cause variation.
4	Two of three points close to process limits – especially in volatile data (wide control lines) can provide early warning requiring further escalation.



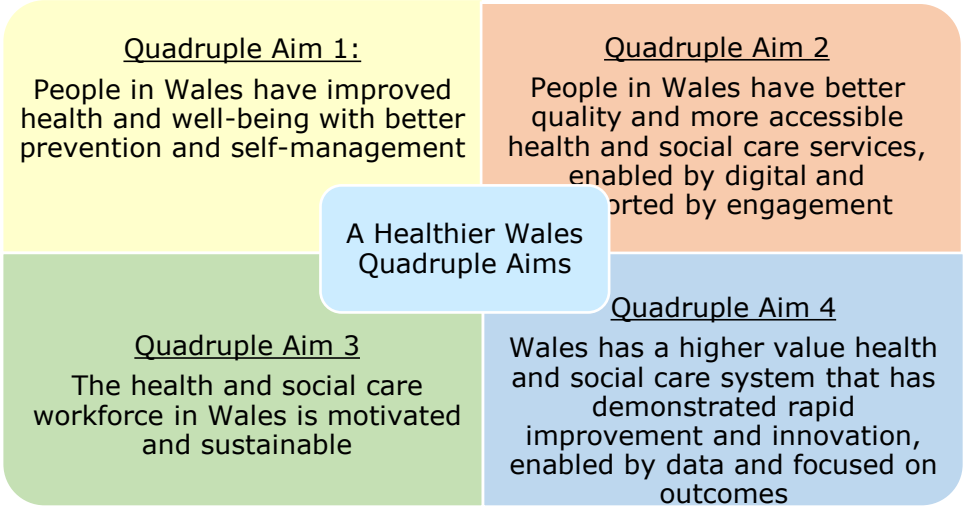
NHS Improvement SPC icons



What is the NHS Performance Framework?

The NHS Performance Framework is a key measurement tool for "A Healthier Wales" outcomes, the 2023/24 revision now consists of 53 quantitative measures of which 9 are Ministerial Priorities and require health board submitted improvement trajectories. A further 11 qualitative measures are also currently included of which assurance is sought bi-annually by Welsh Government

The NHS Wales Quadruple Aim Outcomes are a set of four interconnected goals or aims that aim to guide and improve healthcare services in Wales. These aims were developed to enhance the quality of care, patient experience, and staff well-being within the National Health Service (NHS) in Wales.

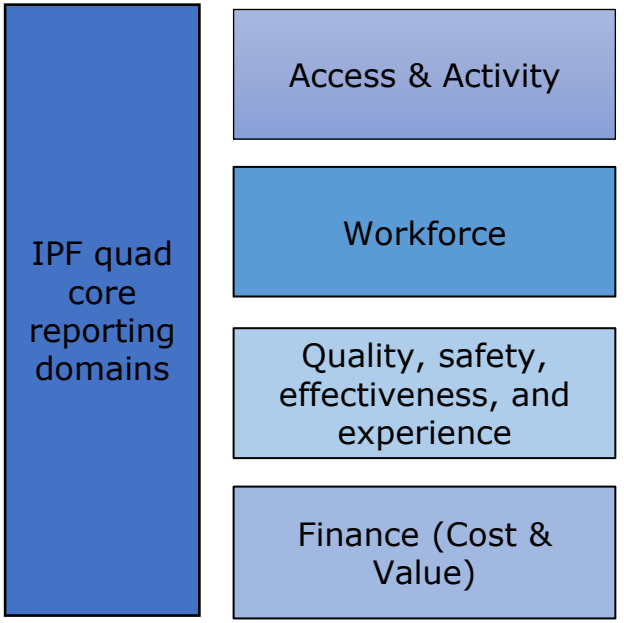


What is the Integrated Performance Framework (IPF) in Powys?

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

The IPF is undergoing phased implementation across the health board with core integration by Q4 2023/24 to run as business as usual.

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



Narrative summary of performance at month 7 (October 2023)

This report provides the Executive Committee with the latest available performance update against the new 2023/24 NHS Wales Performance Framework. The IPR format for Month 7 highlights areas of escalation and exception as a priority. To note detailed slides on compliant measures will only be included bi-annually.

At the end of October 2023 (Month 7) the health board has a significantly challenged position for planned care where key ministerial target trajectories (submitted by the health board) are not being achieved. As a provider of planned care key fragility remains in high demand specialties resulting in longer waits, these specialties include but are not limited to General Surgery, Urology, Orthopaedics, and Ophthalmology. Key reasons for the health boards challenges include an especially fragile in-reach service provision, reliance on commissioned service providers for complex diagnostics (delaying pathways), resource requirement for private insource (which would reduce waiting times), and the health boards reliance on fragile NHS in-reach. Further challenge includes staff vacancies (high turnover) and reliance on agency staff to cover a fragile workforce across the large geographical and rural area of Powys.

Positive elements for the provider include key clinical recruitment strengthening the day case and endoscopy units in Brecon and Llandrindod, review of processes with the aim to improve efficiencies and outcomes. Rollout of new diagnostics in endoscopy (sponge capsule) which has already had very positive feedback from staff, and patients. More capacity but limited by resource constraints from insource with a confirmed start in November resulting in reduced long waiters and improved urgent waits in key specialties. Progress against remedial action plans, for example Therapies service who are escalated have seen improvement in-line with plan reducing breaching pathways.

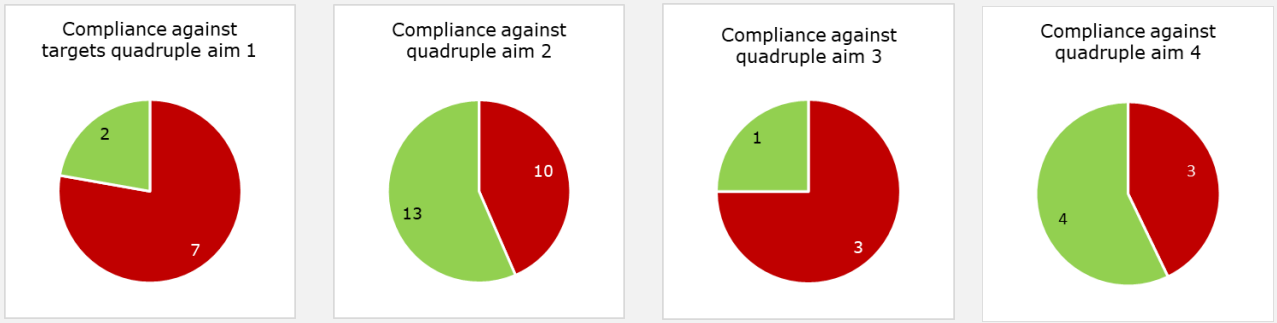
Powys residents in commissioned services see ongoing challenges especially linked to equity of access with shorter RTT waits in England than Wales. There is general improvement across the acute care providers and very long waits are reducing. As a national priority cancer pathways and care remain challenging with significant variation by tumour site and geographical provider area with challenge linked to key themes e.g., diagnostic and reporting delays, physical staffing capacity due to sickness or vacancies, and finally patients choosing to delay their pathways (which are not excluded from pathway breach reporting).

For emergency care Welsh Ambulance performance times remain poor with 46.9% of calls meeting the 8-minute target. For emergency department access Powys minor injuries units continue to perform well with no patients waiting over 12hrs and 99.9% compliance on the 4hr target. However, A&E units in England continue to report challenging performance with extreme system flow pressure remaining. The position of residents accessing Welsh A&E units is slightly better with 61.6% being seen within 4hrs in October. And to support the flow of emergency departments in Wales and England the health board continues to maximise repatriation of patients to improve acute flows and reduce the number of admissions with preventative support.

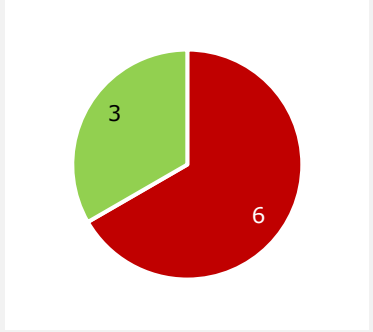
Visual summary of performance at month 7 (October 2023)

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

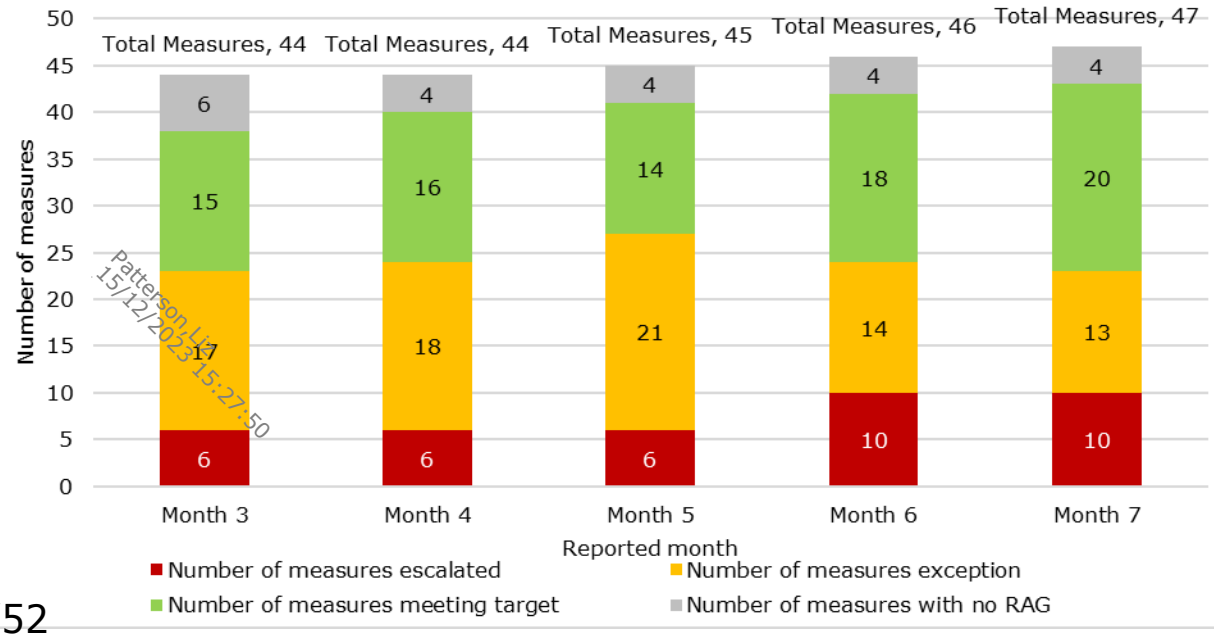
Compliance against NHS Performance Framework measures at month 7 by quadruple aim area.



Compliance against Ministerial priority trajectories.



Exception and Escalation measure guide by month as a provider



- In Month 7 (October) 47 quantitative measures as a provider are reportable of the 53 total in the NHS Performance Framework.
- This graph provides the relative performance of the health board against the NHS Performance Framework that is applicable to the provider e.g., no commissioned or local measures are accounted for even if they are listed within the below exception/escalation reports or other areas of the IPR.
- It should also be noted however that any measure can be raised as an escalation, even if performance meets national target.
- Measures with no RAG rating are those with either insufficient data to determine compliance e.g., 12-month reduction trends (normally new metrics), and those where PTHB reports but has no national target as a non-acute provider.

Escalated Performance Challenges

No.	Abbreviated measure name	Latest available	Target	Current	Last achieved target	SPC variance	Estimated recovery time
7	Percentage of patients offered an index colonoscopy within 4 weeks of booking specialist screening appointment	Sep-23	90%	0.0%	Never		TBC – RAP in place
Why is this an escalated metric?		Escalated by Powys Performance team for historic and current poor target compliance.					
Key performance drivers		**Key actions to recover**					
Poor performance linked to the capacity for diagnostic endoscopy across Wales. Target is and has always been very challenging with low compliance across all providers.		Regular meetings between local operational leads and the Public Health led Wales screening team (BSW). Performance reported and reviewed monthly via LTA contract sheets.					
17	Percentage of interventions started within (up to and including) 28 days following an assessment by LPMHSS for people 18 years and over	Oct-23	80%	41.7%	Never		TBC – plan in place
Why is this an escalated metric?		This measure remains challenged, without intervention it will not meet target and has been escalated					
Key performance drivers		**Key actions to recover**					
Inconsistent data capture across the teams has led to problems with accuracy. Dual system recording WPAS, and WCCIS resulting in timeliness challenge. Deficit in south Powys admin capacity due to sickness.		A recovery and development plan confirmed in Spring 2023 continues to be implemented and includes the standardisation of services. Part 1b performance expected to improve but may be temporarily affected by the implementation of the standard operating procedure.					
25	Number of patients waiting more than 8 weeks for a specified diagnostic	Oct-23	PTHB trajectory =<100	132	Jan-20		NOUS – Q4 Echo Card – TBC Endoscopy – Q4
Why is this an escalated metric?		This metric has been escalated as it is not currently achieving the submitted health board target as a ministerial priority. The service is reporting significant challenge of improvement and sustainability via the internal Performance and Engagement group.					
Key performance drivers		**Key actions to recover**					
Key capacity challenges for diagnostics especially in Cardiology, and Endoscopy where the waiting list position is degrading. Radiology although reporting breaches continues to see improvement as reported within their remedial action plan. All specialties are affected by in-reach fragility and increased demand that challenges current capacity.		Key actions include creation of multiple by specialty remedial action plans to assess and drive recovery with senior engagement, escalation of in-reach providers capacity via Commissioned contracting meetings. Positive feedback on new endoscopy sponge capsule (cyto-sponge) diagnostic which started in October to improve patient experience and service capacity. Senior clinical team vacancy now filled and insource to restart from November.					
26	Percentage of children (under 18) waiting 14 weeks or less for a specified Allied Health Professional	Oct-23	12-month improvement trend	78.1%	New measure data not available	N/A	Mar-24
Why is this an escalated metric?		This measure has been escalated from month 6 as part of the larger therapies escalation as confirmed by service leads (key specialties like speech and language therapy (Paediatrics) is impacting on the overall therapies position of the health board.					
Key performance drivers		**Key actions to recover**					
Majority of breaches are within speech and language therapy linked to key challenges with staffing vacancies, unrecognised backlog of long waiting patients and a high caseload demand. General challenge of staffing and sickness across all therapy's specialties.		Remedial action plan undertaken by services for escalation as required. New standard operating procedure in place to improve service processes. Demand and capacity work has been undertaken to improve flow and recruitment plans underway.					

Escalated Performance Challenges

No.	Abbreviated measure name	Latest available	Target	Current	Last achieved target	SPC variance	Estimated recovery time
27	Number of therapy breaches 14+ weeks	Oct-23	PTHB trajectory =<20	312	Dec-21		Mar-24
Why is this an escalated metric?	This metric has been escalated as it is not currently achieving the submitted health board target and is significantly off trajectory.						
Key performance drivers	**Key actions to recover**						
Significant vacancies across key specialties including physiotherapy, dietetics, podiatry and audiology. For example, podiatry has 33% staffing vacancy pan Powys significantly challenging flow and patient wait times. Large FUP caseload backlog impacting new booking capacity. Ongoing challenge with core reporting which remains escalated with the Digital & Transformation team.	Key actions include creation of multiple by specialty remedial action plans to assess and drive recovery with senior engagement. Weekly Heads of Service waiting list meetings. Additional locum to support MSK physiotherapy, and new graduate from August 2023. Caseload reviews across all therapies. Podiatry, Dietetics and Speech and language therapy (SALT) Heads of service (clinical) have increased their clinical job plans from 1 sessions per week to 4 sessions a week which results in their operational management capacity being reduced. All long waits booked in SALT.						
28	Number of patients waiting over 52 weeks for a new outpatient appointment	Oct-23	PTHB trajectory of 0	80	Jan-23		Potential recovery by Mar-24
Why is this an escalated metric?	This metric has been escalated as it is not currently achieving the submitted health board target as a ministerial priority.						
Key performance drivers	**Key actions to recover**						
Significant capacity challenge, especially in Rheumatology, General Surgery, Orthopaedics, ENT, and Ophthalmology. Ability to recovery for year end is linked to insource in the short term, limited NHS capacity.	Key actions include creation of multiple by specialty remedial action plans to assess and drive recovery with senior engagement. Key clinical vacancies have been recruited to for theatres. Insource starting from November to improve key capacity. In reach service fragility and capacity issues flagged via CQPRM and GIRFT review including efficiency improvement recommendations underway.						
29	Number of patients waiting more than 36 weeks for a new outpatient appointment	Oct-23	PTHB trajectory of 20	257	N/A		Potential recovery by Mar-24
Why is this an escalated metric?	This metric has been escalated as it is not currently achieving the submitted health board target and is significantly off trajectory. The waiting list and breach challenge is expected to grow into Q3 & Q4.						
Key performance drivers	**Key actions to recover**						
As above (measure 28)	As above (measure 28)						
30	Patient follow-up (FUP) pathways delayed 100% and over	Oct-23	PTHB Trajectory =<400	1575	Not available	N/A	Nov-23
Why is this an escalated metric?	FUP pathways recording and reporting was escalated in Q4 2021/22 following service identified significant accuracy challenge in the reporting of pathway time banding. Resulting reporting checks by the Digital Transformation team highlighted a significant quantity of un-reported pathways and local reporting was aligned to the National WPAS team's process. To note currently in this document the health board is reporting all pathways both reportable and non-reportable (Welsh Government holds PTHB to account on only reportable specialties).						
Key performance drivers	**Key actions to recover**						
Ongoing validation reducing inaccurate pathways via data cleansing with service. Challenge to service capacity prioritising urgent suspected cancer/urgent whilst routine and FUP's in some specialties are required to wait longer.	D&T have continued validation although further data quality issues have been raised. From a service perspective Ophthalmology are to commence using patient-initiated follow-ups from November 2023 to improve care for frail patients and further capacity scoping is being carried out including insource and service level agreement discussions with NHS in-source.						

Escalated Performance Challenges

No.	Abbreviated measure name	Latest available	Target	Current	Last achieved target	SPC variance	Estimated recovery time
32	Number of patients waiting more than 52 weeks for treatment	Oct-23	PTHB Trajectory of 0	99	Sep-22		**Potential recovery by Mar-24**
Why is this an escalated metric?		This metric has been escalated as it is not currently achieving the submitted health board target as a ministerial priority.					
Key performance drivers		**Key actions to recover**					
As per measure 28		As per measure 28					
45	Percentage of health board residents 18 years and over in receipt of secondary mental health services who have a valid care and treatment plan	Oct-23	90%	80%	Nov-21		**TBC – remedial action plan required**
Why is this an escalated metric?		Poor compliance with service agreement.					
Key performance drivers		**Key actions to recover**					
Vacancies and sickness absence impact on the ability to meet this target however there has been a data quality challenges including post submission revisions which means that in the next reporting period there will be an impact on performance with improvement anticipated.		A new standard operating procedure has been rolled across the 5 Community Mental Health Teams with review meetings in place to ensure compliance. To note there will be an impact on performance data in the next reporting period. There has been success in recruiting to key vacancies and reduction in reliance on locums. Recruitment efforts will continue with the aim to improve capacity.					

Exception Reporting - measures not meeting required performance

Quadruple Aim 1: People in Wales have improved health and wellbeing with better prevention and self management

No.	Abbreviated measure name	Latest available	Target	Current	Last achieved target	SPC variance	Estimated recovery time
1	Percentage of adult smokers who make a quit attempt via smoking cessation services	Q1 23/24	5% Annual Target	1.29%	Never	N/A	**TBC**
Key performance drivers		**Key actions to recover**					
Q1 2023/24 has seen a step change in performance with Q1 reporting 1.29% significantly higher than 0.68% for the same period 2022/23		Health board to develop promotional campaign for Pharmacy L2 & L3 services inc additional training for technicians. Roll out of GP text message project to offer patient support, and other ongoing promotions of pathways to support smoking cessation.					
2	Percentage of people who have been referred to health board services who have completed treatment for substance misuse (drugs/alcohol)	Q2 23/24	4 quarter improvement trend	56.3%	Q4 2022/23	N/A	
Key performance drivers		**Key actions to recover**					
Interpretation of the target across Wales varies by health board area, vacancies in staff.		Action plan underway encompassing recommendations and focus points from HIW review. PTHB have created a harm reduction coordinator role (2023). Dual diagnosis worker in Mid Powys appointed					
3	Percentage of children up to date with scheduled vaccinations by age 5	Q1 23/24	95%	91.7%	Never	N/A	**Q2 23/24**
Key performance drivers		**Key actions to recover**					
Significant improvement for Q1 2023/24 (91.7%) but known issues include data recording on uptake and linking of digital systems (data cleansing ongoing). Workforce capacity challenges in primary care, reduction in vaccination due to pandemic.		Standard operating procedures (SOPs) have been developed to support primary care clinicians with clear and robust reporting processes with both scheduled and unscheduled immunisations. Lessons learnt from Polio/MMR catchup are being implemented. Equity review undertaken.					
4	Percentage of girls receiving HPV vaccination by age 15	Q1 23/24	95%	84.7%	N/A new metric	N/A	**Awaiting further data - TBC**
Key performance drivers		**Key actions to recover**					
Change in the methodology of age group for reporting. Press reports around change of vaccination schedule, and negative press regarding HPV.		Vaccination promotion in schools appropriately via curriculum, and review implementation of NICE guidelines (NG218) particularly recommendations 1.3.24 to 1.3.39.					
5	Percentage uptake of the influenza vaccination amongst adults aged 65 years and over	Oct-23	75% (by end of season)	57.1%	N/A new metric	N/A	
Key performance drivers		**Key actions to recover**					
Influenza period started September, initial data point, this is a cumulative performance measures until end of flu season.		Active engagement with primary care regarding delivery of vaccinations, and providing support and uptake data where requested.					
6	Percentage uptake of COVID-19 vaccination for those eligible	Oct-23	75% (by end of campaign)	33.5%	Not applicable	N/A	**Q4 23/24**
Key performance drivers		**Key actions to recover**					
Data on COVID-19 vaccination uptake is sourced from PHW surveillance data which is based on total population, citizens only become eligible for a booster if they complete their primary course. National delay on data cleansing cohorts. BA.4.86 variant impact		Targeted interventions on immunosuppressed, ongoing work with care homes, and increasing local clinic offer to improve access. Supporting GP's to provide COVID vaccination clinics.					

Exception Reporting - measures not meeting required performance

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

No.	Abbreviated measure name	Latest available	Target	Current	Last achieved target	SPC variance	Estimated recovery time
18	Percentage of emergency responses to red calls arriving within (up to and including) 8 minutes	Oct-23-23	65%	46.9%	Feb-21		Unavailable for this measure
Key performance drivers		**Key actions to recover**					
Demand for 999 services remains high, handover delays in key A&E sites, Powys geography impacts arrival times due to rurality.		Recent actions include work to improve 'return to footprint' by Powys crews to increase capacity for calls in county. New national dashboard ongoing development to provide improved intelligence around challenge and hotspots.					

22	Percentage of patients who spend less than 4 hours in all major and minor emergency care (i.e. A&E) facilities from arrival until admission, transfer or discharge **– Powys resident view**	Oct-23	Powys – 95% Wales – 95% England – 95%	99.9% 61.4% 47.7% (Sep-23)	Never met across all residents	TBC	**N/A**
Key performance drivers		**Key actions to recover**					
There are no issues with provider MIU services reported, but for Powys residents waits in commissioned units remain poor. Key issues include flow through acute units slowing emergency admissions and resulting in backlog and A&E impact.		To note Powys as a provider will be unable to achieve compliance for residents but the health board fully engages with national daily calls for emergency department pressures, improved repatriation of patients in acute beds to support flow and aim to provide more local support for urgent care access.					

23	Number of patients who spend 12 hours or more in all hospital major and minor emergency care facilities from arrival until admission, transfer or discharge – **Powys resident view**	Oct-23	Powys – 0 Wales – 0 England - 0	0 150 290 (Sep-23)	Never met across all residents	N/A	**N/A**
Key performance drivers		**Key actions to recover**					
Narrative as measure 22.		Narrative as measure 22.					

No.	Abbreviated measure name	Latest available	Target	Current	Last achieved target	SPC variance	Estimated recovery time
34	Children/Young People neurodevelopmental waits	Oct-23	80%	58.7%	Aug-22		**TBC**
Key performance drivers		**Key actions to recover**					
Referral rates into this service have been increasing steadily over the last 3 years, 2022/23 and up to the end of Q2 2023/24 reported special cause concern for the number accepted into the service. Other key challenges include no recurrent funding and a deficiency in permanent workforce to meet increased demand.		The RTT waiting list and assessments in progress backlog continue to be a focus for the ND service. However, capacity remains insufficient to meet the referral demand even with additional Revenue Integration Funding (RIF) posts. The ND Remodel business case is being considered by IBG Scrutiny Panel November 2023, and temporary staff positions have been extended until at least March 2025.					

Exception Reporting - measures not meeting required performance

Local Measures and Assurance

No.	Abbreviated measure name	Latest available	Target	Current	Last achieved target	SPC variance	Estimated recovery time
Commissioning measures	Commissioned referral to treatment (RTT) – Powys resident	Combined Latest Performance – Sep 23	+104 weeks	356	Never	Please look to slide for detail	Commissioned service trajectories - unavailable
			52+ weeks	2243			
			+36 weeks	4683			
			< 26 weeks	62%			
Commissioned RTT performance does not meet any set targets, please look to the slides for further details.							
Link	Powys commissioned private dermatology service (RTT)	Oct-23	< 26 week	76.7%	Not available	N/A	**TBC**
			+36 week	32			
Private provider outsource does not meet any set RTT targets in June, please look to the slide for further details.							
Cancer Measures	SCP - Commissioned Cancer Performance (Wales)	Oct-23	75% <62 days for treatment	50%	Never	Not available	No recovery estimated available
	Cancer pathway breaches in England	SATH - Sept	zero	4 Breaches	N/A		
		WVT - Aug		2 Breaches	N/A		
	Powys provider downgrade performance – 28 days best practice	Sep-23	TBC	24%	N/A		
Commissioned Cancer performance does not meet any set targets where the information is available, please look to slides for further details.							

Exception Reporting - measures not meeting required performance

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

No.	Abbreviated measure name	Latest available	Target	Current	Last achieved target	SPC variance	Estimated recovery time
37	Turnover rate for nurse and midwifery registered staff leaving NHS Wales	Jul-23	Rolling 12-month reduction against a baseline of 2019-20 (9.5%)	13.7%	N/A	N/A	**TBC**
Key performance drivers			**Key actions to recover**				
Health Education and Improvement Wales (HEIW) have produced the analysis and data for this measure along with the methodology. It should be noted that HEIW have noted that current data has anomalies and ongoing work is required to resolve			Managers continue to be encouraged to undertake exit interviews with staff where appropriate to try and gather clear intelligence for the reasons staff leave. HEIW funding to support delivery of Nurse retention plan. Roll out of Team Climate Surveys to support managers and improve retention.				
38	Agency spend as a percentage of the total pay bill	Oct-23	12-month reduction trend	11.4%	Apr-23		**TBC**
Key performance drivers			**Key actions to recover**				
Agency use accounts for the largest proportion of variable pay spend in both Registered Nursing and unregistered Nursing and remains an area of focus. Challenges include limited substantive professional workforce availability, rurality, sickness, and patient acuity & dependency.			Reviewing operational footprint to further reduce reliance on temporary staffing, negotiations with on-contract agencies for additional recruitment. Additional recruitment of overseas nurses (OSN) who undertake Objective Standard Clinical Examination (OSCE) that the nurses must pass in order to re-register from April 2023				
39	PADR Compliance	Oct-23	85%	78.0%	Never		**TBC**
Key performance drivers			**Key actions to recover**				
Staff absence and vacancies has caused challenges in delivery of PADRs. This continues to be a challenge post pandemic with increase service demand and recruitment challenges. As of October 2023, there were 10 service areas/Directorates whose performance was below the national target of 85%.			Workforce & OD Business Partners team continue to discuss compliance at senior management meetings within services. Low compliance is addressed with individual managers and signposting to guidance also takes place.				

Exception Reporting - measures not meeting required performance

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

No.	Abbreviated measure name	Latest available	Target	Current	Last achieved target	SPC variance	Estimated recovery time
42	Percentage of calls ended following WAST telephone assessment (Hear and Treat)	Sep-23	17% or more	9.0%	Never	N/A	**N/A**
Key performance drivers				**Key actions to recover**			
No issues currently reported				This is a commissioned service by the health board, as such Powys has limited actions available to resolve issues.			

No.	Abbreviated measure name	Latest available	Target	Current	Last achieved target	SPC variance	Estimated recovery time
45	Percentage of health board residents 18 years and over in receipt of secondary mental health services who have a valid care and treatment plan	Oct-23	90%	80.0%	Dec-22		**TBC**
Key performance drivers				**Key actions to recover**			
North Powys vacancies and sickness impacting performance, including the local authority challenge for capacity (office duties) which impact PTHB staff. Further ongoing data quality including post submission revisions challenge performance reporting.				Ongoing meetings with local council to resolved responsibilities and capacity challenge (change of duty model being scoped). Ongoing recruitment drive underway, and data cleansing work with review of WCCIS (patient administration system) underway. Remedial action plan is to be put into place by mid-November 2023			

No.	Abbreviated measure name	Latest available	Target	Current	Last achieved target	SPC variance	Estimated recovery time
51	Percentage of Ophthalmology R1 appointments attended which were within their clinical target date or within 25% beyond their clinical target date	Oct-23	95%	66.7%	Never		**TBC**
Key performance drivers				**Key actions to recover**			
In-reach fragility impacts available capacity for specialty. Local staffing challenges reducing capacity include sickness absence, vacancies in theatre staffing and backlog following industrial actions. Further challenge linked to delays in National Digital Eye Care Rollout awaiting outcome (anticipated November 2023).				Working with WVT & Rural health care academy to formalise training opportunities in DGH. League of Friends supporting purchase of equipment for North Powys biometry to support repatriation of cataract pathway. Commencing use of PIFU pathways in WET AMD from November 2023 to improve care pathways for frail patients.			

Healthier Wales Quadruple Aim 1

Access & Activity | **NHS Performance Measure – 1** | **Powys as a provider**

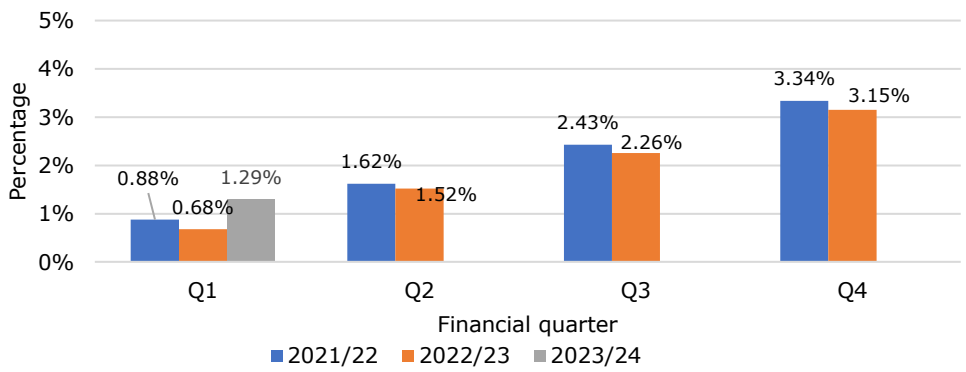
Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Smoking - Percentage of adult smokers who make a quit attempt via smoking cessation services

Executive lead	Executive Director of Public Health	Officer lead	Consultant in Public Health	Strategic priority	2

Latest available	Q1 2023/24		
Reported performance	1.29%	All Wales positional rank and performance.	4th (1.24%)
Target	5% cumulative annual target		
Variance	N/A		Exception
Data quality & Source		Welsh Government Performance Scorecard	

Percentage of adult smokers who make a quit attempt



What the data tells us

Note:
Performance in Quarter 1 2023/24 has seen a step change in performance with 77% year on year increase in smokers being supported by the service to quit.

In 20/21, the National Survey was adapted due to COVID resulting in lower smoking estimates than previously reported. The lower estimates will result in an apparent higher proportion of smokers making a quit attempt during 2021/22 which may not reflect a real improvement in performance.

* This measure has had a retrospective data update (via Welsh Government Performance) for Q1 changing performance from 1.20% to 1.29%.

Issues

- 96% (22/23) of pharmacies continue to deliver a Level 2 service, and 70% (16/23) of pharmacies are delivering Level 3 services, which matches pre pandemic levels. To increase activity (quit attempts and successful quits) to pre-pandemic levels, it has been identified that the pharmacy service needs to be promoted and pharmacy staff trained.
- As the percentage of adult smokers in Powys falls it leaves remaining the group of smokers who find it most difficult to quit and are often facing complex issues.

Actions | Recovery by: TBC

Improving access and client focus
- Smoking Cessation Team are providing more face-to-face clinics across Powys in community venues and some GP Practices. Telephone support continues to be available. Group support is now also available in Brecon and Welshpool.
- Planning is underway to provide additional training in the new year for community pharmacy technicians to increase their confidence in service delivery. Targeted promotion of the service will occur alongside staff training.

Implementation of communication and engagement plan for public, professionals and partner agencies, to improve awareness of service and referral pathways, including:
- The Smoking Cessation Team is delivering a GP Text message project in 5 GP Practices, targeting smokers with offer of support. This has commenced first with GP Practices in more deprived areas. In one practice, initial results show quit attempts in the month when text were sent were more than double the previous month.
- A patient story has recently been filmed with a client who made a successful quit attempt.
- National advertising stop smoking campaign currently being delivered by PHW, linked to local services.

Mitigations

- Work continues to re-orientate services to reach groups in deprived areas.
- Service delivery model continues to reoriented to provided blended model of delivery to include: Telephone support, one-to-one and Group support.

Healthier Wales Quadruple Aim 1

Access & Activity | **NHS Performance Measure – 2** | **Powys as a provider**

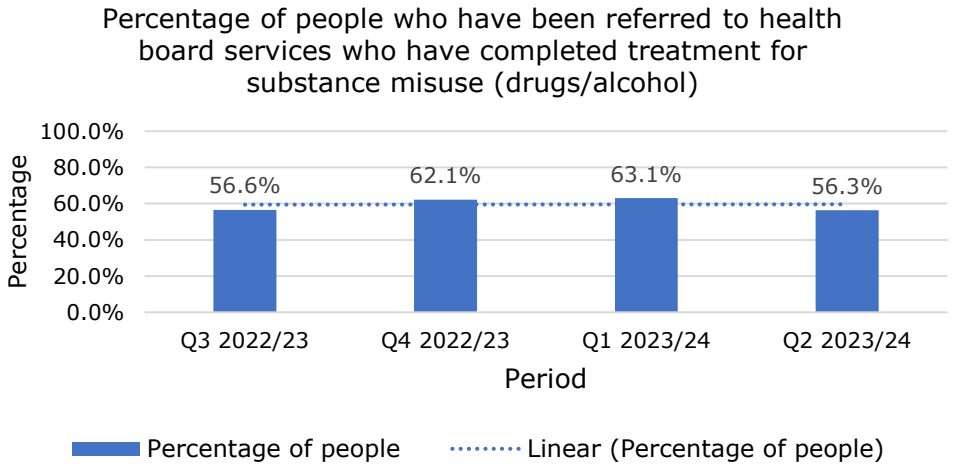
Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

New measure for 2023/24

Substance Misuse – Percentage of people who have been referred to health board services who have completed treatment for substance misuse (drugs/alcohol)

Executive lead	Executive Director of Operations/ Director of Community and Mental Health	Officer lead	Assistant Director of Mental Health	Strategic priority	

Latest available	Q2 2023/24		
Reported performance	56.3%	All Wales benchmark	5th (60.5%)
Target	4 quarter improvement trend		
Variance	N/A		Exception
Data quality & Source		Welsh Government Scorecard	



What the data tells us

This is a new measure for 2023/24 NHS Performance Framework. The measure aims to treatment services that are delivered by NHS teams and does not include voluntary or local authority services.

Reported performance in Q2 2023/24 has not met the required target of a 4-quarter improvement trend.

The health board benchmarks 5th in Wales with an All-Wales position of 60.5%

Issues

Interpretation of the target varies across Wales. PTHB have focussed service to concentrate on harm reduction and enabling service users to take control on reducing the harm of substance misuse therefore, this does not always include complete abstinence and clients may access the service for a significant length of time.

South Powys Dual Diagnosis worker role remains vacant.

Actions | Recovery by

Area planning board (APB) commissioning Manager currently drafting an APB Action Plan encompassing recommendations and focus points from HIW review.

PTHB have created a Harm Reduction Co-ordinator role which was appointed to in 2023.

Dual Diagnosis worker in Mid-Powys appointed, recently recruited to North Powys role. Service Provider part of interview process

Mitigations

The recently retendered contract for drugs and alcohol community treatment service has a new emphasis is on client outcomes and holistic support.

Regular commissioning monitoring meetings with provider in place to monitor community demand.

Complex Needs portfolio – agreed that PCC lead and will co-ordinate partnership meeting in the next quarter. Ongoing Live Well – MH Partnership Priority.

Recruitment campaign for remaining vacant Dual Diagnosis post.

Healthier Wales Quadruple Aim 1

Access & Activity | **NHS Performance Measure – 3** | **Powys as a provider**

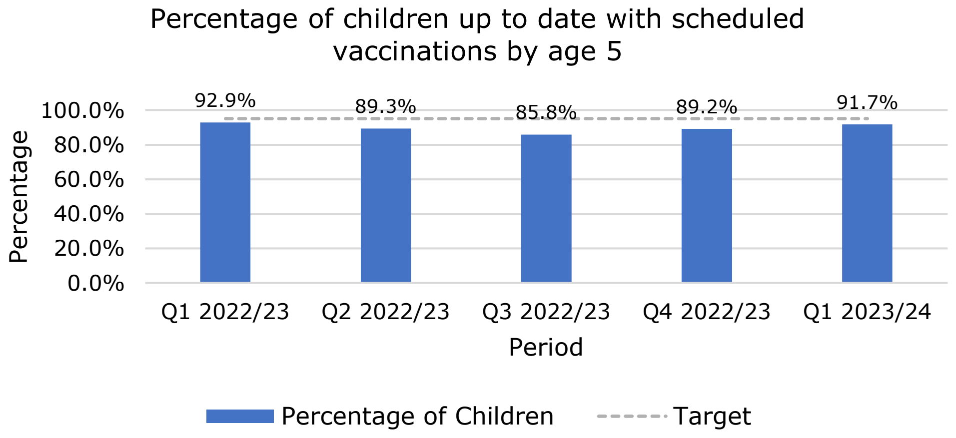
Bwrdd Iechyd Addysgu Powys / Powys Teaching Health Board

Vaccinations – Percentage of children up to date with scheduled vaccinations by age 5

New measure for 2023/24

Executive lead	**Executive Director of Public Health**	**Officer lead**	**Consultant in Public Health**	**Strategic priority**	

Latest available	**Q1 2023/24**		
Reported performance	91.7%	All Wales benchmark	1st (89.7%)
Target	95%		
Variance	N/A		Exception
Data quality & Source		Welsh Government Scorecard	



What the data tells us

This is a new measure for the 2023/24 NHS Performance Framework and replaces the prior 6 in 1 and MMR2 dose vaccination measures.

In 2022/23 there had been a steady decline across 2022/23, from Q1 to Q3, and this reflected a national picture, however this has reversed in Q4 and Q1 2023/24 although performance is slightly lower than the previous year at the same period.

Q1 2023/24 shows improvement to 91.7% and although below target, it is an improvement on the previous quarters and the health board ranks 1st in Wales. This performance improvement reflects the targeted work that's been implemented following decrease in uptake during Q2 & Q3 2022/23.

* This measure has had a retrospective update for Q1 changing performance from 92.7% to 91.7% by Welsh Government Performance

Issues

- Data on uptake is sourced nationally from the Child Health System whilst vaccination is undertaken by GP Practices and recorded on their information system. The Child Health System and GP database are not electronically linked, so information flows means that frequent data cleansing is required to ensure the Child Health System is up-to-date to reflect immunisation status, and people who reside in Powys.

- Vaccination uptake in under 5-year-olds decreased during the pandemic
- Workforce challenges: Some practices have queues due to staffing and working pressures resulting in delayed in timely vaccination. Small numbers will also have a greater impact on percentage uptake variation.

Actions

Recovery by | **Q2 23/24**

- Lessons learnt from the Polio/MMR catch up campaign are being implemented which include:
  - Data cleansing
  - Enhanced monitoring of practice queues lists
  - Rolling enhanced monitoring pre-school project
  - Encouraging GPs to offer unscheduled vaccinations for other missed vaccinations
  - Supporting Health Visitors to follow up where children have missed their vaccinations – SOP written to support this.
  - Reviewing GP immunisation reporting lists which should increase reporting accuracy, and uptake of all childhood immunisations – SOP written to support Primary Care.

- SOPs have been developed to support Primary Care Clinicians with clear and robust reporting processes with both scheduled and unscheduled immunisations.

- An equity review is being undertaken to identify areas of low uptake and any barriers to vaccination to inform targeted actions.

Mitigations

- Ongoing support with Primary Care with queues list monitoring and prompting
- Rolling enhanced surveillance of pre-school vaccination
- Primary Care SOP developed to ensure timely return of Childhood Immunisation clinic lists from Primary Care to Child Health Department.
- Health Visitor SOP developed for Health Visitor Caseload: Follow up of Preschool Children Outstanding Routine Immunisations.

Healthier Wales Quadruple Aim 1

Access & Activity | **NHS Performance Measure – 4** | **Powys as a provider**

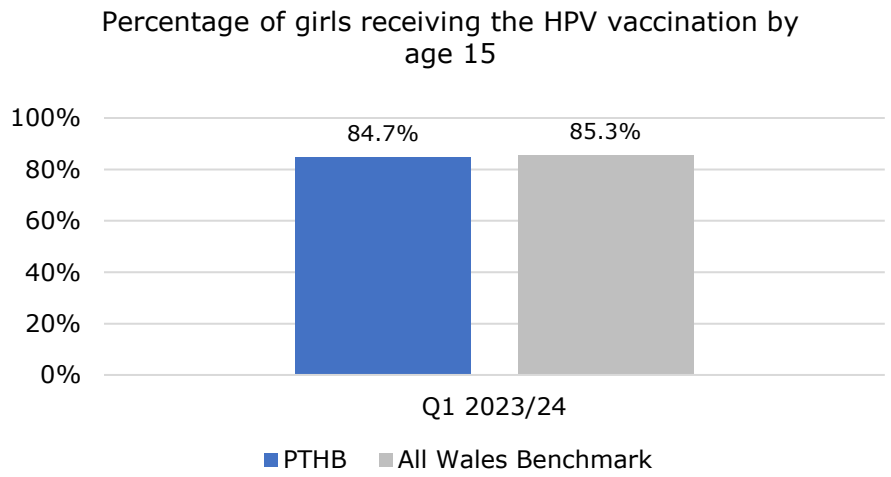
Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

New measure for 2023/24

Vaccinations – Percentage of girls receiving HPV vaccination by age 15

Executive lead	Executive Director of Public Health	Officer lead	Consultant in Public Health	Strategic priority	

Latest available	Q1 2023/24		
Reported performance	84.7%	All Wales benchmark	4th (85.3%)
Target	90%		
Variance	N/A		Exception
Data quality & Source		Welsh Government Scorecard	



What the data tells us

This is a new measures for the 2023/24 NHS Performance Framework.

The health board reports 84.7% against the new 90% target for HPV vaccinations by age 15, this performance is slightly below the All Wales benchmark of 85.3% (ranked 4th).

Previous HPV reporting has been for all children ages and routinely Powys have been around the 75 to 80% uptake, usually achieving higher than the Welsh benchmark.

Issues

- Recent press reports around the change of the vaccination schedule and some of the negative press relating to the HPV vaccine.

Actions	Recovery by	Awaiting further data

- Vaccination promotion in schools in an appropriate way and through the curriculum where possible.
- Review implementation of the NICE guidelines (NG218) Vaccine uptake in the general population particularly recommendations 1.3.24 to 1.3.39 in subsection - Vaccinations for school-aged children and young people to ensure these are being implemented, where appropriate

Mitigations

- New single dose vaccine is being implemented from academic year 2023/24 which should improve uptake further.

Healthier Wales Quadruple Aim 1

Access & Activity | **NHS Performance Measure – 5** | **Powys as a provider**

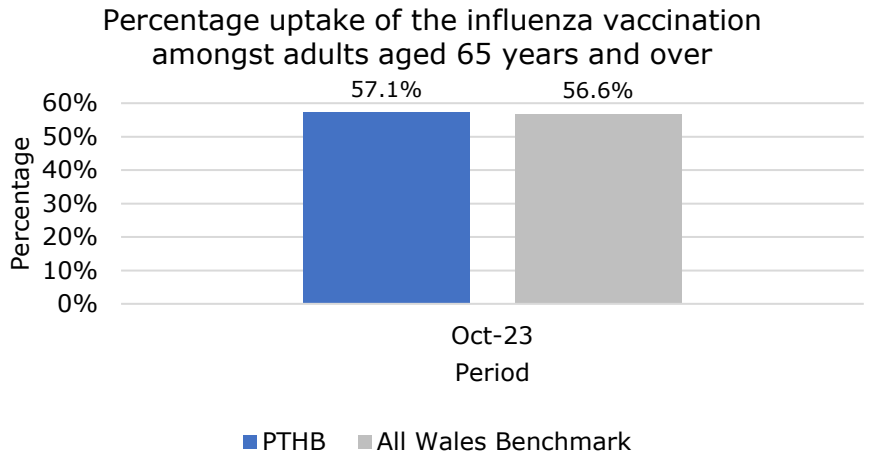
Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

New measure for 2023/24

Vaccinations – Percentage uptake of the influenza vaccination amongst adults aged 65 years and over

Executive lead	Executive Director of Public Health	Officer lead	Consultant in Public Health	Strategic priority	

Latest available	Oct-23		
Reported performance	57.1%	All Wales benchmark	3rd (56.6%)
Target	75%		
Variance	N/A		Exception
Data quality & Source		Welsh Government Scorecard	



What the data tells us

Uptake of influenza vaccine as reported with the initial data (Oct-23) is currently 57.1% for PTHB. This ranks the health board 3rd in Wales, with better performance than the previous year for the same period (54.5%).

To note this is a cumulative measure throughout the 2023/24 influenza vaccination period, and for context in 2022/23 the health board achieved a rate of 73.8% amongst adults aged 65 years and over.

Issues

The influenza vaccination period started in September so this is reporting on the initial uptake for 2023/24.

Actions | Recovery by

Actively engaging with Primary Care regarding delivery of the flu vaccinations, providing support and uptake data, where requested to encourage continued increase in uptake rates.

Mitigations

Continued monitoring of uptake, and engaging with those GPs to encourage further sessions, drop-ins and mop up clinics.

Healthier Wales Quadruple Aim 1

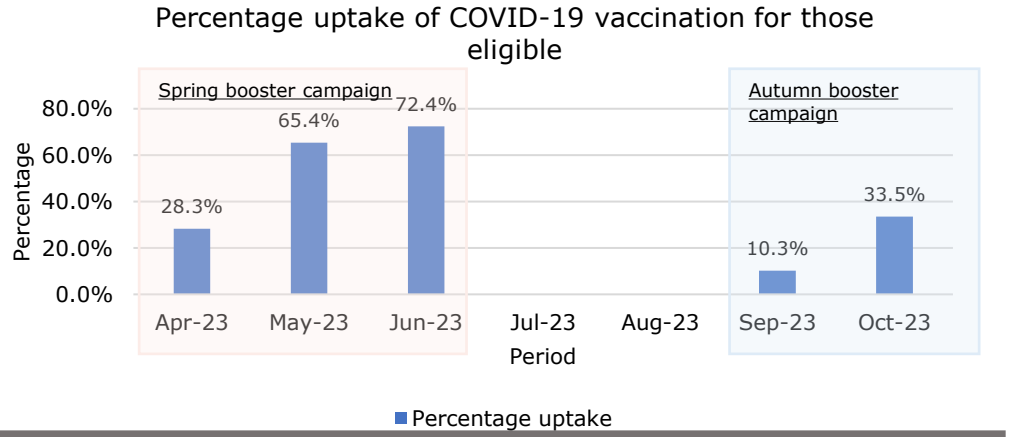
Access & Activity | **NHS Performance Measure – 6** | **Powys as a provider**

Bwrdd Iechyd Addysgu Powys / Powys Teaching Health Board

Vaccinations – Percentage uptake of COVID-19 vaccination for those eligible

Executive lead	Executive Director of Public Health	Officer lead	Programme Manager - Vaccination	Strategic priority	

Latest available	Oct-23		
Reported performance	33.5%	All Wales benchmark	1st (27%)
Target	75% by end of autumn campaign		
Variance	N/A		Exception
Data quality & Source		Welsh Government Scorecard	



What the data tells us

Powys Teaching Health Board is again leading Wales in the vaccination of eligible citizens during the Autumn/Winter 2023/24 COVID-19 Booster Campaign. The Campaign started on 11th September 2023 and runs until 31st March 2024. Health Board performance will increase month on month until the end of the current campaign.

Powys Teaching Health Board lead Wales in the vaccination of eligible people for the Spring COVID-19 Booster Campaign. As of June 2023, 72.4% were reported to have been vaccinated close to the 75% cumulative target for this campaign.

Issues

- Data on COVID-19 Vaccination uptake is sourced from PHW surveillance data, which is based on total population, but citizens only become eligible for a booster vaccination if they have completed their primary course. Uptake in those who had completed a primary course was 85.5% in the Spring campaign.
- There was a National delay in carrying out data cleansing exercises for the Immunosuppressed cohorts (delayed from 8th May until 16th June 2023). This led to complexity around invitations for the immunosuppressed groups in the Spring Campaign.
- Vaccination Service underwent an OCP process between February and May 2023, which directly impacted the workforce. Workforce on Fixed Term contracts until March 2024, impacting on recruitment challenges.
- Four nation concern over new BA.4.86 variant impacted on late change and logistical implications in Health Boards delivery plans for the Autumn/Winter 2023/24 Campaign.

Actions | Recovery by: Q4 23/24

- Service redesign during the Spring Campaign with the move from 3 centres to 2 centre model with increased outreach clinics in areas of lower uptake, in line with substantial reduction in funding.
- Thorough cleansing of priority groups over the summer to ensure denominators are more accurate going into the Autumn Booster Campaign.
- Clinical team carrying out targeted interventions for the immunosuppressed group to counsel on the importance of taking up vaccinations.
- Ongoing work to support care homes with completing the correct paperwork for vaccination prior to vaccination teams visiting care homes in the Autumn Campaign.
- Increase local clinics to offer more access to vaccinations in targeted communities.
- Supporting GPs to provide COVID vaccination clinics for their patients.
- Active offers to eligible citizens who have not completed their primary course to increase the number of citizens in each cohort who will be eligible for a booster vaccination

Mitigations

- Utilising PTHBs community hospitals to offer increase in local clinics to outlying communities to improve accessibility to the covid-19 vaccination throughout the duration of the Autumn Campaign to reduce inequity in access.
- Primary course is being reduced from 2 doses to a single dose (2 doses for immunosuppressed) which will allow us to invite a larger proportion of the population for a booster during the Autumn Campaign.

Healthier Wales Quadruple Aim 1

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

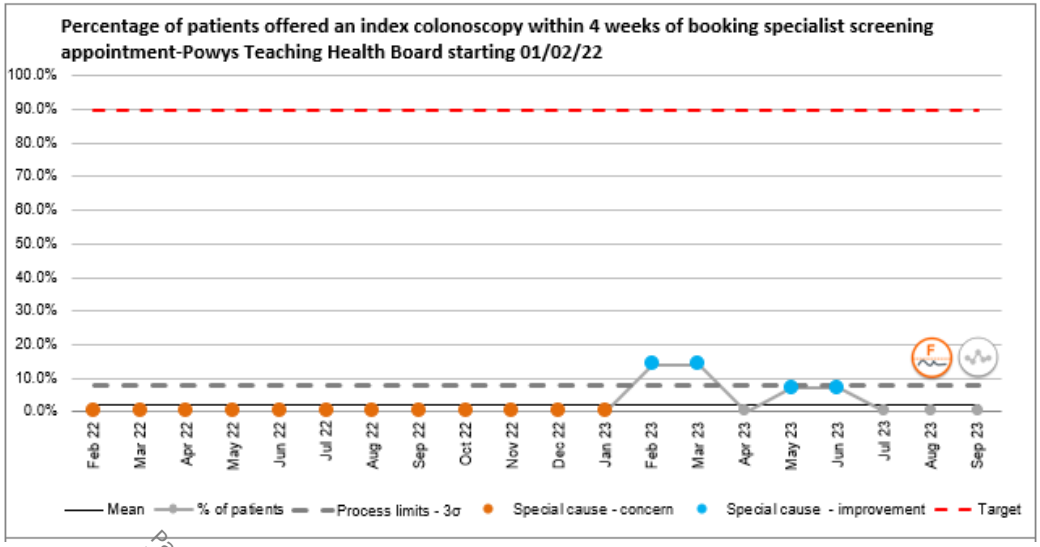
Access & Activity | NHS Performance Measure – 7 | Powys as a provider

New measure for 2023/24

Screening – Percentage of patients offered an index colonoscopy within 4 weeks of booking specialist screening appointment

Executive lead	Interim Executive Director of Operations / Director of Community and Mental Health - TBC	Officer lead	Senior Manager Planned Care	Strategic priority	

Latest available	Sep-23		
Reported performance	0.0%	All Wales benchmark	6th (20.6%)*
Target	90%		
Variance	Common cause		Escalated
Data quality & Source		Welsh Government Scorecard	



What the data tells us

This is a new measure for 2023/24 financial year

Powys performance against this measure is challenged reporting 0.0% in September 2023, All Wales performance is also significantly challenged against this measure.

Due to poor performance compliance this metric has been escalated by the Powys Performance team.

Issues

- Key issues across Wales are linked to the capacity of Endoscopy and the ability to offer diagnostics in a timely manner against target.
- As a large area Powys residents will attend screening outside of PTHB including cross border in England.
- Powys is contracted to carry out Bowel Screening Wales (BSW) activity within its diagnostic/day case units.
- No health board in Wales meets required targets.
- Team leader recruitment under re-assessment following several unsuccessful recruitment rounds.

Actions	Recovery by	No recovery estimate available (RAP in place)

- Regular meetings between local operational leads and the Public Health led Wales screening team (BSW).
- Interim assistant medical director planned care working in partnership with Public Health Wales and clinical leads to review selection criteria and standard operating protocols for endoscopy including bowel screening.
- Requested capacity for bowel screening from commissioned health providers via the CQPRM.
- The Powys Performance team have escalated this new measure, with a remedial action plan requested. This plan will engage with both the provider and commissioner aspects of bowel screening in Powys.

Mitigations

- Successfully recruited to 2x band 6 bowel screening specialist nurses.
- Work ongoing with regional partners around the provision of sustainable services going forward.
- Powys physical capacity (treatment rooms) offered as part of mutual aid for regional solutions.

Healthier Wales Quadruple Aim 2

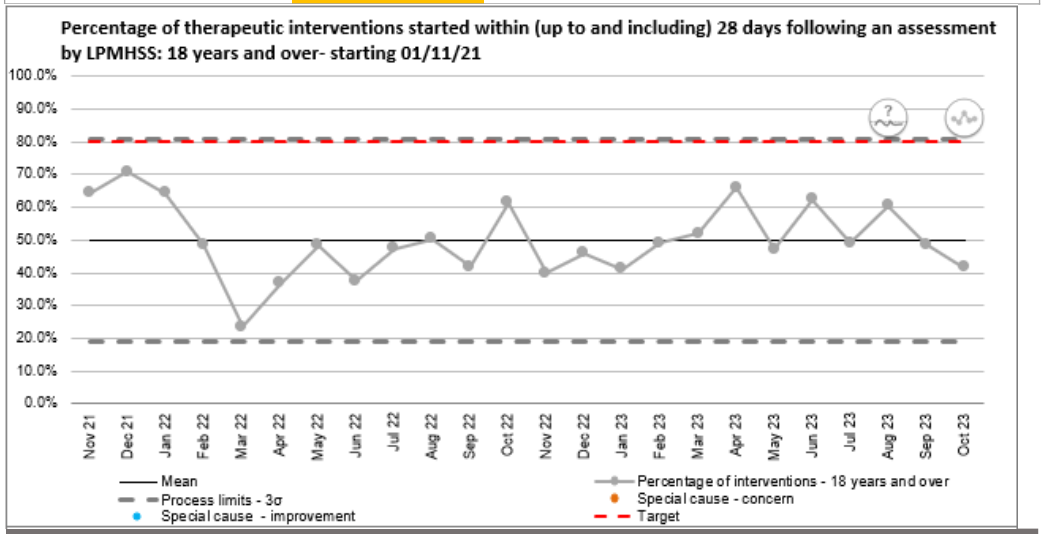
Access & Activity | **NHS Performance Measure - 17** | **Powys as a provider**

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

Mental Health Interventions - Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS for people aged 18 years and over

Executive lead	Interim Executive Director of Operations / Director of Community and Mental Health	Officer lead	Assistant Director of Mental Health	Strategic priority	10

Latest available	Oct-23		
Reported performance	41.7%	All Wales benchmark	*6th (71.3%)*
Target	80%		
Variance	Common cause		Escalation
Data quality & Source		PTHB Mental Health Service	



What the data tells us

- Health board performance for adult interventions has not met the required target of 80% reporting 41.7% in October.
- This is a decline on the 48.5% reported in September.
- This measure remains challenging with reported common cause variation, it is unlikely that this measure will routinely meet the national target without intervention and has been **escalated**.
- PTHB ranks poorly, 6th against the All-Wales position of 71.3% for the September benchmark snapshot available.
- Data quality and timeliness continue to be challenges for the Mental Health submissions with regular retrospective change/validation.

Issues

- Inconsistent data capture across the teams has led to problems with accuracy but this has now been resolved.
- Data entry is duplicated on WCCIS and WPAS with some teams delaying entry on the one system, this backlog causes inaccurate data capture. Deficits in admin capacity in South Powys LPMHSS due to sickness needs to be resolved.
- Work to ensure practices are fully standardised across Powys are ongoing and alignment with Matrics Cymru stepped care model is a longer-term action within the remedial plan

Actions — Recovery by: TBC

- Recovery and Development Plan being implemented; Actions include;
  - •A standard operating procedure (SOP) has been put in place to ensure consistent data capture and align capture of workflow across all areas with weekly touch points arranged to monitor consistency of reporting. This establishes clear Referral to Treatment (RTT) criteria - Tier 1 (part 1b; 28-day RTT) vs Tier 2 (part 2; 26-week RTT) criteria to ensure clients are placed on the appropriate RTT waiting list
  - •Implement clear cancellation and DNA Policy and CBP/DNA rates (north and south)
  - •Introduction of centralised W/L and allocation process with treatment in turn in south Powys
  - Build resilience and flexibility in existing model
  - Improve case management processes including sessional limit and introduction of job plans.
- This measures has been escalated following the internal Integrated Performance Framework performance and engagement meeting with key service leads and clinical staff. A service recovery plan is in place and will be converted into a remedial action plan for Executive review and engagement.

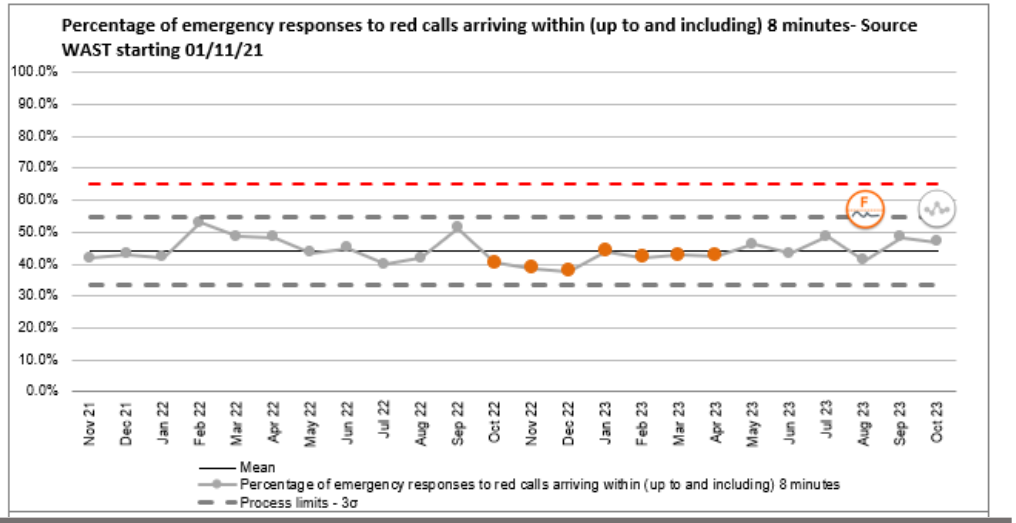
Mitigations

- We expect our Part 1b performance to improve but this may be temporarily affected by the implementation of the Standard Operating Procedures (SOP).
- As mentioned under issues section above, the remedial plan includes a review of current service model against Matrics Cymru stepped care approach, longer term plans to implement actions from review of use of 3rd sector, Silvercloud (inc blended), Psychology and alternative sources of mental health support / talking therapies and explore feasibility of pan-Powys online psychological groups
- A Service Manager position has been put in place to cover LPMHSS and psychology service Pan Powys (FTE to end of March)

Red Calls- Percentage of emergency responses to red calls arriving within (up to and including) 8 minutes

Executive lead	Interim Executive Director of Operations / Director of Community and Mental Health	Officer lead	Senior Manager Unscheduled Care	Strategic priority	11

Latest available	Oct-23		
Reported performance	46.9%	All Wales benchmark	4th (47.2%)
Target	65%		
Variance	Common cause		Exception
Data quality & Source		WAST	



What the data tells us

- The reported performance in October has dropped to 46.9% compliance for the 8-minute emergency response target for red calls.
- Performance is common cause variation with a shift above mean in October 2023.
- PTHB ranks 4th but the All-Wales position for the same period is also poor at 47.2%

Issues

- This is a commissioned service by the health board, as such Powys has limited actions available to resolve issues.
- Handover delays at A&E sites especially Wrexham Maelor, Morriston, Glangwili, Prince Charles Hospital, and the Grange are increasing the time ambulance crews are spent static as opposed to quick turnaround times
- Impact of Covid 19 and industrial action during this period continues to cause significant impact on staff availability and rotas.
- Delayed discharges - for patients declared medically fit for discharge (MFFD) the number occupying hospital beds slowing system flow.

Actions | Recovery by: TBC

- All hospital providers running A&E services have been asked to improve flow so that ambulance turnaround times can be improved
- All Wales urgent care system escalation calls being held daily (often more than once per day)
- Health Boards asked to review Local Options Frameworks. Most Health Board who run acute services have now deployed elements of this service resilience option.
- Action has been taken to improve 'return to footprint' by Powys crews to increase capacity for calls in county.
- New national dashboard ongoing development to provide improved intelligence around challenge and hotspots.

Mitigations

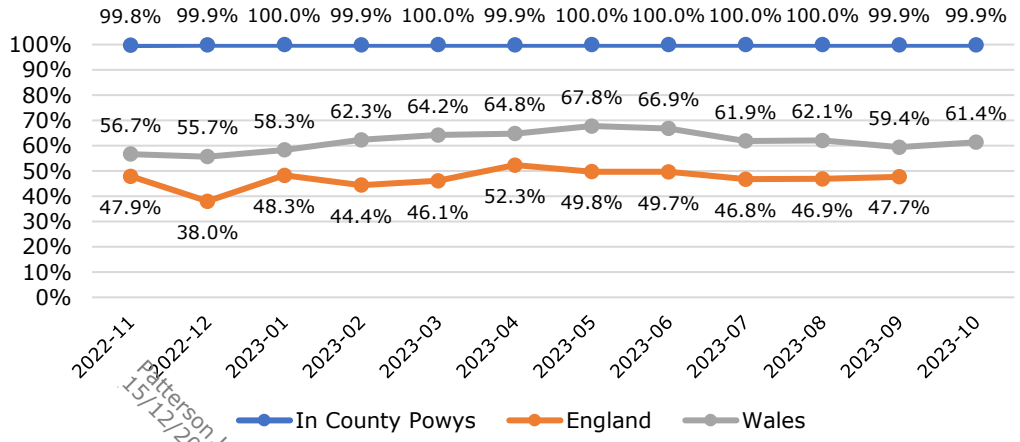
- Wider system calls being held daily with the aim to improve overall system flow.
- Engagement with the Ambulance Service to develop actions to reduce handover delays, including enhancement of current in-county pathways to reduce admission
- Regular meetings are carried out between the health board and WAST, these meeting cover performance, patient experience, incidents and resultant investigations, clinical indicators and staff safety.

Emergency Access - Percentage of patients who spend less than 4 hours in all major and minor emergency care (i.e. A&E) facilities from arrival until admission, transfer or discharge

Executive lead	Interim Executive Director of Operations / Director of Community and Mental Health	Officer lead	Senior Manager Unscheduled Care	Strategic priority	11

Latest available	Oct-23 (Sep-23 England)		
Reported performance	Pow – 99.9% Wal – 61.4% Eng – 47.7%	All Wales benchmark	1st as provider (68.7%)
Target	Wales & England- 95%		
Variance	Powys – Common cause variation		Exception
Data quality & Source		DHCW EDDS	

Percentage of patients who spend less than 4hrs in all major and minor emergency care departments by location – source DHCW EDDS



What the data tells us

- Powys as a provider of care via MIU's continues to provide excellent compliance in meeting the 4hr target. Performance is common cause variation, and the target has not been missed in at least 5 years of reporting.
- Powys residents in Welsh emergency units have had 61.4% compliance against the 4hr target in October.
- Powys residents attending English emergency units see the longest wait with 47.7% (September 2023) meeting the 4hr target.

Issues

- No issues with the Powys MIU's currently reported.
- Powys residents attending English emergency departments generally wait longer to be seen.
- Key issues for acute care providers include high levels of demand with variance across sites.
- Discharge speed for patients effecting the hospitals flow and resulting emergency department congestion.

Actions	Recovery by	N/A

- Reinstatement of Delivery Coordination Group from Q2 2023/24 to focus on key areas of challenge because of increasing pressure.

Mitigations

- Powys as a provider monitors acute providers with daily updates from England and national daily workstream within Wales.
- The provider aim to repatriate patients as soon as possible where appropriate to reduce bed blocks in acute providers.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

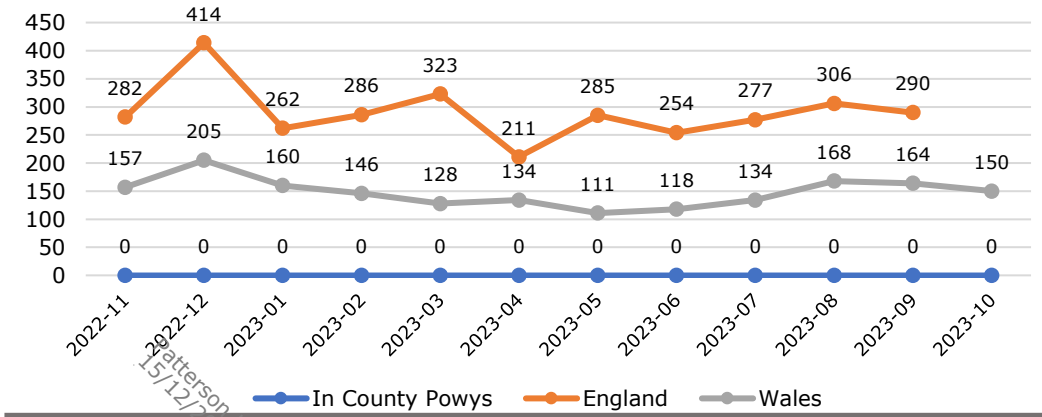
Access & Activity | **NHS Performance Measure - 23** | **Powys residents view**

Emergency Access - Number of patients who spend 12 hours or more in all hospital major and minor emergency care facilities from arrival until admission, transfer or discharge

Executive lead	Interim Executive Director of Operations / Director of Community and Mental Health	Officer lead	Senior Manager Unscheduled Care	Strategic priority	11

Latest available	Oct-23 (Sep-23 England)		
Reported performance	Pow – 0 Wal - 150 Eng - 290	All Wales benchmark	1st as provider (9,934)
Target	Zero		
Variance	N/A		Exception
Data quality & Source			

Number of patients who spend 12 hours or more in all hospital major and minor emergency care facilities from arrival until admission, transfer or discharge – source DHCW EDDS



What the data tells us

- Powys as a provider of care via MIU's continues to provide excellent compliance in meeting the 12hr target. Performance is common cause variation, and the target has not been missed in at least 5 years of reporting.
- Welsh emergency departments are reporting a more stable position when compared to 2022/23 but remain challenged with breaches reducing slightly for the October snapshot.
- English emergency departments are reporting a slight decrease in September in the number of 12hr breaches.

Issues

- No issues with the Powys MIU's currently reported.
- Significant performance variance by provider/unit attended.
- Key issues for acute care providers include high levels of demand with pressure currently building into autumn.
- Discharge speed for patients effecting the hospitals flow and resulting emergency department congestion.

Actions | **Recovery by** | **N/A**

- Powys as a provider monitors acute providers with daily updates from England and national daily workstream within Wales.
- The provider aim to repatriate patients as soon as possible where appropriate to reduce bed blocks in acute providers.

Mitigations

Healthier Wales Quadruple Aim 2

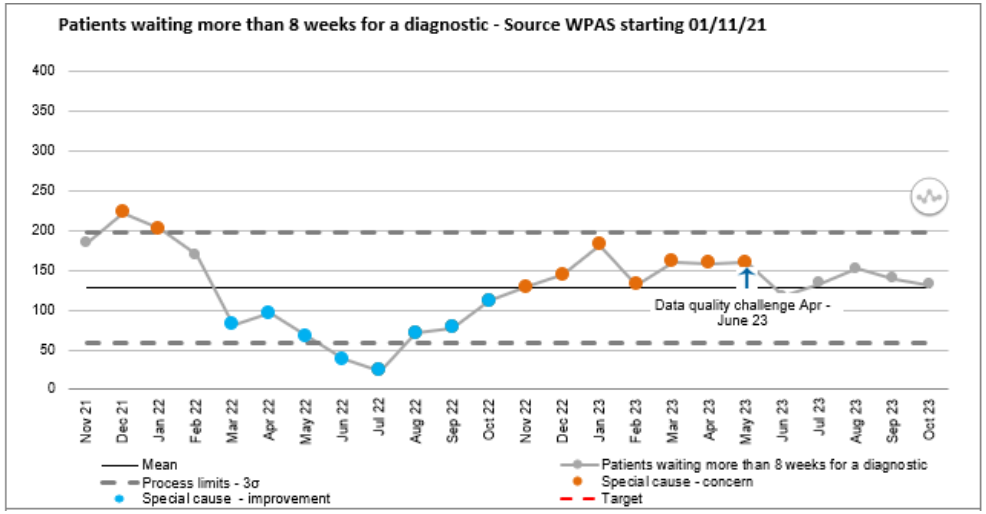
Access & Activity | **NHS Performance Measure - 25** | **Powys as a provider**

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

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

Executive lead	Interim Executive Director of Operations / Director of Community and Mental Health	Officer lead	Assistant Director of Community Services Group	Strategic priority	5

Latest available	Oct-23		
Reported performance	132	All Wales benchmark	1st (51,278)*
Target	PTHB trajectory target <100		
Variance	Common cause		Escalated
Data quality & Source		WPAS	



What the data tells us

This measure includes various diagnostic provisions, echo cardiograms, endoscopy, and non-obstetric ultrasound.

- The health board has reported 132 breaches in October 2023, 73 breaches are for Echo Cardiograms, 36 within Endoscopy, and a 45 reported for Non-Obstetric Ultrasound.
- This measure has not met the PTHB submitted trajectory and remains **escalated**.

Please note detail on Endoscopy detail is available on the next slide

Issues

Non-Obstetric Ultrasound (NOUS)

- North Powys continues to have an in-reach challenge from BCUHB, this is a result of an alternating radiologist specialist e.g., intermittent capacity as a result of only being able to provide alternate specialty for "lumps & bumps" vs Muscular Skeletal (MSK)
- South Powys have a similar challenge with SBUHB effecting capacity type and resulting breaches.

Cardiology

- Cardiology (Echo Cardiogram scans) remain under pressure in South Powys, due to in reach fragility (Aneurin Bevan University Health Board) and increasing demand

Actions	Recovery by
	NOUS - Q4 (but at risk) **Echo Cardiogram – TBC**

Non-Obstetric Ultrasound (NOUS)

- Remedial action plan undertaken 6/9/23, recovery on-track but still fragile for Q3/Q4.
- Use of agency for breaching patients
- Urgent referrals are routed to acute providers
- Demand and Capacity workstream to assess system efficiency and implement improvements
- PTHB have appointed own Sonographers
- Training of sonographer underway for "lumps and bumps".

Cardiology – (Echo Cardiogram)

- Working with in-reach to review capacity due to changes in clinical practice (escalated via CQPRM)
- Development of clinical waiting list validation within reach clinical team – On-going
- Roll –out of GPSI cardiology transformation programme into South Powys, implementation plan in place – start TBC
- Remedial action plan in place but capacity has not yet been identified to recover position.

Mitigations

Non-Obstetric Ultrasound (NOUS)
Continuous monitoring of waiting list

Cardiology
Escalated via CQPRM, capacity shortfall escalated as part of in sourcing proposal

Diagnostics – Number of patients waiting more than 8 weeks for a specified diagnostic (Endoscopy specific narrative)

Executive lead	Interim Executive Director of Operations / Director of Community and Mental Health	Officer lead	Assistant Director of Community Services Group	Strategic priority	5

What the data tells us

When looking at Endoscopy specifically breaches have increased from the previous month (25) with 36 patients now breaching target in October.

Issues

- In-reach clinician fragility resulting in service gaps and clinical handover challenges, this is caused by the retirement in Q2 2022/23 of Clinical Director, awaiting formal replacement proposal from Cwm Taf Morgannwg UHB (CTMUHB) as an outstanding risk to service.
- General surgery capacity does not meet demand, routine and urgent pathways wait longer as Urgent Suspected Cancer is prioritised.
- Colonoscopy capacity is insufficient without supplementary insourcing
- Bowel screening (BS) FIT test changes from Oct-22 have increased demand.
- Delays in DGH diagnostics, especially Histology/Pathology risk timeliness of pathways including USC.
- Staff challenges including senior clinical lead for theatres vacancy since June 2022 (now recruited too)

Actions

Recovery by

Backlog recovery potential by Mar-24 if insource capacity confirmed.

- Additional capacity has recommenced via insource from November 2023 to support backlog clearance for both outpatients and diagnostic general surgery.
- Service have escalated the CTMUHB in-reach fragility, and diagnostic challenges for histology & pathology (this is currently reported as a high risk for the health board). Proposal being developed by CTM to address (awaited).
- Cancer pathways and patient tracking review in the provider underway (currently in-reach capacity impacts on recorded patient waits).
- Mutual aid and offer of repatriation still open for gastro patients from Wye Valley NHS Trust to Llandrindod Wells Hospital (ongoing with ABUHB support).
- Trans nasal endoscopy (TNE) standard operating procedure awaiting approval, specialist equipment acquisition underway, clinical specialist training underway with regional workstream. TNE in Llandrindod Wells has been delayed to Q4 2023/24, awaiting ratification of clinical protocols.
- Start of sponge capsule (cytosponge) from 2nd October in PTHB as enhanced diagnostic improving patient experience and reducing demand on staffing resource. Feedback so far has been excellent from both staff and patients.
- Remedial action plan in place and under regular review to enhance scrutiny and support of challenge, this action plan however is for general surgery specialty which is key demand driver/in-reach specialty for endoscopy in south Powys.
- Review of standard operating procedures (SOP's) and related documentation with an aim for service improvement & efficiencies.

Mitigations

- Rolling programme of clinical and administrative waiting list validation.
- Additional in-sourcing capacity requested but awaiting financial package confirmation to allow utilisation.
- Working at Regional level to support service sustainability offering estate capacity endoscopy suite as part of regional solution mutual aid
- Powys physical capacity (treatment rooms) offered as part of mutual aid for regional solutions.
- PTHB has improved capacity for Gastroscopy following training of JAG accredited clinical endoscopists.
- Recruitment complete for 8b Senior clinician theatre endoscopy.
- Interim fixed term Assistant Medical Director Planned Care currently reviewing SOP's with the aim of improving service methods and efficiencies.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

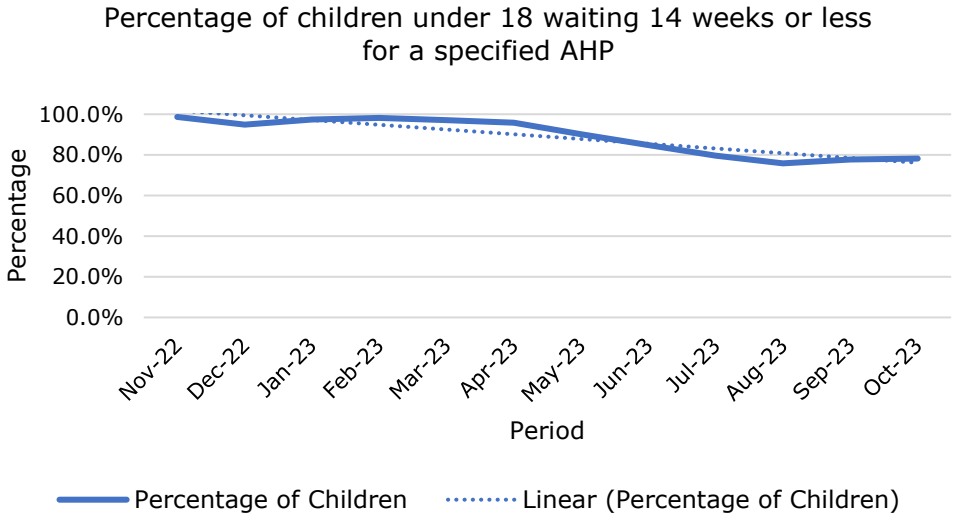
Access & Activity | **NHS Performance Measure - 26** | **Powys as a provider**

New measure for 2023/24

Percentage of children under 18 waiting 14 weeks or less for a specified Allied Health Professional (AHP)

Executive lead	Interim Executive Director of Operations / Director of Community and Mental Health	Officer lead	Assistant Director of Community Services Group	Strategic priority	5

Latest available	Oct-23		
Reported performance	78.1%	All Wales benchmark	6th (82.5%)*
Target		12-month improvement trend	
Variance	N/A		Escalated
Data quality & Source		PTHB Information team (IFOR)	



What the data tells us

- The percentage of young people (<18s) who are waiting under 14 weeks for a specified allied health professional (AHP) has improved but does not meet the 12-month improvement trend reporting 78.1% in October.
- 79 patients breach 14 weeks in total, predominately these breaches are within speech and language therapy (60 breaches), with a limited number in Occupational Therapy (17) and a further 2 in physiotherapy and podiatry.
- This measures has been **escalated** from Month 6 as part of the larger therapies escalation as confirmed by service leads.

Issues

- Majority of breaches are within speech and language therapy linked to the key challenges;
  1. Significant staffing vacancy
  2. Unrecognised backlog of long waiting patients
  3. High caseload demand
- General challenge of staffing and sickness across all therapy's specialties.

Actions — Recovery by: March-24

- Remedial action plan undertaken by services for escalation as required.
- New standard operating procedure in place (SOP) to improve service processes.
- Demand and capacity work is being undertaken to improve flow.
- Recruitment plans underway:
  1. 3x 1.0 Whole time equivalent (WTE) band 5 staff now commenced
  2. 1.2 WTE band 3 staff has started and are supporting delivery of therapy.
  3. Team working in more defined episodes of care to reduce cases open for extended periods of time.

Mitigations

- Parents/carers have been offered to attend training/education (which is part of the pathway) whilst on the waiting list (Waiting well) following triage so they can start to implement strategies.

Healthier Wales Quadruple Aim 2

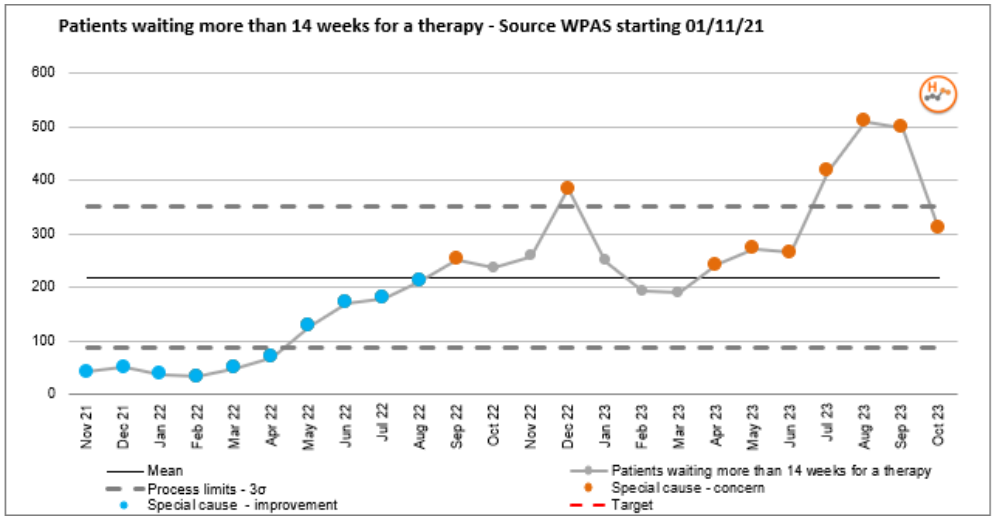
Access & Activity | **NHS Performance Measure - 27** | **Powys as a provider**

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Number of patients waiting more than 14 weeks for a specified therapy (Inc. Audiology)

Executive lead	Interim Executive Director of Operations / Director of Community and Mental Health	Officer lead	Assistant Director of Community Services Group	Strategic priority	5

Latest available	Oct-23		
Reported performance	312	All Wales benchmark	2nd (10,974)*
Target	PTHB Trajectory – =<20 (Oct-23)		
Variance	Special cause concern		Escalated
Data quality & Source		PTHB Information warehouse	



What the data tells us

- 312 patients breached the 14-week target in October, this is a significant reduction in the number of breaches.
- The SPC chart continues to flag special cause concern for the last 6 months.
- As the measure is has not met the required target since December 2021 it remains **escalated** to Service & Executive lead.
- This measure does not meet the submitted trajectory of 20 or less breaches failing the ministerial priority target set by the health board.
- Key breaching specialties include adult audiology, adult physiotherapy, routine podiatry, and speech and language therapy.

Issues

- Musculoskeletal (MSK), Podiatry, and Speech and Language Therapy (SALT) all have severe challenges to workforce and resultant capacity. These workforce problems are caused by both vacancies and long-term sickness in key subspecialties.
- MSK pelvic health service provided by 2 clinicians (pan Powys) 1 clinician is currently unavailable due to long term sickness. Locum in place for virtual consultations
- Podiatry is challenged by 33% vacancy pan Powys impacting on capacity of service.
- Speech and Language unable to recruit or resource to support transgender/voice speech and language specialty
- Follow-up (FUP) caseload backlog impacting on new booking capacity
- Challenges with core reporting support escalated with Digital Transformation team.

Actions	Recovery by	Mar-24 (details in mitigations)

- Weekly management of waiting lists by Heads of Service.
- Remedial action plan templates completed for all challenge specs for escalated with significant improvement expected by March 2024.
- Additional locum to support MSK physiotherapy, and new graduate (now commenced September 2023)
- Caseload review across all therapies, each head of service to have plan in the Community Service Group (excluding Paediatrics OT/Physio) .
- Podiatry (clinical) has increased their clinical job plans from 1 sessions per week to 4 sessions a week which results in their operational management capacity being reduced – we are unable to recruit locum to vacancies at present in these areas
- SALT – Head of service reviewing on weekly basis. SALT –maternity leave in team, locum in place to cover; all long waits booked.

Mitigations

<u>Improvement planned for full recovery by *Mar-24</u>

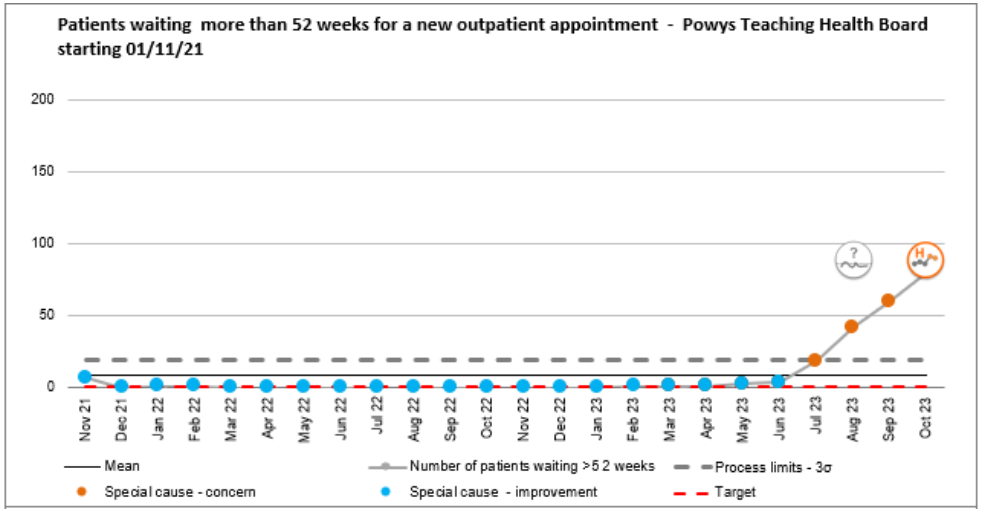
- MSK physiotherapy planned Q3 23/24
- Podiatry planned Q4 23/24
- Speech and language therapy Q4 23/24

*Projections are based on recruitment plan/return to work, and that no other incidents of long-term sickness or maternity leave occur which results in capacity challenge/gaps in service.

New Outpatient – Number of patients waiting over 52 weeks for a new outpatient appointment

Executive lead	Interim Executive Director of Operations / Director of Community and Mental Health	Officer lead	Assistant Director of Community Services Group	Strategic priority	5

Latest available	Oct-23		
Reported performance	80	All Wales benchmark	1st (51,652)*
Target	PTHB Trajectory – 0 (Oct-23)		
Variance	Special cause - concern		Escalated
Data quality & Source		DHCW	



What the data tells us

- Powys as a provider is starting to see slippage against this measure and its target, October reports 80 pathways waiting over 52 weeks for a new outpatient appointment.
- This measure continues to show special cause concern as breaches continue a shift beyond the upper control limit.
- This measure breaches the Powys set trajectory for 2023/24 of zero patients waiting for a new outpatient appointment over 52 weeks and remains **escalated**.
- 80.8% of all the over 52-week waiters in PTHB are stage 1.

Issues

- Specific issues for the Rheumatology breaches include increased demand from long COVID-19, consultant availability as a result of short notice in-reach fragility (patient was not suitable for alternative e.g., specialist nurse attendance or virtual solution)
- Ongoing risk of fragile in-reach consultant led pathways within the provider, General Surgery is particularly fragile with significant capacity deficit.
- Increased demand of urgent and urgent suspected cancer referrals impacting on routine referrals especially in General Surgery, this short fall of capacity will cause significant challenge in meeting planned care measures

Actions	Recovery by	Backlog recovery potential by Mar-24 if insource capacity confirmed.

- Additional capacity has recommenced via insource from November 2023 to support backlog clearance for key challenge specialties.
- Review of inter provider pathways with CTMUHB around general surgery, endoscopy and USC pathways commenced Q1 2023/4
- In reach service fragility and capacity issues flagged via CQPRM
- Progressing additional in reach support with Commissioning
- Baseline assessment review of PTHB services against GIRFT OP recommendations undertaking with implementation plan under development
- OPD reviewing use of virtual Age-Related Macular Degeneration (AMD) group clinics
- Remedial action plan templates created for senior escalation on key challenged specialties.

Mitigations

- Outpatient transformation focussing on MDT approach to ensure patient seen at right time by right PTHB clinician – to support improvements in access times, care closer to home, environmental impact less miles travelled
- Utilising in reach to support capacity shortfalls in oral surgery & general surgery.
- Reviewing use of see on symptoms (SOS)/ patient-initiated follow-ups (PIFU) across specialities.
- Managing service level agreements for Planned Care via PTHB Commissioning assurance framework process within reach providers.
- Recruitment complete for 8b Senior clinician theatre endoscopy.
- Interim fixed term Assistant Medical Director Planned Care currently reviewing SOP's with the aim of improving service methods and efficiencies.

Healthier Wales Quadruple Aim 2

Access & Activity | **NHS Performance Measure - 29** | **Powys as a provider**

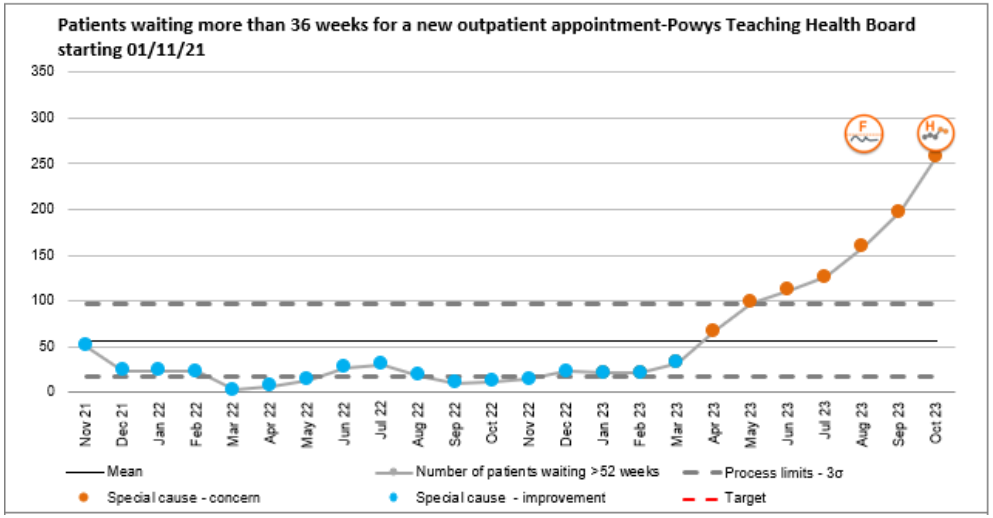
Bwrdd Iechyd Addysgu Powys / Powys Teaching Health Board

New measure for 2023/24

New Outpatient – Number of patients waiting over 36 weeks for a new outpatient appointment

Executive lead	Interim Executive Director of Operations / Director of Community and Mental Health	Officer lead	Assistant Director of Community Services	Strategic priority	5

Latest available	Oct-23		
Reported performance	257	All Wales benchmark	1st (107,108)*
Target	PTHB trajectory – 20 (Oct-23)		
Variance	Special cause - concern		Escalated
Data quality & Source		DHCW	



What the data tells us

- Current performance has shifted away from expected trajectory with an increase to 257 patients waiting over 36 weeks for a new outpatient appointment (stage 1).
- This measures is flagging as **escalated** and is of special cause concern, it fails to meet the ministerial priority target of 20 or less breaches and the data shows a system out of control without intervention.

Issues

- In-reach clinician fragility resulting in service gaps and clinical handover challenges, this is caused by the retirement in Q2 2022/23 of Clinical Director, awaiting formal replacement proposal from Cwm Taf Morgannwg UHB (CTMUHB) as an outstanding risk to service.
- General surgery capacity even does not meet demand, routine and urgent pathways wait longer as USC prioritised to all available clinic/diagnostic slots.
- Delays in DGH diagnostics (soft tissue & nerve conduction in particular) Histology/Pathology risk timeliness of pathways including USC.
- Other challenging specialties within the provider include ENT, Orthopaedics, Ophthalmology and Rheumatology due to increased demand/reduced capacity due to in-reach fragility or diagnostic requirements.
- In-reach Anaesthetics is a particular challenge with cover provided by in-source
- Fragility of PTHB staffing and recruitment challenges nationally

Actions	Recovery by	**Backlog recovery potential by Mar-24 if insource capacity confirmed.**

- Service have escalated the CTMUHB in-reach fragility, and diagnostic challenges for histology & pathology (this is currently reported as a high risk for the health board). Proposal being developed by CTM to address (awaited).
- Any patients requiring urgent treatment are transferred to DGH urgent pathways if immediate lists are not available in PTHB.
- Job description reviewed & banding uplift for Senior Clinician Theatres/Endoscopy with recruitment be undertaken in Jul/Aug 2023, successful appointment made candidate to commence 16th Oct 2023
- Interim fixed term Assistant Medical Director Planned Care in post from 28th Sept 1 session per week for 3 months whilst substantive position is re-advertised.
- Measure has been escalated and waiting list challenges raised via the new Performance and Engagement group with remedial action plans created.

Mitigations

- Improvement work to manage waiting lists in line with the National Planned Care Programme Outpatient Transformation , Speciality Clinical Networks and Regional Programmes continues with activity levels closely monitored locally via the daily review of patient lists and weekly RTT meetings.
- Standard Operating Procedures (SOPS) continually reviewed in line with updated Royal College, PHW and national guidance.

Healthier Wales Quadruple Aim 2

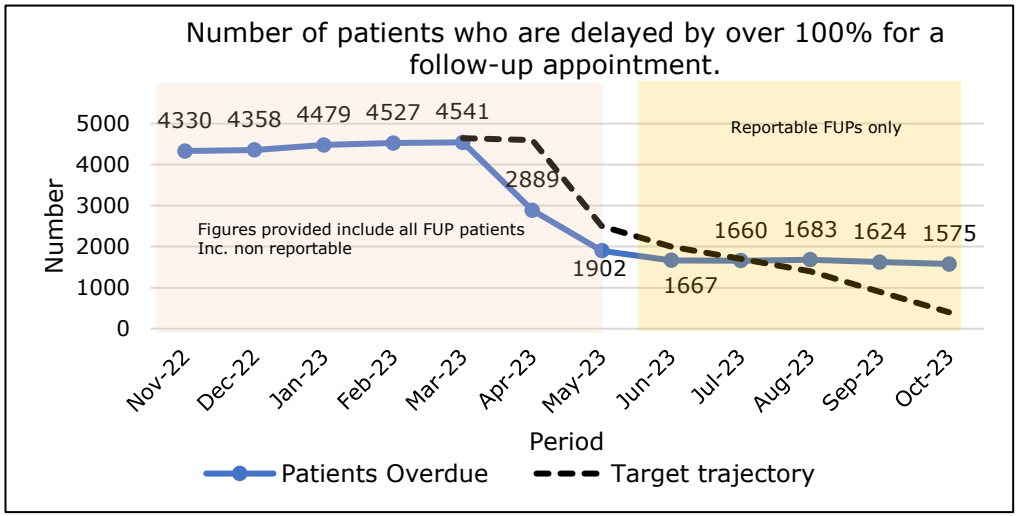
Access & Activity | **NHS Performance Measure - 30** | **Powys as a provider**

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Follow Up Outpatient (FUP) – Number of patients waiting for a follow-up outpatient appointment who are delayed by over 100%

Executive lead	Interim Executive Director of Operations / Director of Community and Mental Health*	Officer lead	Assistant Director of Community Services*	Strategic priority	5

Latest available	Oct-23		
Reported performance	1575	All Wales benchmark	1st (247,276)
Target	PTHB set trajectory target equal or less than 400 (Oct-23)		
Variance	N/A		Escalated
Data quality & Source		WPAS	



What the data tells us

- PTHB is reporting "reportable" only FUP's to Welsh Government (WG) from April as required by the national measure. Prior to this figures reported to board included all FUP pathways overdue.
- It should be noted that the recovery trajectory was set for 2023/24 included all FUP's within the calculation.
- This measure remains in an **escalated** state as not meeting the submitted trajectory of 400 or less for October and until the data quality issues are satisfactorily resolved.

Issues

- Reporting was updated to use National teams digital reporting stored procedure which returned significantly more pathways 2021/22.
- Digital & Transformation (D&T) team capacity limitations required Performance & Ops service lead Phase 1 validation to be undertaken without the closure/fixing of incorrect pathways (this left a significant number of pathways that could not be closed by the service due to system problems). Phase 2 validation supported by D&T was unable to start until circa 12 months later, ongoing phases of validation underway with services.
- Ongoing incorrect reported volumes result in challenges for service demand planning.
- Service capacity pressure prioritising urgent, and USC pathways, which in turn places pressure of compliance on routine and FUP pathways.
- Clinical teams do not consistently use see on symptoms (SOS) and patient-initiated pathways (PIFU) which can result in overdue standard FUP pathways.
- Formal recovery trajectory set as part of the ministerial priorities to have no breaches reported by November 2023, this is an ambitious target and will not be achieved by March.
- Capacity challenges in planned care result in prioritisation of USC, urgent appointments with routine and FUP appointment timeliness impact.

Actions — Recovery by: Nov-23

- D&T team continue to progress with Phase 4 (183 records have been cleansed of 211 flagged). Phase 5 validation is currently underway with a further 196 records flagged for validation.
- Commencing use of PIFU pathways in WET AMD from November 2023 to improve care pathways for frail patients.
- Operational services continue to support the validation of records and provide challenge identification for the D&T team to investigate.

Mitigations

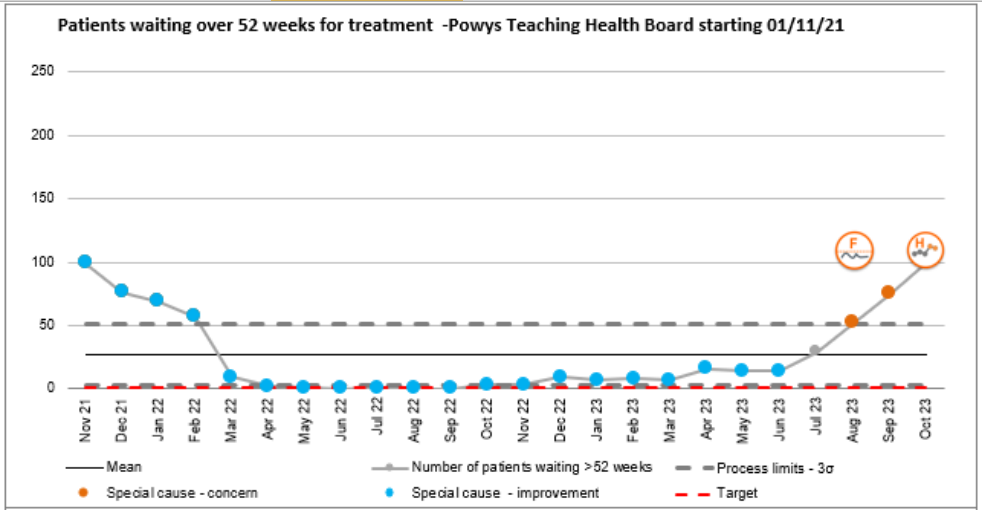
- Reportable waiting lists are clinically validated, and risk stratified in addition to administrative waiting list validation, this is carried out to reduce the risk to pathways.
- Work with services during 2023/24 to implement the correct use of see on symptoms (SOS) and patient initiated FUP (PIFU) pathways to reduce the incorrect usage of a "standard" FUP pathway resulting in +100% waiters who are actually a PIFU.
- Investigatory group for FUP validation meeting regularly with deep dive in quarter 4.

* This measure and they follow-up investigation, validation and recovery is currently led by the Interim Director of Performance & Commissioning and Director of Finance and ICT and Interim Deputy Chief Executive.

Referral to Treatment – Number of patients waiting more than 52 weeks for treatment

Executive lead	Interim Executive Director of Operations / Director of Community and Mental Health	Officer lead	Assistant Director of Community Services Group	Strategic priority	5

Latest available	Oct-23		
Reported performance	99	All Wales benchmark	1st (133,519)*
Target	PTHB Trajectory - 0		
Variance	Special cause - concern		Escalated
Data quality & Source		DHCW	



What the data tells us

- The health board has failed to meet the submitted trajectory of zero or less breaches in October with an increase to 99 patients waiting over 52 weeks for treatment.
- The measure still reports special cause concern and performance continues to shift above the upper control limit.
- As a ministerial priority that is not meeting the PTHB set trajectory it remains **escalated**.

Issues

- In-reach clinician fragility resulting in service gaps and clinical handover challenges, this is caused by the retirement in Q2 2022/23 of Clinical Director, awaiting formal replacement proposal from Cwm Taf Morgannwg UHB (CTMUHB) as an outstanding risk to service.
- General surgery capacity even does not meet demand, routine and urgent pathways wait longer as USC prioritised to all available clinic/diagnostic slots.
- Delays in DGH diagnostics (soft tissue & nerve conduction in particular) Histology/Pathology risk timeliness of pathways including USC.
- Other challenging specialties within the provider include ENT, Orthopaedics, Ophthalmology and Rheumatology due to increased demand/reduced capacity due to in-reach fragility or diagnostic requirements.
- In-reach Anaesthetics is a particular challenge with cover provided by in-source
- Fragility of PTHB staffing and recruitment challenges nationally

Actions	Recovery by	Backlog recovery potential by Mar-24 if insource capacity confirmed.

- Service have escalated the CTMUHB in-reach fragility, and diagnostic challenges for histology & pathology (this is currently reported as a high risk for the health board). Proposal being developed by CTM to address (awaited).
- Any patients requiring urgent treatment are transferred to DGH urgent pathways if immediate lists are not available in PTHB.
- Capacity requirements provided for insourcing consideration corporately Q1 2023/4
- Recruitment to Clinical Director Planned Care new medical leadership post revised timeline now Q4 2023/24
- Measure has been escalated and waiting list challenges raised via the new Performance and Engagement group with remedial action plans created.

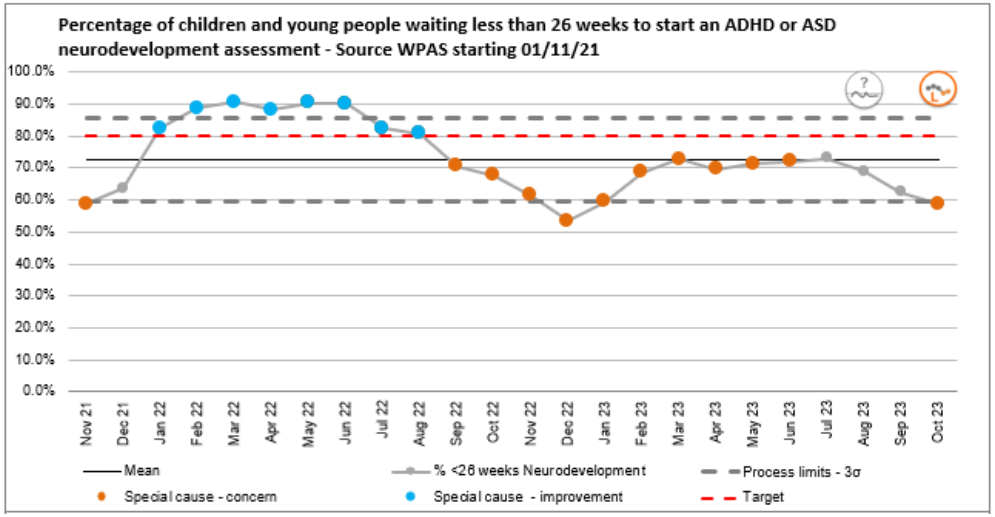
Mitigations

- Improvement work to manage waiting lists in line with the National Planned Care Programme Outpatient Transformation , Speciality Clinical Networks and Regional Programmes continues with activity levels closely monitored locally via the daily review of patient lists and weekly RTT meetings.
- Standard Operating Procedures (SOPS) continually reviewed in line with updated Royal College, PHW and national guidance.
- Recruitment complete for 8b Senior clinician theatre endoscopy.
- Interim fixed term Assistant Medical Director Planned Care currently reviewing SOP's with the aim of improving service methods and efficiencies.

Neurodevelopment (ND) Assessment – Percentage of children and young people waiting less than 26 weeks to start an ADHD or ASD neurodevelopment assessment

Executive lead	Interim Executive Director of Operations / Director of Community and Mental Health	Officer lead	Assistant Director of Women's and Children's	Strategic priority	10

Latest available	Oct-23		
Reported performance	58.7%	All Wales benchmark	1st (29.3%)*
Target	80%		
Variance	Special cause - concern		Exception
Data quality & Source		WPAS	



What the data tells us

- Performance for neurodevelopmental assessment has fallen to below the lower control limit in October (58.7%), if performance does not recover this will result in an escalation event and will require a remedial action plan.
- Performance is flagged as special cause concern
- Although not meeting target PTHB benchmarks positively against the All-Wales position routinely.

Issues

- The average referral rate of 20 per month pre COVID has drastically increased again during Qtr2 to 69 per month in 2023/24 thus far. This peaked to 108 in July 2023.
- From April 2022 the ND service has been in receipt of non-recurrent funding via the Regional Partnership Board's (RPB) Revenue Integration Fund (RIF) (2022-26) plus Welsh Government Neurodivergence monies (2022-25), all of which is supporting temporary staff to address the RTT and waiting list backlog.
- The Referral To Treatment (RTT) time position, and the 'Assessments in progress' backlog has not reduced as anticipated due to the overwhelming referral demand and deficient workforce.
- Given the consistent increase in referral demand since June 2021, ND waiting lists have not been addressed to a satisfactory position as of 31st October 2023.

Actions — Recovery by: TBC

- As a result of continued demand pressure, the Neurodevelopment service is prioritising patients waiting for first appointment, and those patients whose assessment is in progress.
- As part of the Powys Integrated Performance Framework approach the Womens & Childrens services will be undertaking the Performance and Engagement group work from Q4 2023/24.

Mitigations

- The RTT waiting list and assessments in progress backlog continue to be a focus for the ND service.
- However, capacity remains insufficient to meet the referral demand even with additional Revenue Integration Funding (RIF) posts.
- The ND Remodel business case is being considered by IBG Scrutiny Panel November 2023, and temporary staff positions have been extended until at least March 2025.

Powys resident – Commissioned referral to treatment waits (RTT)

Executive lead	Interim Executive Director of Planning, Performance and Commissioning	Officer lead	Assistant Director of Performance & Commissioning	Strategic priority	5

	Oct-23	No. long waits by cohort, with latest SPC variance						
Welsh Providers	% of Powys residents < 26 weeks for treatment (Target 95%)	Over 36 wks (inc 52 and over 104)		over 52 wks (inc over 104)		Over 104 weeks		Total Waiting
Aneurin Bevan Local Health Board	67.2%	616		363		60	L	2556
Betsi Cadwaladr University Local Health Board	46.6%	280	H	189		56		713
Cardiff & Vale University Local Health Board	52.6%	138		91	L	15	L	407
Cwm Taf Morgannwg University Local Health Board	61.9%	177	L	106	L	11	L	628
Hywel Dda Local Health Board	56.1%	470	L	258	L	46	L	1497
Swansea Bay University Local Health Board	57.6%	579	L	349	L	114	L	1943
Total	59.5%	**2260**	L	**1356**	L	**302**	L	**7744**

	Sep-23	No. long waits by cohort, with latest SPC variance						
English Providers	% of Powys residents < 26 weeks for treatment (Target 95%)	Over 36 wks (inc 52 and over 104)		over 52 wks (inc over 104)		Over 104 weeks		Total Waiting
English Other	70.9%	41		14		0	L	265
Robert Jones & Agnes Hunt Orthopaedic & District Trust	60.2%	845	H	383	L	11	L	3301
Shrewsbury & Telford Hospital NHS Trust	67.9%	685	L	203	L	0		3862
Wye Valley Trust	63.8%	789	H	256	H	0	L	3626
Total	64.3%	**2360**		**856**	L	**11**	L	**11054**

What the data tells us

Commissioned services in Wales are reporting slow improvement across the long wait metrics of +104, over 36 weeks, and new OP 52+ weeks.

The table below is for Welsh providers and can be used to view relative improvement of waiting lists.

Wales Measures	Oct-22	Oct-23
Total pathways over 36 weeks	2552	2260
Pathways waiting +52 new outpatient	712	316
Pathways waiting 104+ weeks	606	302

English providers still report an improved position when compared to waiting pathways in Wales. Very long waits 104+ weeks are limited to RJAH consisting of complex spinal cases. It should be noted that Wye Valley Trust pathway size are flagged as special cause concern because of growth in the 36+ and over 52 week wait bands totals.

English Measures	Sep- 22	Sep-23
Total pathways over 36 weeks	2446	2360
Pathways waiting 104+ weeks	12	11

Powys residents are being impacted by significant geographical equity for care, especially those who have waited and remain waiting over 2 years for treatment. English acute health trusts providing a better service for residents in the North & East of the county. Those residents who live within the southwest health economy have the poorest access times for treatment and wait the longest.

Return to provider RTT slides

Powys resident – Commissioned referral to treatment waits (RTT)

Executive lead	Interim Executive Director of Planning, Performance and Commissioning	Officer lead	Assistant Director of Performance & Commissioning	Strategic priority	5

Issues

- PTHB continues to work with commissioned service providers to obtain an understanding of referrals, demand and capacity, waiting list profiles at specialty level and convert outpatients into Indicative Activity Plans including detail on anticipated performance trajectories to deliver against NHS Wales and NHS England targets 2023/24. Recovery forecasts for waiting lists across all providers have been particularly challenging with increased demand, and staffing fragility impacting through put.
- English and Welsh providers reporting workforce challenges including clinical staff retirements, recruitment, industrial action.
- Powys residents are being impacted by significant geographical equity for care, especially those who have waited and remain waiting over 2 years for treatment. Patients who can have their pathways within the Powys as a provider have the quickest reported care, and with English acute health trusts providing more timely access for residents in the North & East of the county. Those residents who live within the southwest health economy have the poorest access times for treatment and wait the longest.
- Data access and quality provide ongoing challenges for waiting list review and engagement in a timely manner.

Actions	Recovery by	Commissioned service trajectories – awaited from providers

- Welsh & English providers, including Powys provider services have mobilised additional capacity be that insourcing, outsourcing or the increase usage of additional payments for clinical activity.
- Ongoing work with NHS Wales Delivery Unit around weekly Welsh waiting list provision including information on pathways such as staging, actual wait time, and identifiers to help with commissioned service engagement.
- Ongoing repatriation scoping workstream for Powys residents who may be able to have treatment/care within PTHB or alternative provider.
- The health board continues to engage on a regular basis with all commissioned providers via contracting, quality and performance meetings. These meetings are used to discuss challenges and highlight key concerns but primarily to support the best possible care for Powys responsible patients within current health contracts. Also note progress against GIRFT pathway and case mix recommendations are discussed and noted.
- Opportunities being explored with RJAH for increased insourcing capacity for high volume, low complexity long waiting orthopaedic patients to be repatriated to PTHB.
- Long waiting patients: Through contracting, quality and performance meetings commissioned service providers requests to provide assurance that all long waiting patients are contacted to ensure that they have access to support and information whilst waiting for their appointment, actions that they can take to keep themselves well and to confirm the prehab support offered to patients to ensure that they are fit for their proposed treatment. PTHB developing proposal to secure additional insourced capacity.
- Health Boards have received additional funding to ensure patients waiting over 104 weeks are treated during 2023/24, the majority of PTHB patients in this cohort are sitting with commissioned providers.
- PTHB to use 'Your NHS Experience' survey to obtain feedback from patients accessing commissioned services.

Mitigations

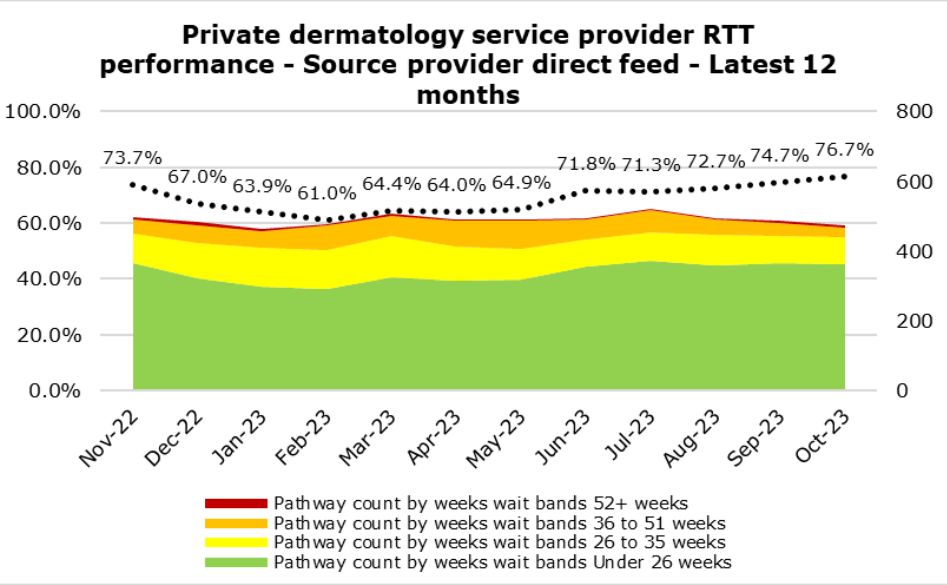
All patients waiting are being managed in accordance with clinical need, clinical surgical prioritisation and duration of wait.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Access & Activity | **NHS Performance Measure** | **Powys contracted**

Insourcing/Outsourcing - Private dermatology service provider – Referral to Treatment (RTT)

Executive lead	Interim Executive Director of Planning, Performance and Commissioning	Officer lead	Assistant Director of Performance & Commissioning	Strategic priority	5



Snapshot month	% under 26 weeks	Pathway count by weeks wait bands				Total Waiting
		Under 26 weeks	26 to 35 weeks	36 to 51 weeks	52+ weeks	
Nov-22	73.7%	367	83	41	7	498
Dec-22	67.0%	323	101	48	10	482
Jan-23	63.9%	297	113	47	8	465
Feb-23	61.0%	291	113	68	5	477
Mar-23	64.4%	326	116	57	7	506
Apr-23	64.0%	315	98	75	4	492
May-23	64.9%	318	88	80	4	490
Jun-23	71.8%	354	79	58	2	493
Jul-23	71.3%	371	81	64	4	520
Aug-23	72.7%	359	89	41	5	494
Sep-23	74.7%	364	79	36	8	487
Oct-23	76.7%	362	78	28	4	472

What the data tells us

In October 2023, the provider RTT performance has shown further improvement to 76.7% of the waiting list being under 26 weeks. Patients that wait over 36 weeks has reduced from 44 (September) to 32 in October with a corresponding reduction of pathways over 1 year (4).

Issues

- Patients waiting > 52 weeks.
- Reduced NHS contract capacity for routine (Wye Valley NHS Trust). Currently exploring alternative providers including capacity commissioned from private provider.

Actions | Recovery by: N/A

- Private provider requested to confirm mitigating actions for patients waiting 52 weeks and over.
- Scoping exercise being undertaken to identify additional capacity requirements (routine).

Mitigations

- None reported

Please note that the RTT data has been updated for the 2023/24 financial year. Non-Powys responsible patients were included within the return and have now been validated and removed. This has improved the compliance for every single month from April for both percentage under 26 weeks and long waiters.

Healthier Wales Quadruple Aim 2

Access & Activity | **NHS Performance Measure** | **Resident Access**

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Powys resident – Commissioned Cancer Waits

Executive lead	Interim Executive Director of Planning, Performance and Commissioning	Officer lead	Assistant Director of Performance & Commissioning	Strategic priority	5

Welsh Single Cancer Pathway Performance Powys Residents "Percentage of patients who started treatment within target (62 days from point of suspicion)" target 75% - Source DHCW

Provider	2022-11	2022-12	2023-01	2023-02	2023-03	2023-04	2023-05	2023-06	2023-07	2023-08	2023-09	2023-10
Aneurin Bevan Local Health Board	48%	48%	56%	82%	85%	69%	55%	56%	69%	67%	55%	65%
Betsi Cadwaladr University Local Health Board	38%	53%	29%	20%	29%	100%	63%	57%	25%	100%	0%	100%
Cardiff & Vale University Local Health Board	100%	0%	0%									
Cwm Taf Morgannwg University Local Health Board	0%	50%	20%	25%	33%	29%	75%	0%	50%	33%	67%	43%
Hywel Dda Local Health Board	57%	57%	20%	57%	20%	56%	17%	13%	63%	100%	50%	43%
Swansea Bay University Local Health Board	60%	100%	38%	67%	50%	33%	50%	25%	100%	50%	80%	17%
Total number treated within target (numerator)	26	26	19	20	29	17	16	15	20	18	16	19
Total pathways that started treatment (denominator)	52	50	51	37	46	32	31	39	33	30	27	38
Total monthly percentage compliance	50%	52%	37%	54%	63%	53%	52%	38%	61%	60%	59%	50%

Data Quality & Source

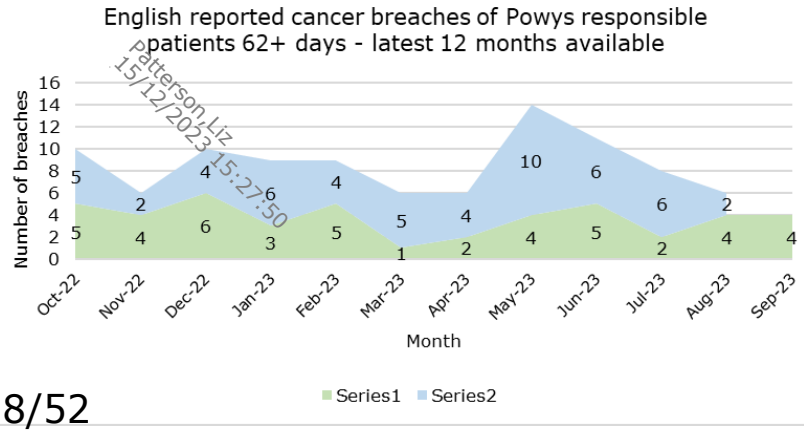
DHCW -
Please note SCP data is not finalised until quarterly refresh is carried out by submitting health boards

What the data tells us

Wales

Performance in Wales remains challenging for cancer pathways, provisional data for October 2023 shows 62-day cancer compliance at 50% with 19 of 38 pathways treated within target. However key challenges reported include service flow, surgical, and diagnostic capacity in secondary care. Another challenge is the marked variation across health boards particularly in relation to Breast, Gynaecology and Head and Neck SCP performance within Wales. Finally, it should also be noted that patients flowing into Cwm Taf Morgannwg could have initial diagnostics and outpatient appointments carried out by the Powys hosted in-reach services (PTHB has one of the highest median waits for first outpatients in Wales and this could impact target compliance).

To provide comparison against the All-Wales position in September, compliance against the SCP for all patients on treatment pathways was 53% (page 40) whilst 59% of PTHB residents in Wales had received treatment within the 62-day target for the same month.



What the data tells us

England

- Shrewsbury and Telford Hospital (SATH) NHS Trust reported 4 breaches for Powys residents of their cancer pathways that breached in September. Both breaches were patients waiting over 104 days, and all breaches were because of inadequate capacity in outpatient and or diagnostic including reporting. SATH have confirmed via recent meeting with the Commissioning team that as at the end of November they are ahead of their cancer recovery trajectory.

- Wye Valley NHS Trust (WVT) reports 2 breaches of their cancer pathway for Powys residents in August 2023. Both were reported over 104 days, and all reasons are linked to inadequate capacity in outpatient and or diagnostic including reporting.

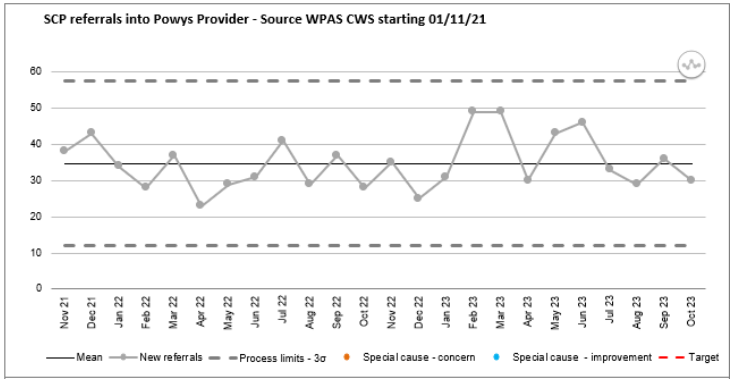
Healthier Wales Quadruple Aim 2

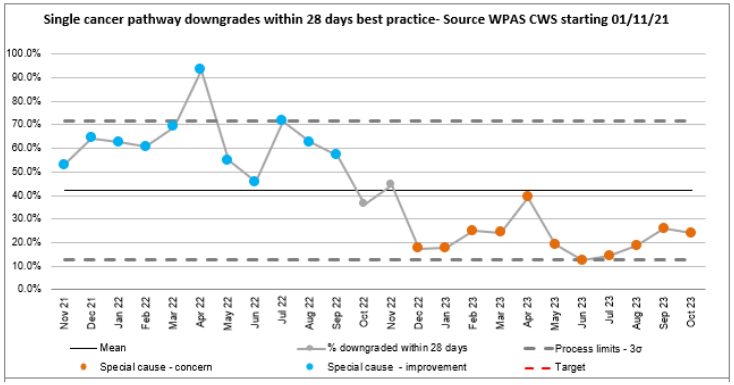
Access & Activity | **Local Measure** | **Powys Provider**

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

SCP - Powys provided cancer pathways (Powys does not provide treatment, but the health board is required to submit and validate downgrades)

Executive lead	Interim Executive Director of Operations / Director of Community and Mental Health	Officer lead	Assistant Director of Community Services Group	Strategic priority	5





What the data tells us

- There is significant challenge with Powys cancer pathways where key outpatient and diagnostic endoscopy are undertaken. October reported 30 referrals into PTHB pathways. Downgrade performance against the 28-day best practice (not an NHS Performance Framework metric) has reported a slight fall to 24% in October.
- It should be noted that complex diagnostics are carried out within acute care providers although the patient remains tracked by PTHB.

Issues

- In-reach clinician fragility resulting in service gaps and clinical handover challenges, this is caused by the retirement in Q2 2022/23 of Clinical Director, awaiting formal replacement proposal from Cwm Taf Morgannwg UHB (CTMUHB) as an outstanding risk to service.
- General surgery capacity even with private insource does not meet demand, routine pathways wait longer as urgent/USC prioritise available clinic/diagnostic slots.
- Colonoscopy capacity is not sufficient without supplementary insource.
- Bowel screening (BS) FIT test changes from Oct-22 have increased demand.
- Delays in DGH diagnostics, especially Histology/Pathology risk timeliness of pathways including USC.
- Powys local red-card process is not compatible with CTMUHB in-reach clinical processes and capacity (e.g., some patients are clinical downgrades/discharged but their pathway remains "digitally" open until red card is completed, this adversely effects downgrade performance).

Actions | Recovery by: N/A

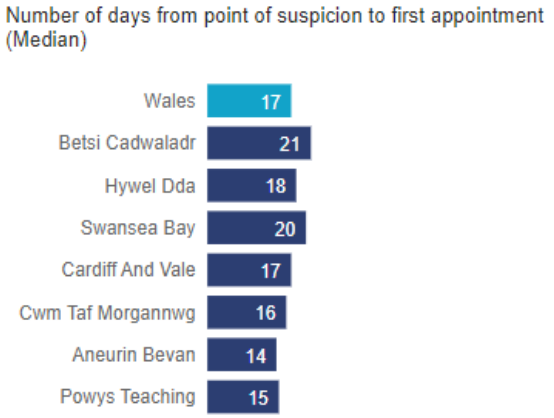
- Service have escalated the CTMUHB in-reach fragility, and diagnostic challenges for histology & pathology (this is currently reported as a high risk for the health board). Proposal being developed by CTM to address (awaited).
- Q4 2022/23, PTHB trains first JAG accredited clinical endoscopist for gastroscopy increasing capacity and resilience (limited capacity risk for gastroscopy in the provider).
- Cancer pathways and patient tracking review in the provider underway (currently in-reach capacity impacts on recorded patient waits).
- Trans nasal endoscopy (TNE) standard operating procedure awaiting approval, specialist equipment acquisition underway, clinical specialist training underway with regional workstream. TNE in Llandrindod Wells has been delayed to Q4 2023/24, awaiting ratification of clinical protocols.
- Work with Welsh Government and DHCW reporting team ongoing to assess validation of records submitted, the methodology and its appropriateness for PTHB pathways as reported nationally.
- Quality and Safety undertaking an audit on provider cancer pathways

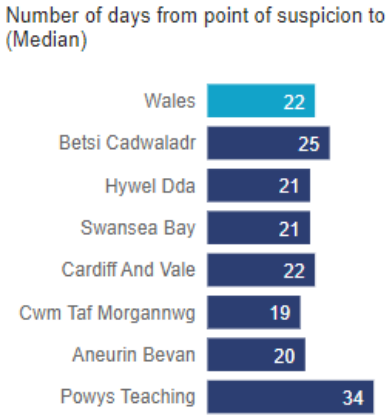
Mitigations

- Rolling programme of clinical and administrative waiting list validation.
- Additional in-sourcing capacity provided from November
- Powys has a limited proportion of the resident cancer referrals and for predominately general surgery, and incidental findings in ENT or Dental. Most USC referrals go directly to acute care or rapid diagnostic centres.
- Regional working on-going as part of National Diagnostic workstream
- Cancer tracking post appointed to in operations from August 2023 – improving local tracking significantly.
- Recruitment complete for 8b Senior clinician theatre endoscopy.
- Interim fixed term Assistant Medical Director Planned Care currently reviewing SOP's with the aim of improving service methods and efficiencies.

Single cancer pathway All Wales summary - dashboard exerts September 2023 – source DHCW SCP dashboard (Welsh providers only)

Median pathway waits for first appointment and to diagnostic test from point of suspicion in days September 2023

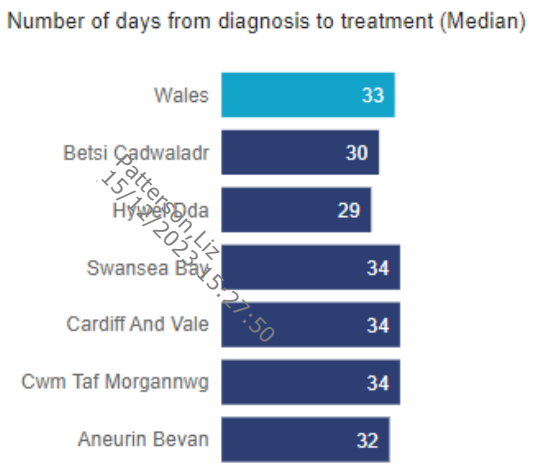


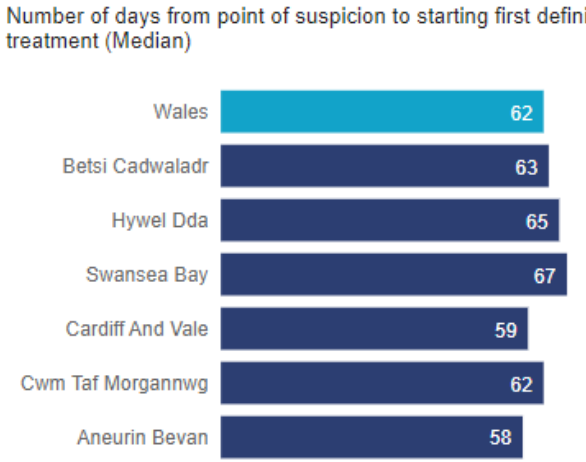


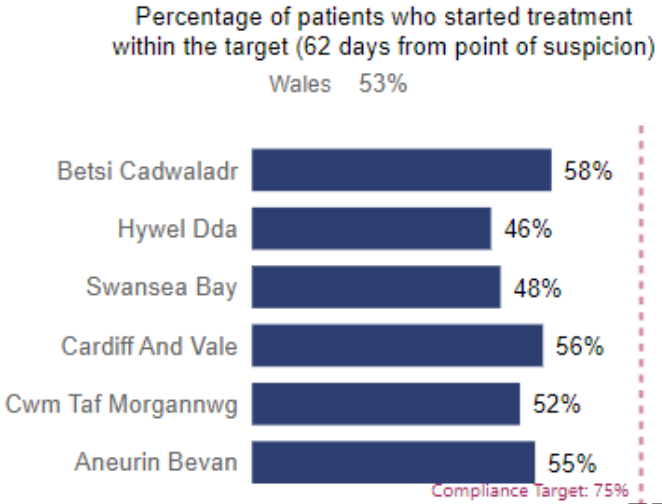
Comments

- Powys provider during Sep-23 provided better than All Wales median waits for first appointments, but the data shows noticeably worse performance for suspicion to diagnostics. It should be noted that suspicion to diagnostics performance includes tests carried out and reported in acute providers (CT/MRI etc). As an example, in September the average wait for a colonoscopy in Powys was 22 days.
- Powys is not included in the treatment performance (below) as a non-acute provider. It should be noted that Powys responsible patients have treatment pathways in all Welsh health boards reported. Of those patients whose pathway closed in September (treated) 59% were treated within 62 days.

Median pathway waits from diagnosis to treatment (all patients in Wales), suspicion to treatment, and percentage compliance against 62-day target for treatment providers September 2023







Healthier Wales Quadruple Aim 3

Workforce | **NHS Performance Measure - 37** | **Powys as a provider**

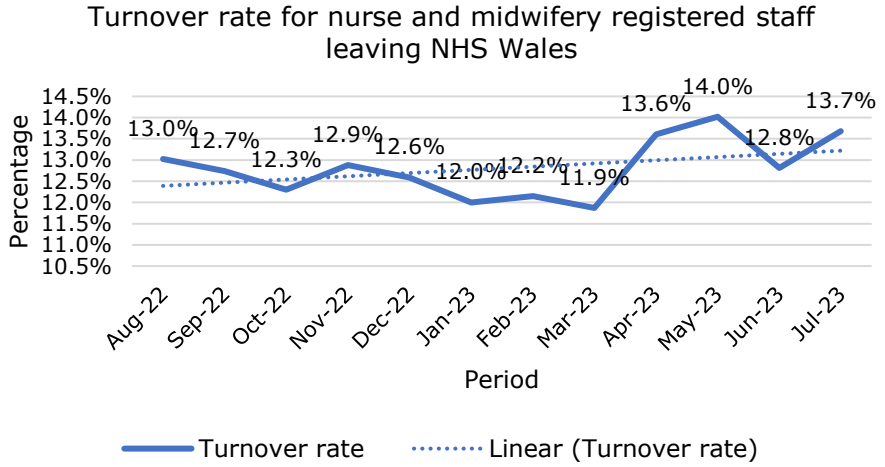
Workforce – Turnover rate for nurse and midwifery registered staff leaving NHS Wales

Bwrdd Iechyd Addysgu Powys / Powys Teaching Health Board

New measure for 2023/24

Executive lead	Executive Director of Workforce and OD	Officer lead	Deputy Director of Workforce and OD	Strategic priority	

Latest available	Jul-23		
Reported performance	13.7%	All Wales benchmark	9th (7.5%)
Target	Rolling 12-month reduction against a baseline of 2019-20 (9.5%)		
Variance	N/A		Exception
Data quality & Source		Welsh Government Scorecard	



What the data tells us

- This is a new measure for the 2023/24 NHS Performance Framework. This metric focuses on the measurement of staff leaving employment, and the identification of key causes and how best to tackle them. High staff turnover results in both high costs and a negative effect on services. It should be noted that this performance data is sourced from Welsh Government performance, and the data is classed as "experimental".
- Performance is declining over the last 12 months , and July reported another high 13.7% turnover rate.

Issues

- Health Education and Improvement Wales (HEIW) have produced the analysis and data for this measure along with the methodology, as such the health board cannot replicate this information locally.
- HEIW have noted that " *current data has some anomalies and we will be going to organisations to discuss the raw data to iron these out"*

Actions

Recovery by **TBC**

- Managers continue to be encouraged to undertake exit interviews with staff where appropriate to try and gather clear intelligence for the reasons staff leave.
- The Workforce and Organisational Development (WOD) Directorate are working to develop good practice guides to support managers in working to improve retention.
- The WOD Directorate will continue to roll out Team Climate surveys which will support managers and teams to identify actions which they can take to support retention.
- HEIW have confirmed funding for health boards to utilise to support the delivery of the Nurse Retention plan.

Mitigations

- The Workforce and OD Directorate together with the Trade Unions and colleagues from services continue to roll out a series of Staff Roadshows across all Hospital sites. The aim of these events is to support staff wellbeing and promote the support that is available within the Health Board.

There has been a change in the method of headcount calculations resulting in some slight changes to turnover figures since the August 2023 report was produced. This new methodology will be used going forward.

Healthier Wales Quadruple Aim 3

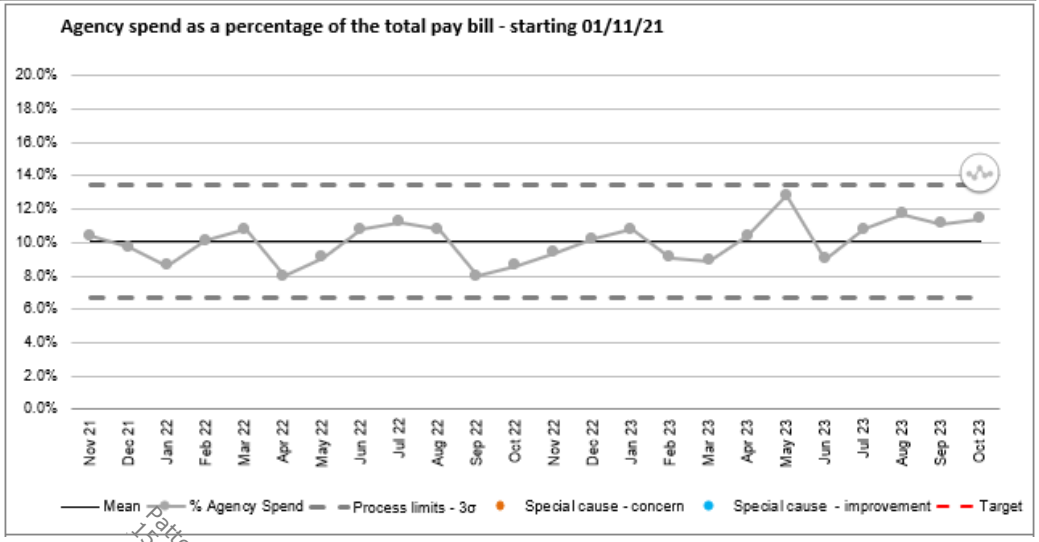
Finance (Cost & Value) | **NHS Performance Measure - 38** | **Powys as a provider**

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agency Spend – Agency spend as a percentage of the total pay bill

Executive lead	Interim Executive Director of Operations / Director of Community and Mental Health	Officer lead	Assistant Director of Community Services Group	Strategic priority	13

Latest available	Oct-23		
Reported performance	11.4%	All Wales benchmark	12th (5.4%) (Aug-23)
Target	12-month reduction trend		
Variance	Common cause		Exception
Data quality & Source		PTHB Finance	



What the data tells us

- The provider agency spend as a percentage of total pay bill varies as a response to demand.
- This reduction is not achieved and reported spend increased to 11.4% (October), this is above average for the 24 months.
- Variation remains common cause.

Issues

- Limited substantive Professional workforce availability
- Rurality
- COVID & impacts of short-term Sickness absence
- Patient acuity & dependency

Actions	Recovery by	TBC

- Reviewing operational footprint to further reduce reliance on temporary staffing
- Negotiating with on-contract agencies for additional recruitment and long-lining of staff
- refresh of actions from establishment review
- Additional recruitment of overseas nurses (OSN) who undertake Objective Standard Clinical Examination (OSCE) that the nurses must pass in order to re-register from April 2023

Mitigations

- Further tightening of operational processes including;
- Earlier roster planning
- Improved roster compliance and sign off
- Targeting of Bank over agency
- Targeted recruitment campaigns
- Long lining of on contract agency
- Establishment review
- Recruitment of 5 overseas registered nurses into Welshpool
- Roster scrutiny and accountability.
- Targeted analysis of enhanced levels of care to support pre planning of staffing requirements.
- Conversion of agency to substantive in one setting
- Conversion of Thornbury nurses to on framework agency in high-cost area.

Healthier Wales Quadruple Aim 3

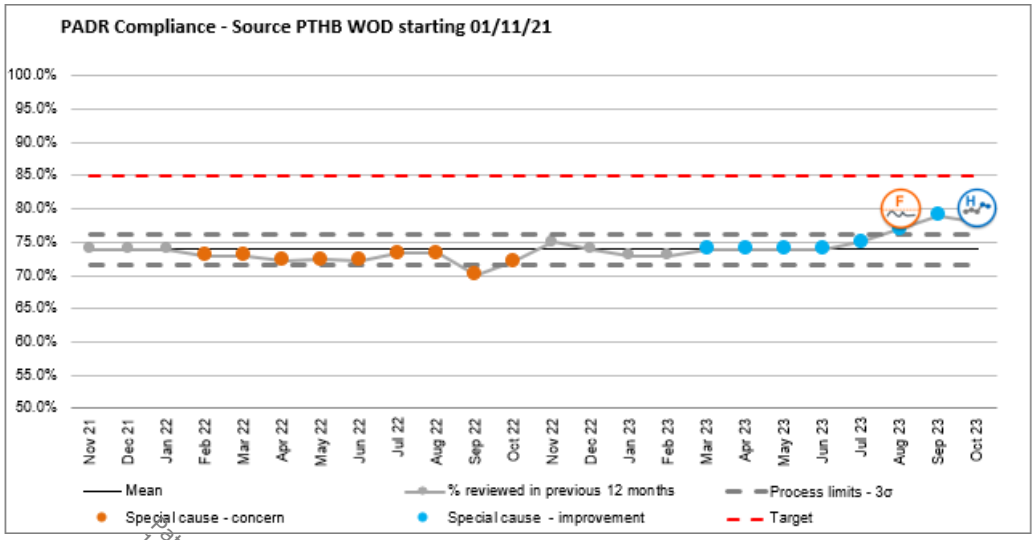
Workforce | **NHS Performance Measure - 39** | **Powys as a provider**

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

PADR Compliance - Percentage of headcount by organisation who have had a Personal Appraisal and Development Review (PADR)/medical appraisal in the previous 12 months (incl. Doctors and Dentists in training)

Executive lead	Executive Director of Workforce and Organisational Development	Officer lead	Deputy Director of Workforce and OD	Strategic priority	14

Latest available	Oct-23		
Reported performance	78.0%	All Wales benchmark	5th (72.3%) (Aug-23)
Target	85%		
Variance	Special cause- improvement		Exception
Data quality & Source		PTHB WOD	



What the data tells us

- THB PADR compliance is reported at 78.0% for October 2023, 7% below the national target of 85%.
- Statistically the SPC chart reports special cause improvement with consistent performance above average over the last 24 months.
- The health board benchmarks positively when compared the All-Wales position of 72.3% (August 2023).

Issues

- Staff absence and vacancies has caused challenges in delivery of PADRs. This continues to be a challenge post pandemic with increase service demand and inability to recruit.
- As of October 2023, there were 10 service areas/Directorates whose performance was below the national target of 85%.

Actions	Recovery by	TBC

•Workforce & OD Business Partners team continue to discuss compliance at senior management meetings within services.

•Low compliance is addressed with individual managers and signposting to guidance also takes place.

Mitigations

- WOD Business Partners discuss alternative methods of PADR delivery with Service Managers e.g., Group PADRs and delegated responsibility.
- Managers toolkit on Pay progression has been developed and implemented.
- Frequently asked questions and guidance has been developed and shared

Healthier Wales Quadruple Aim 4

Quality, Safety, Effectiveness and Experience | **NHS Performance Measure - 42** | **Powys as a provider**

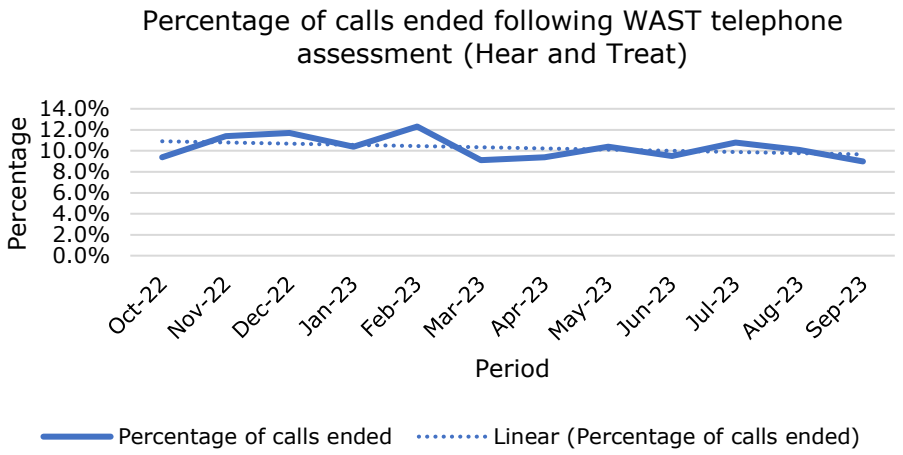
Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

New measure for 2023/24

Percentage of calls ended following WAST telephone assessment (Hear and Treat)

Executive lead	**Executive Director of Operations/ Director of Community and Mental Health**	**Officer lead**	**Assistant Director of Community Services Group**
Strategic priority			

Latest available	**Sep-23**		
Reported performance	9%	All Wales benchmark	7th (12.5%)
Target	17% or more		
Variance	N/A		Exception
Data quality & Source		Welsh Government Scorecard	



What the data tells us

This is a new measure for the 2023/24 NHS Performance Framework. Hear and Treat enables 999 callers who are deemed to have a non-life-threatening condition to receive advice over the phone or to be triaged to a non-emergency service. This helps ambulance vehicles to be despatched quickly to patients who need to be admitted to an emergency department. Hear and Treat helps to reduce ambulance transportation, hospital admission and patient flow. It also makes it easier and quicker for patients to the right advice or treatment closer to home.

Powys has not met the national target in September with 9% reported against the 17% target. It should be noted that the health board area ranks 7th against the All-Wales position of 12.5%.

Issues

- This is a commissioned service by the health board, as such Powys has limited actions available to resolve issues.

Actions	**Recovery by**	**TBC**
-		

Mitigations

- Regular meetings are carried out between the health board and WAST, these meeting cover performance, patient experience, incidents and resultant investigations, clinical indicators and staff safety.

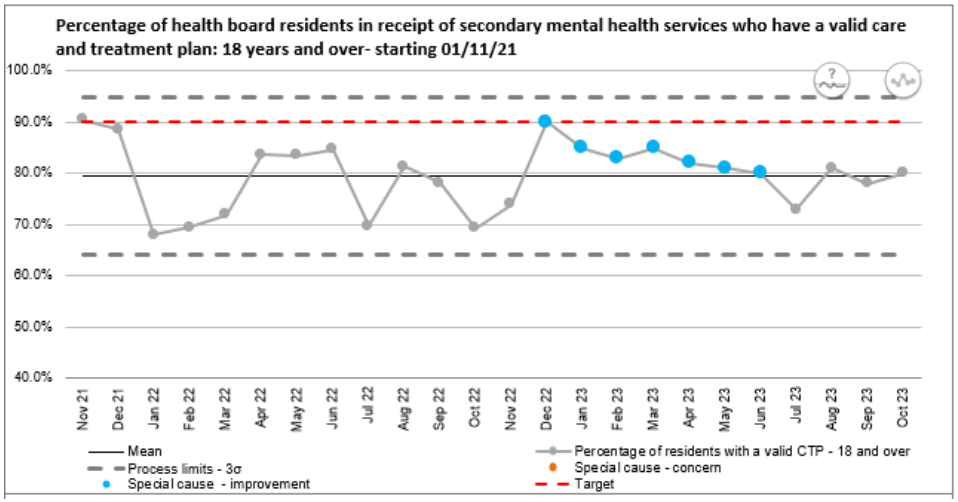
Healthier Wales Quadruple Aim 4

Quality, Safety, Effectiveness and Experience | **NHS Performance Measure - 45** | **Powys as a provider**

Mental Health CTP, 18 years+ Percentage of health board residents 18 years and over in receipt of secondary mental health services who have a valid care and treatment plan

Executive lead	Interim Executive Director of Operations/ Director of Community and Mental Health	Officer lead	Assistant Director of Mental Health	Strategic priority	10

Latest available	Oct-23		
Reported performance	80.0%	All Wales benchmark	5th (75%)*
Target	90%		
Variance	Common cause		Escalated
Data quality & Source		PTHB Mental Health Service	



What the data tells us

- Adult and older CTP compliance has measured at 78.0% and reports common cause variation, which has improved since July.
- In September PTHB benchmarked 5th against an All-Wales position of 75%.
- This measure has been **escalated** because of poor compliance with service agreement.

Issues

- North Powys vacancies and sickness absence continue to impact.
- The service is further affected by Social Services inability to undertake their share of Office Duty, which places additional demand on NHS staff. There has recently been some success in recruitment which will remove agency locums from community provision ensuring longevity and consistency in caseload with direct impact on CTP measure.
- Data quality challenge including post submission revisions.

Actions	Recovery by	TBC – remedial action plan required

- Series of meetings undertaken with Director of Social Services and Head of Adults over Powys County Council's responsibilities in Community Mental Health Teams. However, this has not resolved PCC Social worker capacity challenges. A change to the duty and assessment model is being scoped with investment from 6 goals to mitigate for the impact this has placed on capacity for urgent care.
- Continue to advertise recruitment positions.
- A standard operating procedure (SOP) has been put in place to standardise data collection pan Powys with review meetings underway to check consistency.
- Remedial action plan is to be put into place by mid-November 2023

Mitigations

- Clinical assessment and prioritisation of caseloads.
- Prioritising data cleansing and data accuracy.
- Currently investigating a 'MH Measure' data recording area of WCCIS to replace and centralise current means of data collection.
- Recruitment to vacant posts within the service.
- Change to Service Manager model to create portfolios that will focus on specific services i.e. one service manager for all Adult CMHTs

Healthier Wales Quadruple Aim 4

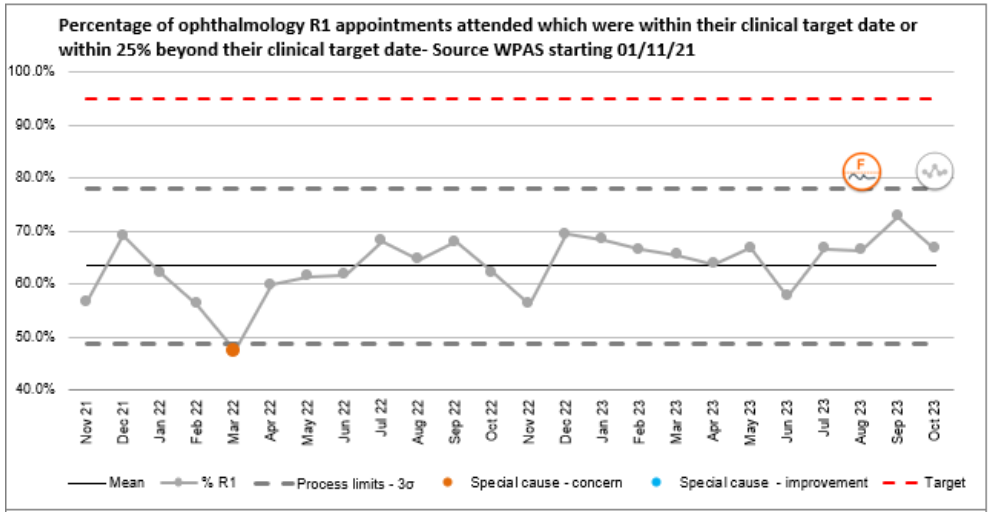
Access & Activity | **NHS Performance Measure - 51** | **Powys as a provider**

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Ophthalmology - Percentage of ophthalmology R1 appointments attended which were within their clinical target date or within 25% beyond their clinical target date

Executive lead	Interim Executive Director of Operations/ Director of Community and Mental Health	Officer lead	Assistant Director of Community Services Group	Strategic priority	5

Latest available	Oct- 23		
Reported performance	66.7%	All Wales benchmark	3rd (62.9%)
Target	95%		
Variance	Common cause		Exception
Data quality & Source		WPAS	



What the data tells us

- Performance for R1 appointments attended does not meet the 95% target falling to 66.7% in October 72.8%, performance remains common cause variation. The health board ranking has fallen as well to 3rd in Wales.
- All Wales performance is 62.9% for the same period.

The quality of this data is still subject to review as part of the waiting list and FUP reporting changes.

Issues

- In-reach fragility impacts available capacity for specialty.
- Local staffing challenges reducing capacity include sickness absence, vacancies in theatre staffing, and industrial actions during Q4 (NHS England Industrial Action is having a particular impact on eyecare as majority of provision is from WVT).
- Regional recruitment challenges include Mid Wales Joint Committee recruitment for PTHB/HDUHB ophthalmology consultant lead post.
- Ongoing demand and capacity challenge resulting from inaccuracies with follow-up (FUP) reporting impacting service planning assumptions.
- National Digital Eye Care pilot delayed since May-22, this impacts outpatient nursing team support and roll out with in-reach ophthalmology clinical lead for Ystradgynlais & phase 2 in North Powys.
- Awaiting outcome of DHCW Review of National Digital Eye Care Programme anticipated November 2023

Actions	Recovery by	TBC

- Working with WVT & Rural Health Care Academy to formalise training opportunities in DGH, extending OP role to include eye care scrub for potential future clean room developments in PTHB.
- League of Friends supporting purchase of equipment for North biometry to support repatriation of cataract pathway
- Commencing use of PIFU pathways in WET AMD from November 2023 to improve care pathways for frail patients.

Mitigations

- Enhancing staffing – including first non-registrant Ophthalmic health care scientist in the UK (supporting MDT development), and work with Rural Health Care Academy on career pathways for eye care in PTHB has resulted in trainee Eye care developmental post recruitment.
- One stop shop cataracts biometrics pre assessment, consultant appointment pan Powys – from Q3 2022/23.
- Wet Age-related macular degeneration (AMD) service has been extended into mid Powys, embedded as service model for Llandrindod/Brecon Hospitals. PTHB 1st nurse eye care injector trained, plans in place for 2nd PTHB injector training (complete 2023/24).
- Service SOPs in place utilising best practice from Birmingham and Midland Eye Centre.
- Local Safety Standard for Invasive Procedures (LOCSIPs) in place for Eye Care & other outpatient department specialities first HB in Wales.
- Failsafe officer in place for WET AMD aligning fail safe duties within general ophthalmology

Appendix 1

Quadruple Aim 1: People in Wales have improved health and wellbeing with better prevention and self management

2022/23 Performance Framework Measures							Performance				Welsh Government Benchmarking (*in arrears)	
Area	Executive Lead	Officer Lead	No.	Abbreviated Measure Name	Ministerial Priority	Target	Latest Available	12month Previous	Previous Period	Current	Ranking	All Wales
Quadruple Aim 1: People in Wales have improved health and well-being with better prevention and self-management	Executive Director of Public Health	Consultant in Public Health	1	% Attempted to quit smoking		5% annual target	Q1 2023/24	0.68%		1.29%	4th	1.24%
	Interim Executive Director of Operations / Director of	Assistant Director of Mental Health	2	Percentage of people who have been referred to health board services who have completed treatment for substance misuse (drugs/alcohol)		4 quarter improvement trend	Q2 2023/24	59.0%	63.1%	56.3%	5th	60.5%
	Executive Director of Public Health	Consultant in Public Health	3	% of children up to date with scheduled vaccinations by age 5		95%	Q1 2023/24	92.9%	89.2%	91.7%	1st	87.9%
	Executive Director of Public Health	Consultant in Public Health	4	% of girls receiving HPV vaccination by age 15		90%	Q1 2023/24			84.7%	4th	85.3%
			5	Flu Vaccines - 65+		75%	Oct-23			57.1%	3rd	56.6%
			6	% uptake of COVID-19 vaccination for those eligble		75%	Oct-23		10.3%	33.5%	1st	27.0%
	Interim Executive Director of Operations / Director of Community and Mental Health - TBC	Senior Manager - Planned Care	7	% of patients offered an index colonoscopy within 4 weeks of booking specialist screening appointment	✓	90%	Sep-23	0.0%	0.0%	0.0%	6th*	20.6%
	Interim Executive Director of Operations / Director of Community and	Assistant Director of Women's and Childrens Services	8	% of well babies completing the hearing screening programe within 4 weeks		90%	Aug-23	97.1%	95.7%	94.8%	7th	98.4%
			9	% of eligble newborn babies who have a conclusive bloodspot screening result by day 17		95%	Sep-23	95.7%	96.3%	95.3%	7th	96.8%

Appendix 1

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

2022/23 Performance Framework Measures							Performance				Welsh Government Benchmarking (*in arrears)	
Area	Executive Lead	Officer Lead	No.	Abbreviated Measure Name	Ministerial Priority	Target	Latest Available	12month Previous	Previous Period	Current	Ranking	All Wales
Quadruple Aim 2: People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement	Interim Deputy Chief Executive and Director of Finance, IT and Information Services	Assistant Director of Primary Care	10	% of GP practices that have achieved all standards set out in the National Access Standards for In-hours GMS	✓	100%	2022/23	100.0%		100.0%	1st	95.5%
			11	% of primary care dental services (GDS) contract value delivered (new,new urgent and historic patients)	✓	Month on Month increase towards a minimum of 30% contract value delivered by Sep-23/100% by	Oct-23		37.8%	44.3%	4th	45.2%
			12	No of patients referred from primary care (optometry, general medical practitioners) into secondary care ophthalmology services	✓	PTHB Trajectory - <= 128	Oct-23	88	85	82	1st*	5,960
	Medical Director	Chief Pharmacist	13	No of consultations delivered through the Pharmacist Independent Prescribing Service (PIPS)	✓	Increase on the number in the equivalent month in the previous year	Sep-23	231	463	374	7th	6,185
	Interim Executive Director of Operations / Director of Community and Mental Health	Assistant Director of Mental Health	14	Assessments <28 days <18	✓	80%	Oct-23	100.0%	97.1%	100.0%	2nd*	80.2%
			15	Interventions <28 days <18	✓	80%	Oct-23	88.0%	80.8%	89.2%	2nd*	44.7%
			16	Assessments <28 days 18+	✓	80%	Oct-23	91.7%	89.7%	87.5%	4th*	66.2%
			17	Interventions <28 days 18+	✓	80%	Oct-23	61.4%	48.5%	41.7%	6th*	71.3%
	Interim Executive Director of Operations / Director of Community and Mental Health	Senior Manager Unscheduled Care	18	Percentage of emergency responses to red calls arriving within (up to and including) 8 minutes	✓	65%	Oct-23	40.5%	48.3%	46.9%	4th	47.2%
			19	Median emergency response time to amber calls	✓	12 month improvement trend	Oct-23	01:22:02	00:51:51	00:50:58	1st	01:29:13
			22	% of patients who spend less than 4 hours in all major & minor emergency care facilities from arrival until admission, transfer or discharge	✓	Improvement compared to the same month in 2022-23, towards the national target of	Oct-23	99.8%	99.9%	99.9%	1st	68.7%
			23	Number of patients who spend 12 hours or more in all hospital major and minor emergency care facilities from arrival until admission, transfer or discharge	✓	PTHB Trajectory - 0	Oct-23	0	0	0	1st	9,934
	Interim Executive Director of Operations / Director of Community and Mental Health	Assistant Director of Community Services	25	Number of diagnostic breaches 8+ weeks	✓	PTHB trajectory of < = 100	Oct-23	111	139	132	1st*	51,278
			26	% of children <18 waiting 14 weeks or less for a specified AHP	✓	12 month improvement trend	Oct-23	98.4%	77.5%	78.1%	6th*	82.5%
			27	Number of therapy breaches 14+ weeks (all ages) inc. audiology	✓	PTHB Trajectory - 20	Oct-23	236	499	312	2nd*	10,974
			28	Number of patients waiting >52 weeks for a new outpatient appointment	✓	PTHB Trajectory - 0	Oct-23	0	60	80	1st*	52,623
			29	Number of patients waiting >36 weeks for a new outpatient appointment	✓	PTHB Trajectory - 20	Oct-23	12	197	257	1st*	107,108
			30	Number of patient follow-up outpatient appointment delayed by over 100%	✓	PTHB Trajectory - 400	Oct-23	4548	1624	1575	1st	247,276
			31	RTT patients waiting more than 104 weeks	✓	PTHB Trajectory - 0	Oct-23	0	0	0	1st*	26,439
			32	RTT patients waiting more than 52 weeks	✓	PTHB Trajectory - 0	Oct-23	3	75	99	1st*	133,519
		Assistant Director of Mental Health	33	CAMHS % waiting <28 days for first appointment	✓	80%	Oct-23	95.7%	100.0%	100.0%	1st	91.3%
		Assistant Director of Women's and Children's	34	Children/Young People neurodevelopmental waits	✓	80%	Oct-23	67.8%	62.3%	58.7%	1st*	29.3%
		Assistant Director of Mental Health	35	Adult psychological therapy waiting < 26 weeks	✓	80%	Oct-23	91.9%	90.0%	89.0%	2nd*	63.6%

Appendix 1

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

2022/23 Performance Framework Measures							Performance				Welsh Government Benchmarking (*in arrears)	
Area	Executive Lead	Officer Lead	No.	Abbreviated Measure Name	Ministerial Priority	Target	Latest Available	12month Previous	Previous Period	Current	Ranking	All Wales
Quadruple Aim 3: The health and social care workforce in Wales is motivated and sustainable	Executive Director of Workforce and Organisational Development	Head of Workforce	36	(R12) Sickness Absence	✓	12 month reduction trend	Oct-23	6.0%	5.6%	5.5%	4th (Aug-23)	6.2%
			37	Turnover rate for nurse and midwifery registered staff leaving NHS Wales	✓	Rolling 12 month reduction against a baseline of 2019/20	Jul-23	13.1%	12.8%	13.7%	9th	7.5%
	Interim Executive Director of Operations / Director of Community and Mental Health	Assistant Director of Community Services Group	38	Agency spend as a percentage of the total pay bill	✓	12 month reduction trend	Oct-23	8.6%	11.1%	11.4%	12th (Aug-23)	5.4%
	Executive Director of Workforce and Organisational Development	Head of Workforce	39	Performance Appraisals (PADR)	✓	85%	Oct-23	72.1%	79.0%	78.0%	5th (Aug-23)	72.3%

Appendix 1

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

2022/23 Performance Framework Measures							Performance				Welsh Government Benchmarking (*in arrears)	
Area	Executive Lead	Officer Lead	No.	Abbreviated Measure Name	Ministerial Priority	Target	Latest Available	12month Previous	Previous Period	Current	Ranking	All Wales
Quadruple Aim 4: Wales has a higher value health and social care system that has demonstrated rapid improvement and innovation, enabled by data and focused on outcomes	Interim Deputy Chief Executive and Director of Finance, IT and Information Services	Head of Information-Digital Transformation and Informatics	40	% of episodes clinically coded within one month post discharge end date	✓	Maintain 95% target or demonstrate an improvement trend over 12 months	Jul-23	100.0%	100.0%	100%	1st	75.6%
			41	% of all classifications' coding errors corrected by the next monthly reporting submission	✓	90%	Sep-23		80.0%	100.0%	1st	45.0%
	Interim Executive Director of Operations / Director of Community and Mental Health	Assistant Director of Community Services	42	% of calls ended following WAST telephone assessment (Hear and Treat)	✓	17% or more	Sep-23	8.8%	10.0%	9.0%	7th	12.5%
			43	No of Pathways of Care delayed discharges	✓	12 month reduction trend	Oct-23		65	60	2nd	1,551
		Assistant Director of Mental Health	44	% residents with CTP <18	✓	90%	Oct-23	97.7%	96.0%	93.0%	1st*	90.4%
			45	% residents with CTP 18+	✓	90%	Oct-23	69.3%	78.0%	80.0%	5th*	75.0%
	Executive Director of Nursing and Midwifery	Assistant Director of Quality & Safety	46	No of patient experience surveys completed and recorded on CIVICA		Month on Month Improvement	Data currently not available					
	Executive Director of Nursing and Midwifery	Deputy Director of Nursing	47	HCAI - Klebsiella sp and Aeruginosa cumulative number		Health Board Specific Target	Oct-23		0	0	PTHB is not nationally benchmarked for infection rates	
			48	HCAI - E.coli, S.aureus bacteraemia's (MRSA and MSSA) - Cumulative rate of confirmed cases per 100,000		Health Board Specific Target	Oct-23		3.01	2.57		
			49	HCAI - cumulative rate of C.Difficile cases per 100,000 population		Health Board Specific Target	Oct-23	12.82	16.54	18.00		
	Interim Executive Director of Operations / Director of Community and Mental Health	Assistant Director of Community Services	51	Percentage of ophthalmology R1 patients who attended within their clinical target date (+25%)	✓	95%	Oct-23	68.0%	72.8%	66.7%	3rd	62.9%
	Executive Director of Nursing and Midwifery	Assistant Director of Quality & Safety	53	No of patient safety incidents that remain open 90 days or more		12 month reduction trend	Oct-23	2	3	4	3rd	263

Appendix 2

Progress against Ministerial Priorities 2023/24 – (trajectories submitted to Welsh Government performance in Mar-23)

Submitted trajectories vs Actuals

Ministerial Priority Measures			Month											Risk of delivery R.A.G
Measure	Target		Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	
Number of patients referred from primary care (optometry and General Medical Practitioners) into secondary care Ophthalmology services	Improvement trajectory towards a national target of reduction by March 2024	Performance Trajectory	135	135	135	135	135	135	128	120	113	105	98	90	
		Actual	98	97	100	74	53	85	82						
Number of patients waiting more than 52 weeks for a new outpatient appointment	Improvement trajectory towards a national target of zero by June 2023	Performance Trajectory	0	0	0	0	0	0	0	0	0	0	0	0	
		Actual	1	3	4	19	42	60	80						
Number of patients waiting more than 36 weeks for a new outpatient appointment	Improvement trajectory towards a national target of zero by March 2024	Performance Trajectory	35	35	35	30	30	25	20	15	10	5	5	0	
		Actual	67	98	112	126	159	197	257						
Number of patients waiting more than 104 weeks for referral to treatment	Improvement trajectory towards a national target of zero by June 2023	Performance Trajectory	0	0	0	0	0	0	0	0	0	0	0	0	
		Actual	0	0	0	0	0	0	0						
Number of patients waiting more than 52 weeks for referral to treatment	Improvement trajectory towards a national target of zero by March 2025	Performance Trajectory	20	15	10	5	5	0	0	0	0	0	0	0	
		Actual	16	14	14	29	52	75	99						
Number of patients waiting over 8 weeks for a specified diagnostic	Improvement trajectory towards a national target of zero by March 2024	Performance Trajectory	160	160	150	130	120	110	100	80	50	30	15	0	
		Actual	159	160	117	134	152	139	132						
Number of patients waiting over 14 weeks for a specified therapy	Improvement trajectory towards a national target of zero by March 2024	Performance Trajectory	190	190	180	170	120	70	20	0	0	0	0	0	
		Actual	243	273	265	418	511	499	312						
Number of patients waiting for a follow-up outpatient appointment who are delayed by over 100%	Improvement trajectory towards a national target of reduction by March 2024	Performance Trajectory	4,600	2,500	2,000	1,700	1,400	900	400	0	0	0	0	0	
		Actual	4,763	1902	1667	1660	1683	1624	1575						
Number of patients who spend 12 hours or more in all major and minor emergency care facilities from arrival until admission, transfer or discharge	Improvement trajectory towards a national target of zero by March 2024	Performance Trajectory	0	0	0	0	0	0	0	0	0	0	0	0	
		Actual	0	0	0	0	0	0	0						

Please note that retrospective changes have been made to the reported values for those patients referred from primary care for Ophthalmology in April & June 2023 the variance was <2.

Appendix 2

Progress against Ministerial Priorities 2023/24 – (trajectories submitted to the Delivery Unit)

Submitted trajectories vs Actuals

Ministerial Priority Measures			Month											
Measure	**Target**		**Apr-23**	**May-23**	**Jun-23**	**Jul-23**	**Aug-23**	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**
% LMPHSS assessments undertaken within 28 days from the date of receipt of referral - Under 18	80%	Performance Trajectory	98.0%	95.0%	95.0%	95.0%	90.0%	90.0%	95.0%	95.0%	90.0%	90.0%	95.0%	95.0%
		Actual	98.0%	100.0%	100.0%	95.6%	100.0%	97.1%	100.0%					
% LMPHSS assessments undertaken within 28 days from the date of receipt of referral - 18 & over		Performance Trajectory	80.0%	82.0%	82.0%	82.0%	80.0%	80.0%	82.0%	82.0%	80.0%	80.0%	82.0%	82.0%
		Actual	80.4%	91.6%	92.9%	91.9%	97.9%	89.7%	87.5%					
% therapeutic interventions started within 28 days following an LPMHSS assessment - Under 18	80%	Performance Trajectory	77.5%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%
		Actual	78%	83%	88%	90%	79%	80.8%	89.2%					
% therapeutic interventions started within 28 days following an LPMHSS assessment - 18 & Over		Performance Trajectory	66.0%	68.0%	70.0%	72.0%	70.0%	75.0%	78.0%	80.0%	80.0%	80.0%	80.0%	80.0%
		Actual	65.8%	47.2%	62.3%	49.0%	60.5%	48.5%	41.7%					
% patients waiting less than 28 days for first appointment for sCAMHS		Performance Trajectory	98.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
		Actual	97.2%	100.0%	100.0%	100.0%	95.8%	100.0%	100%					
% children & young people waiting less than 26 weeks to start ADHD or ASD ND assessment		Performance Trajectory	70.0%	71.0%	74.0%	75.0%	77.0%	78.0%	79.0%	80.0%	80.0%	80.0%	80.0%	80.0%
		Actual	69.7%	71.3%	72.2%	72.9%	68.9%	62.3%	58.7%					
% patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult MH		Performance Trajectory	86.0%	93.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%
		Actual	87.6%	93.0%	95.7%	96.6%	90.5%	90.0%	89.0%					
% HB residents in receipt of secondary MH services who have a valid CTP - Under 18	90%	Performance Trajectory	97.8%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%
		Actual	97.8%	98.0%	89.3%	94.5%	94.3%	96.2%	92.6%					
% HB residents in receipt of secondary MH services who have a valid CTP - 18 & over		Performance Trajectory	82.0%	83.0%	85.0%	86.0%	87.0%	88.0%	89.0%	90.0%	90.0%	90.0%	90.0%	90.0%
		Actual	87.4%	89.6%	87.6%	80.6%	81.0%	77.6%	80.1%					

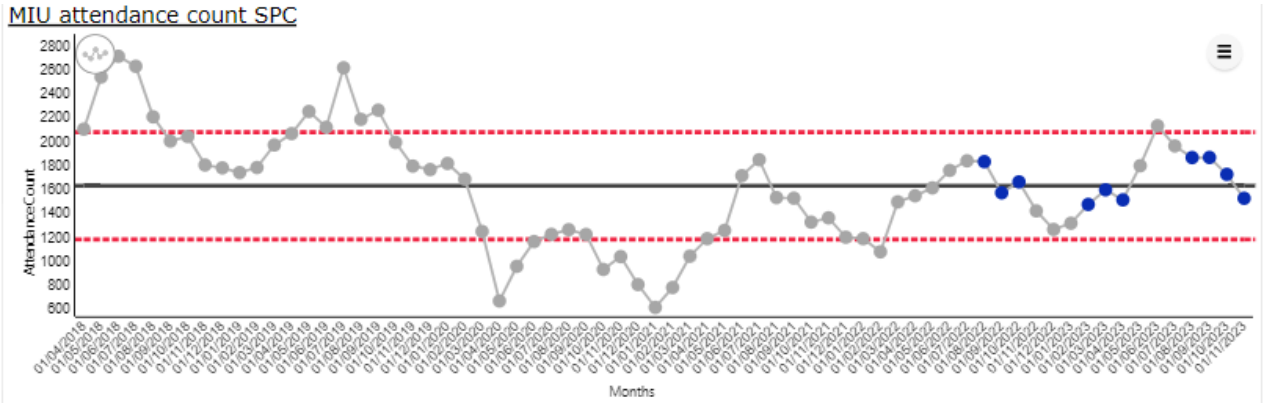
Emergency access action 2.2

Updated 13/12/2023

Delivery & Performance Committee – 19 December 2023
Deep Dive – item 2.3

PTHB MIU's

MIU activity – Attendances over time

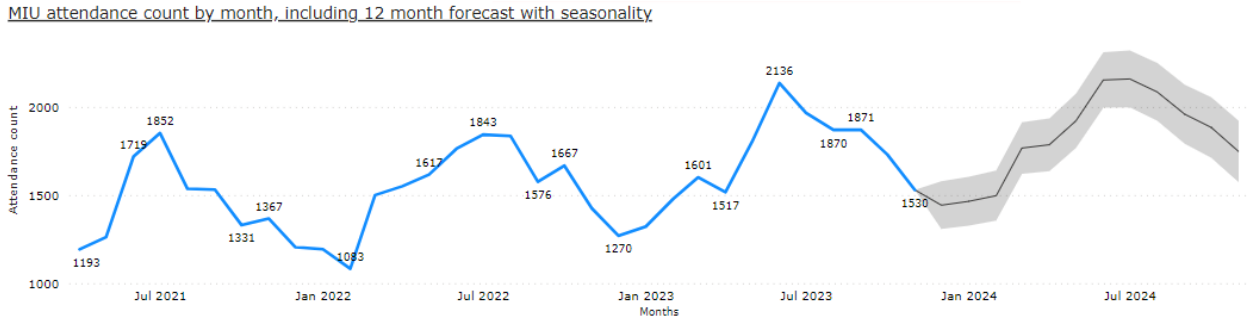


All unit's attendance, all hours, Inc. weekends, actual data April 2018 to November 2023, forecast 12 months with seasonality.

MIU activity over time

The graph includes all reported MIU activity from April 2018 to November 2023 e.g., in & out of hours, weekends, and new/re-attend patients.

- **2051** average attendances per month for 24 months prior to COVID (1/04/2018 to 31/03/2020)
- **1488** average attendances per month, latest 24 months of same period (01/04/2021 to 31/03/2023)
- Average attendance is 27.5% less in the latest comparable period.

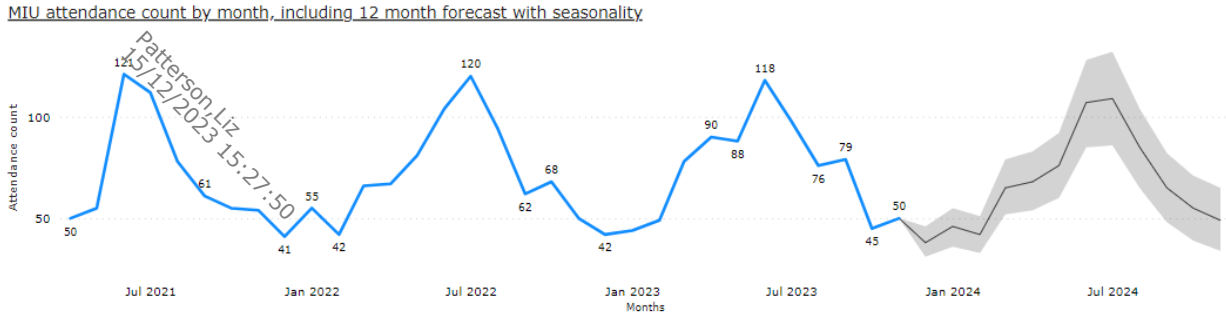


All units attendance, out of hours only, Inc. weekends , actual data April 2018 to November 2023, forecast 12 months with seasonality.

MIU activity from April 2021 Inc. forecast total attendances

MIU total attendances show seasonal fluctuations with increased access requirements during summer months. Non-Powys resident MIU attendances also increase in the summer but for example in August 2023 only make up 18% of total attendances.

Using data for the last 3 years and seasonality 2024/25 is forecast to have similar attendance levels to 2023/24.



MIU activity from April 2021 Inc. forecast out of hours attendances

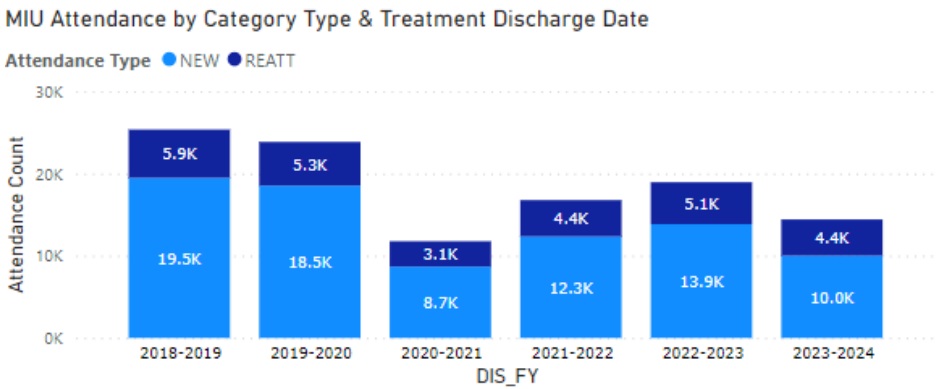
Out of hours MIU activity is very limited with an average of 72 per month from April 2021 across all units excluding Ystradgynlais (this unit does not open out of hours or weekends).

Opening Hours

- Brecon – 24/7 (risk around staffing fragility)
- Llandrindod Wells – 07:00-00:00 - 7 days per week
- Welshpool – 08:00-20:00 - 7 days per week
- Ystradgynlais – 8:30-16:30 – Mon-Friday excluding BH's

MIU activity – Financial Year Comparison

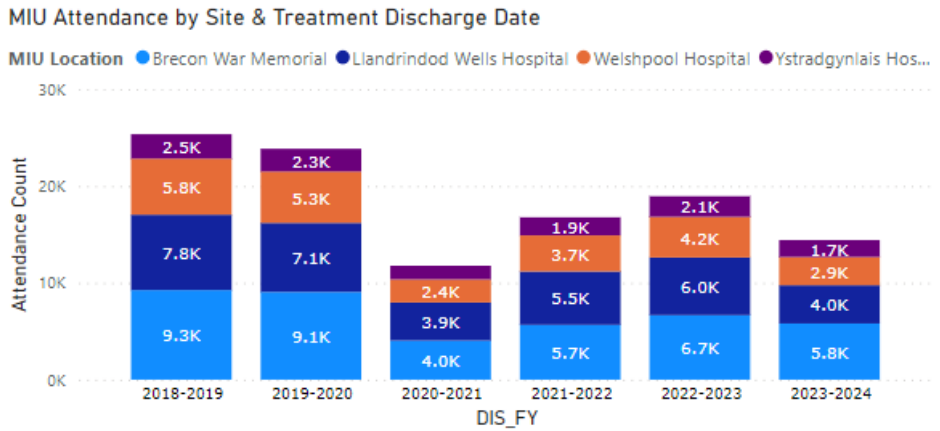
FY comparison for new & re-attenders 2018/19 to latest (Nov-23)



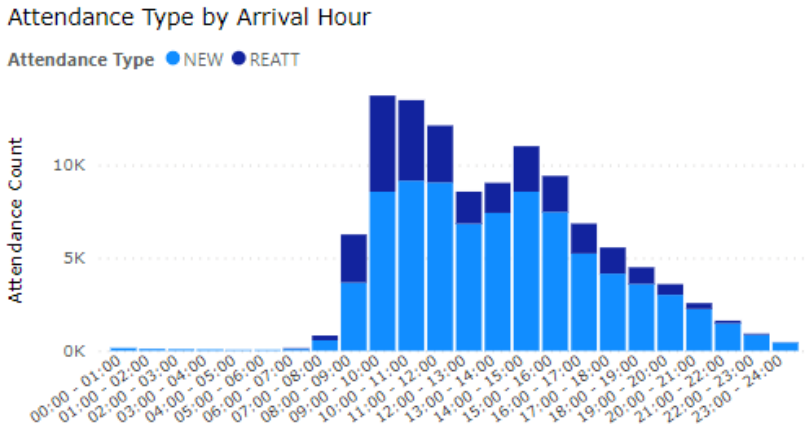
When looking at the longer-term picture of 5 complete years and partial data for 2023/24 we can see that;

- Brecon and Llandrindod have significantly the largest proportion of attendances
- MIU units have limited activity between midnight and 7am.
- Circa 19% are paediatric attendances
- Patients re-attending make up between 22% & 27% of the total activity

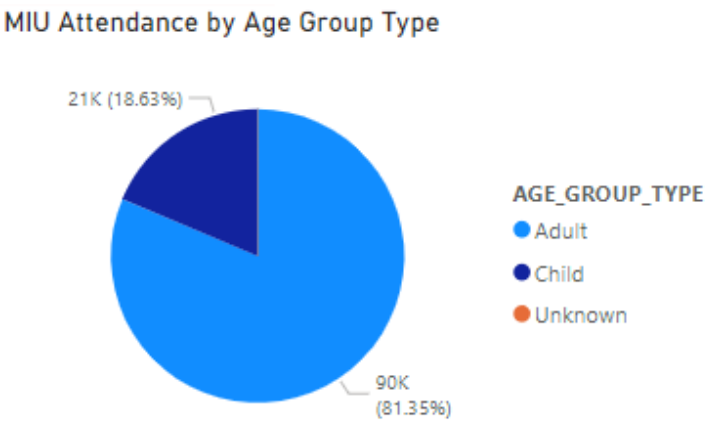
FY comparison total activity by site 2018/19 to latest (Nov-23)



Patient arrival time by hour, 2018/19 to latest (Nov-23)



Adult or Paed attender 2018/19 to latest (Nov-23)



Example of total cost by attendance 2022/23 financial year Powys MIU's

Powys MIU site	Total attendace cost	Average cost per activity
Ystradgynlais Hospital	£ 425,659.80	£ 200.12
Llandrindod Wells Hospital	£ 514,725.54	£ 86.57
Welshpool Hospital	£ 541,442.96	£ 128.76
Brecon War Memorial	£ 753,447.60	£ 112.98
Grand Total	£ 2,235,275.90	£ 117.98

The table on the left is an example of the cost per attendance within Powys facilities by MIU site in the 2022/23 financial year.

This data has been provided by PTHB finance and is based on a fixed cost per attendance with included variable and semi variable costing.

A&E Access PTHB residents

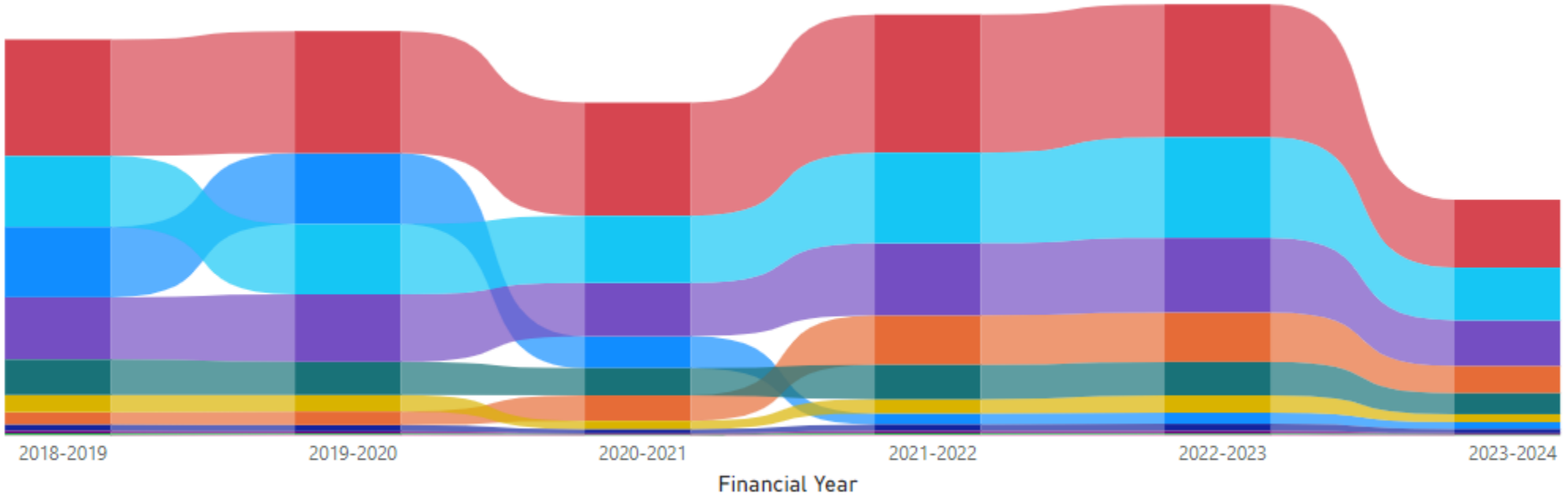
Powys resident access challenges in major units

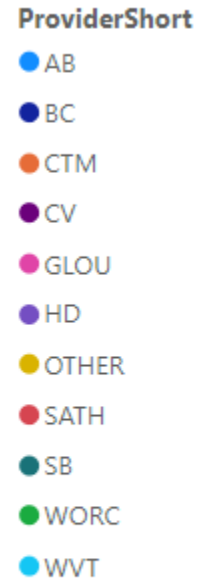
- Resident waits in major A&E units, latest 12 months where available.
- Only units with more than 100 attendances within 12 months are included
- Units are sorted by total attendance volume largest to smallest
- No units meet the Welsh 95% target for patients to be seen within 4hrs.
- All units have breaches over the 12hr target

Hospital	Measures	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Average
Shrewsbury And Telford Hospital Nhs trust	Total attendances	640	639	537	488	660	629	625	631	664	649	654	No data available for Oct-23 until next refresh	**620**
	% under 4hrs	37.5%	33.5%	41.7%	36.3%	40.8%	46.6%	43.4%	39.6%	37.2%	37.1%	42.2%		**39.6%**
	Over 12 hrs	177	211	141	147	187	136	167	154	174	186	178		**169**
Wye Valley Nhs Trust	Total attendances	454	552	449	437	486	507	547	457	503	474	498		**488**
	% under 4hrs	46.0%	33.7%	40.1%	40.3%	38.5%	47.3%	44.2%	45.5%	42.9%	42.0%	40.2%		**41.9%**
	Over 12 hrs	92	184	110	131	124	70	100	90	96	110	101		**110**
Bronglais General Hospital	Total attendances	331	334	318	310	289	326	350	336	368	362	343	340	**334**
	% under 4hrs	56.5%	54.8%	55.7%	55.2%	60.9%	58.9%	64.3%	59.8%	51.1%	56.4%	51.3%	51.8%	**56.4%**
	Over 12 hrs	30	58	51	34	29	45	25	38	49	58	57	47	**43**
Prince Charles Hospital	Total attendances	213	240	218	219	234	203	213	202	218	211	231	217	**218**
	% under 4hrs	40.4%	42.5%	43.6%	50.7%	49.1%	55.2%	55.9%	55.4%	58.7%	49.3%	44.6%	50.7%	**49.7%**
	Over 12 hrs	62	66	53	52	57	47	28	34	36	51	51	43	**48**
Morriston Hospital	Total attendances	139	170	137	141	159	135	184	167	161	183	171	183	**161**
	% under 4hrs	41.7%	44.7%	55.5%	60.3%	62.9%	60.7%	62.5%	64.7%	54.7%	61.2%	56.7%	56.8%	**56.9%**
	Over 12 hrs	48	54	36	36	27	26	43	30	33	31	40	39	**37**
The Grange University Hospital	Total attendances	65	60	46	57	45	41	64	68	57	52	57	55	**56**
	% under 4hrs	61.5%	53.3%	50.0%	54.4%	55.6%	58.5%	62.5%	57.4%	61.4%	55.8%	49.1%	52.7%	**56.0%**
	Over 12 hrs	9	16	11	15	6	7	8	9	9	9	8	13	**10**
Wrexham Maelor Hospital	Total attendances	24	36	32	34	36	30	19	20	24	22	38	24	**28**
	% under 4hrs	37.5%	36.1%	62.5%	70.6%	58.3%	63.3%	63.2%	55.0%	79.2%	54.5%	63.2%	66.7%	**59.2%**
	Over 12 hrs	1	6	3	3	4	3	1	2	0	5	5	1	**3**
Glangwili General Hospital	Total attendances	34	20	19	17	14	13	21	20	16	20	20	22	**20**
	% under 4hrs	58.8%	60.0%	63.2%	70.6%	50.0%	38.5%	38.1%	55.0%	50.0%	35.0%	60.0%	45.5%	**52.1%**
	Over 12 hrs	2	3	1	0	4	3	3	4	3	8	2	2	**3**
University Hospital Of Wales	Total attendances	12	10	12	13	14	13	14	9	12	15	10	11	**12**
	% under 4hrs	66.7%	70.0%	58.3%	84.6%	57.1%	76.9%	71.4%	66.7%	58.3%	46.7%	90.0%	63.6%	**67.5%**
	Over 12 hrs	1	0	0	1	0	1	0	0	2	1	0	1	**1**

Powys resident major unit attendance flow (ribbon chart)

New major unit attendance by provider and financial year





Please note Nevill Hall Hospital (ABUHB) switched from Major to Minor unit is November 2020

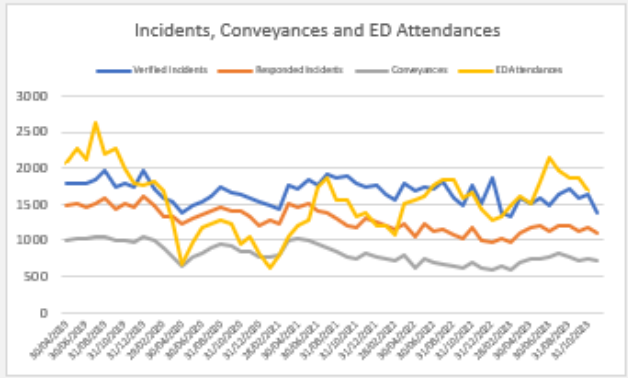
- Long term flow mirror the data in slide 7 with most attendances occurring in SATH. It should be noted that ABUHB (NHH) took a large flow of A&E patients up until downgrade, this has resulted in increased attendance at PCH (CTMUHB) and Hereford County Hospital (WVT).

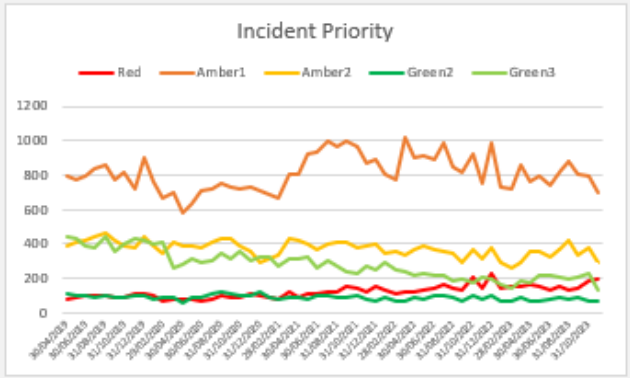
WAST performance & activity

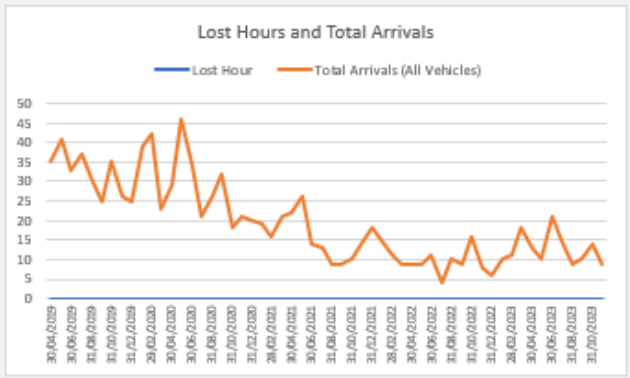
Wales Ambulance Service

Access and Activity

Monthly Dashboard - Powys

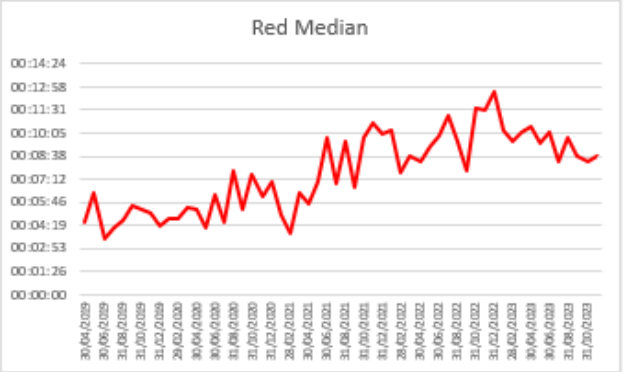


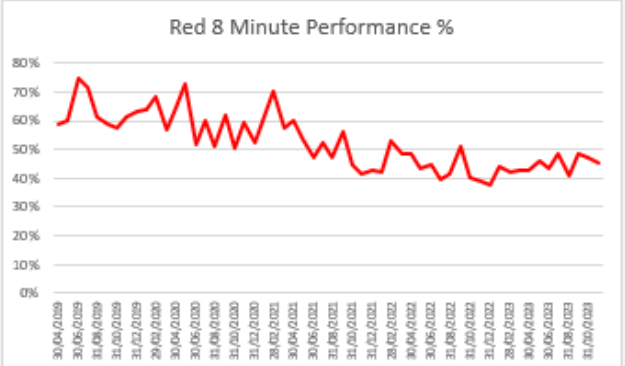


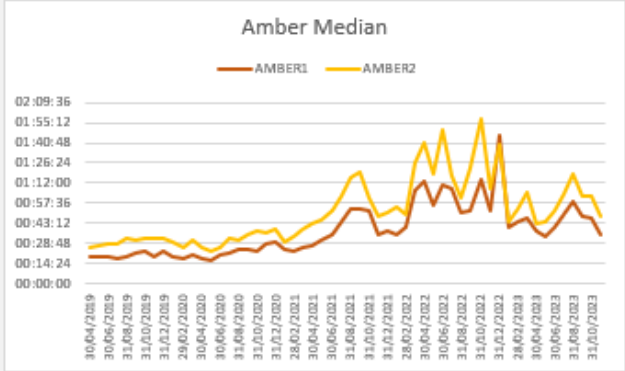


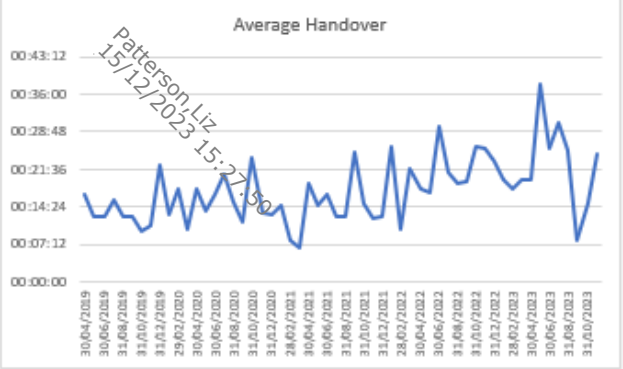
Select LHB

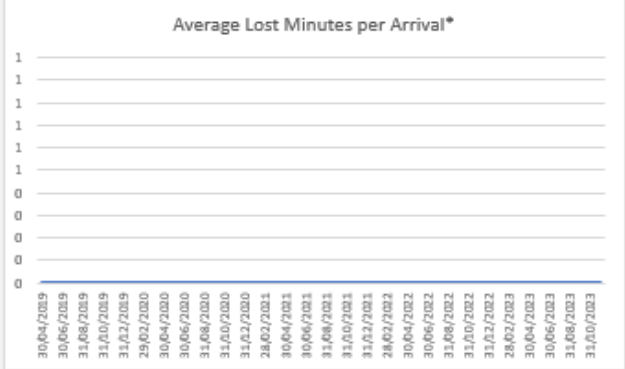
LHB
- Cardiff and Vale
- Cwm Taf Morgannwg
- Hywel Dda
- NHS Wales
- Out of Area
- Powys
- Swansea Bay
- (blank)

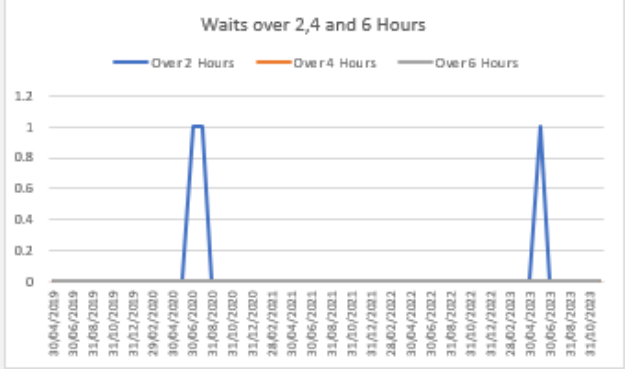










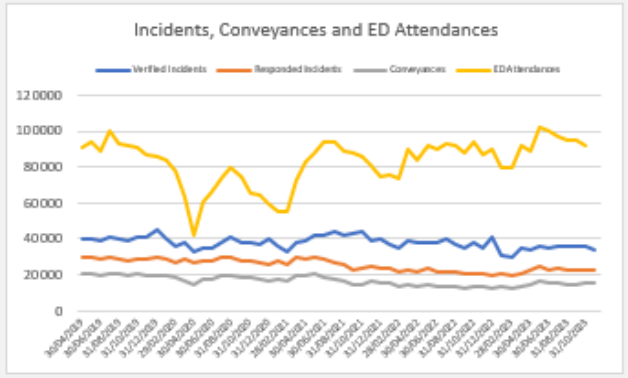


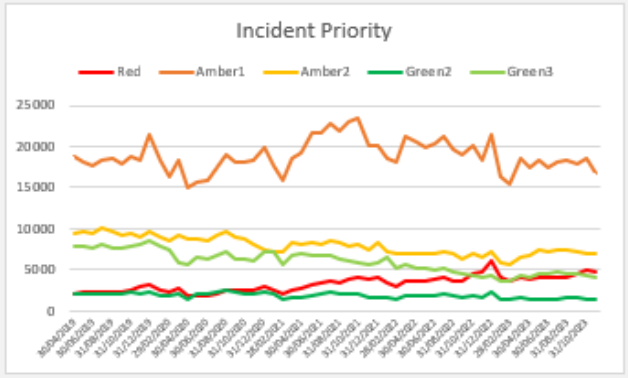
* Based on all vehicles per incident for all hospital sites

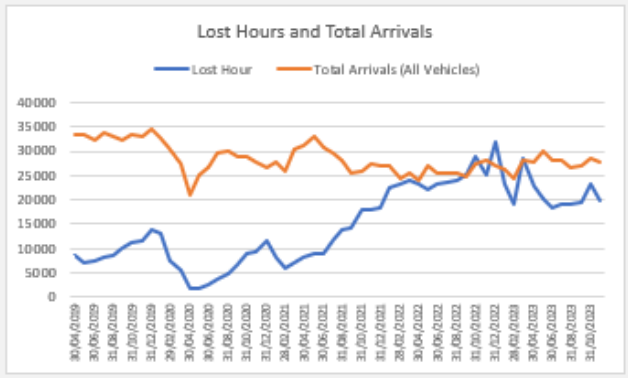
Wales Ambulance Service

Access and Activity

Monthly Dashboard - NHS Wales

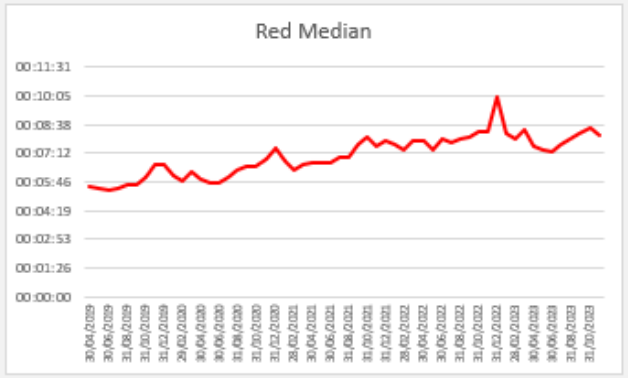


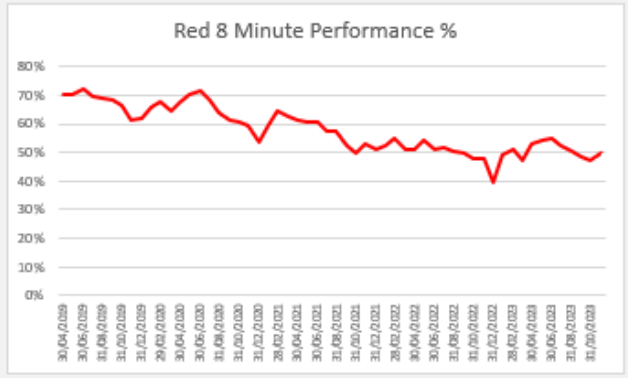


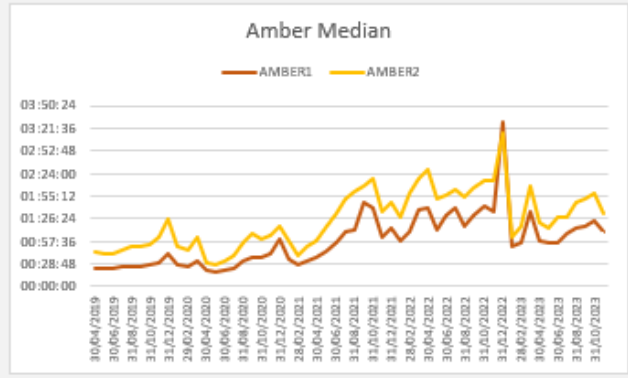


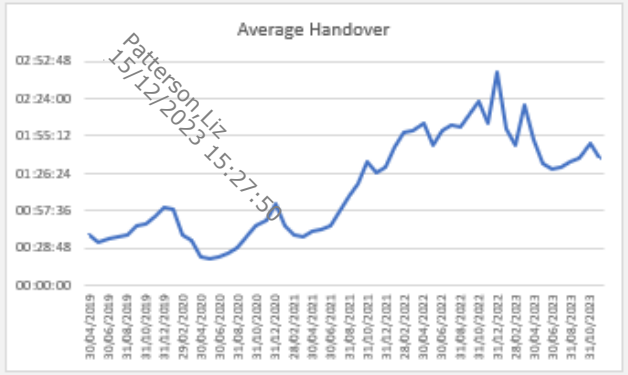
Select LHB

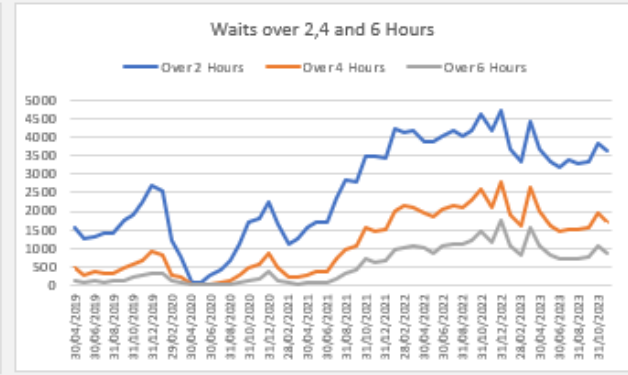
LHB
- Cardiff and Vale
- Cwm Taf Morgannwg
- Hywel Dda
- NHS Wales
- Out of Area
- Powys
- Swansea Bay
- (blank)









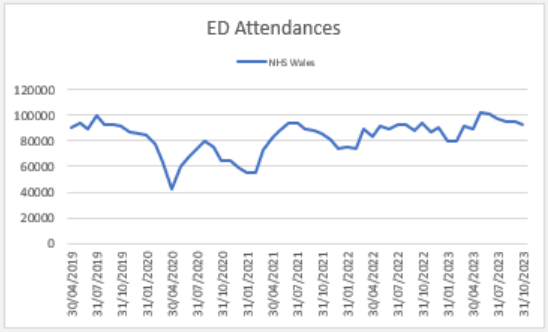


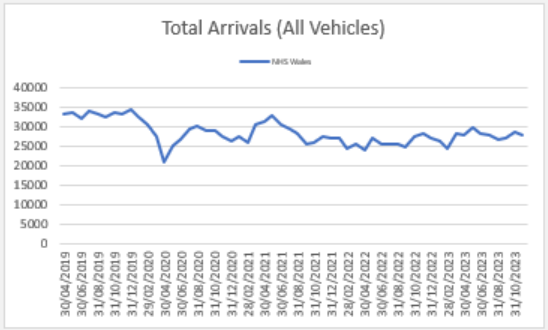
* Based on all vehicles per incident for all hospital sites

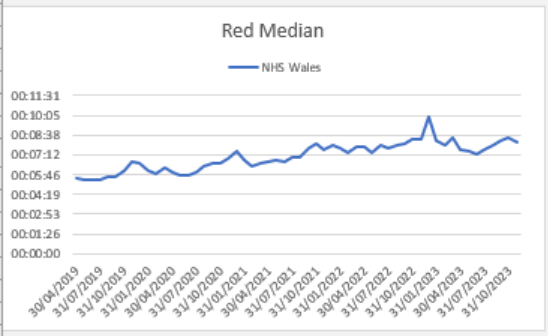
Wales Ambulance Service

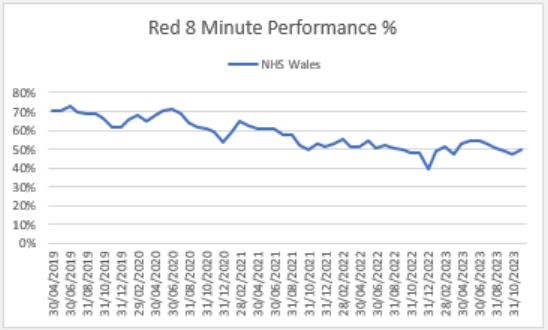
Access and Activity

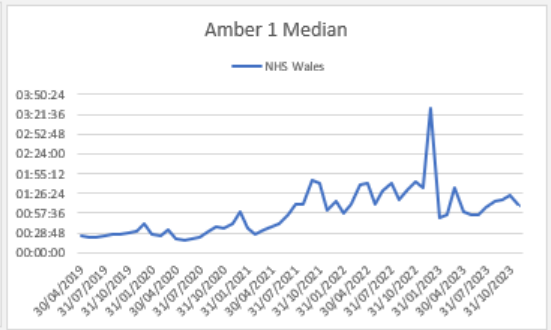
Monthly Trends by Major ED Sites for NHS Wales

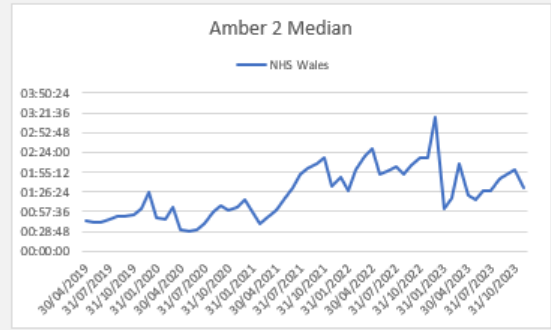


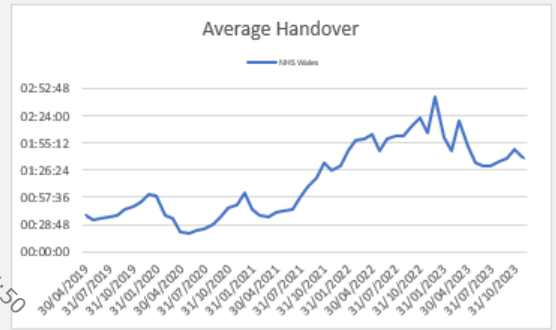












Patterson, Liz
15/12/2023 15:27:50

Select Healthboard

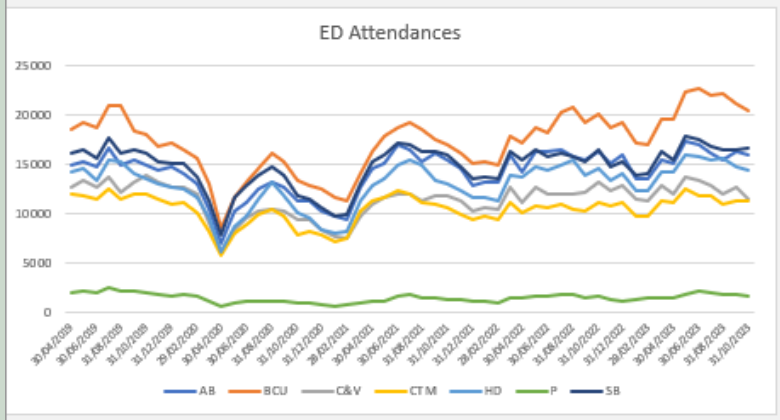
LHB

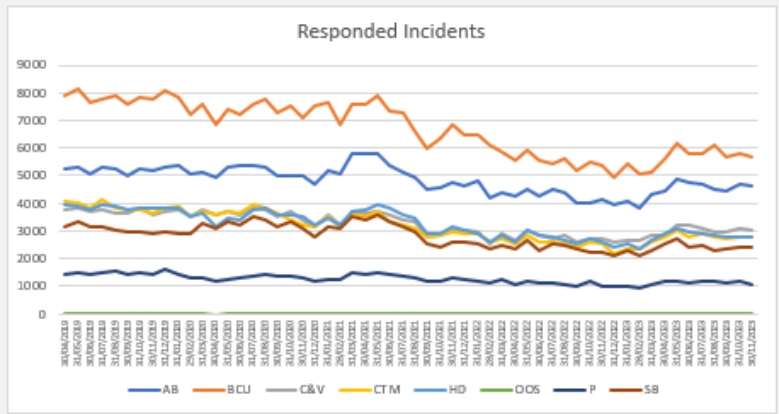
- Cardiff and Vale
- Cwm Taf Morgannwg
- Hywel Dda
- NHS Wales
- Out of Area
- Powys
- Swansea Bay
- (blank)

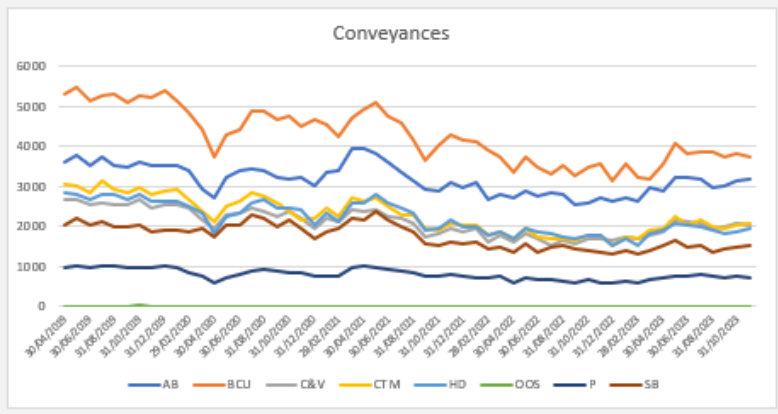
Wales Ambulance Service

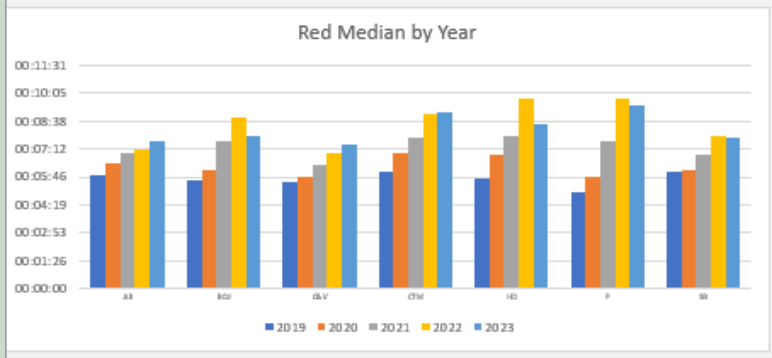
Access and Activity

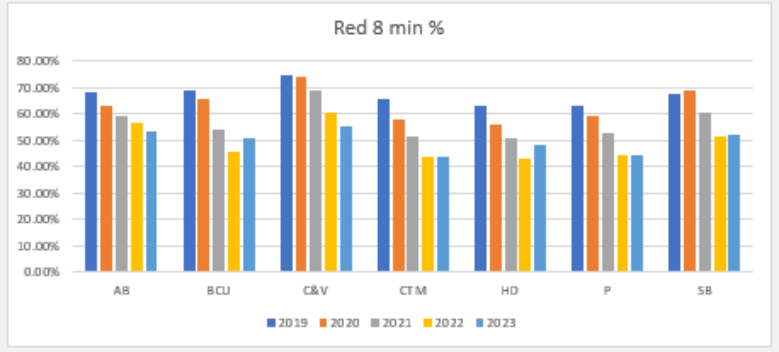
Monthly Trends - Health Board Comparison

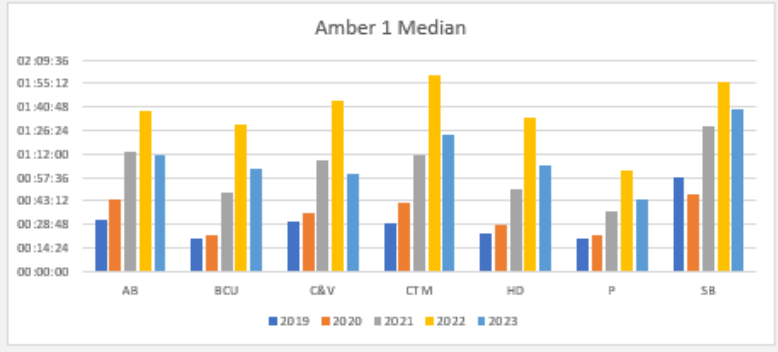


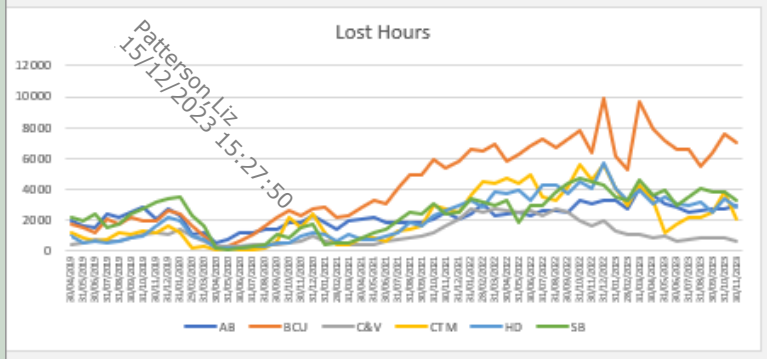


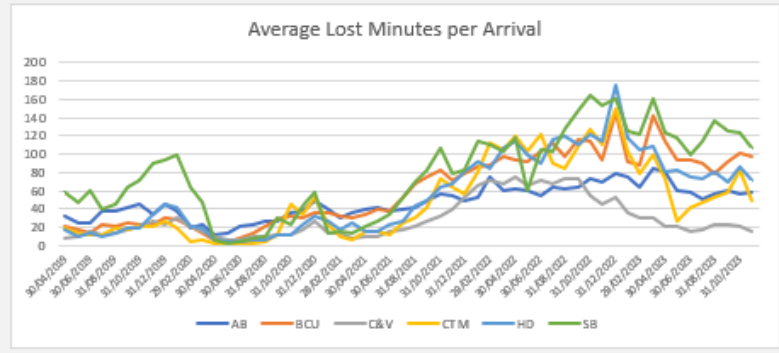


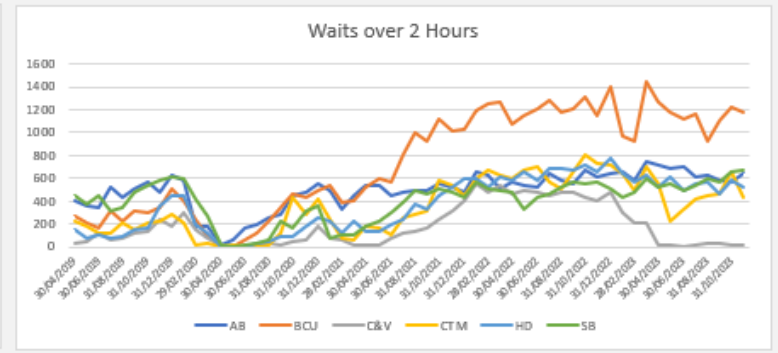








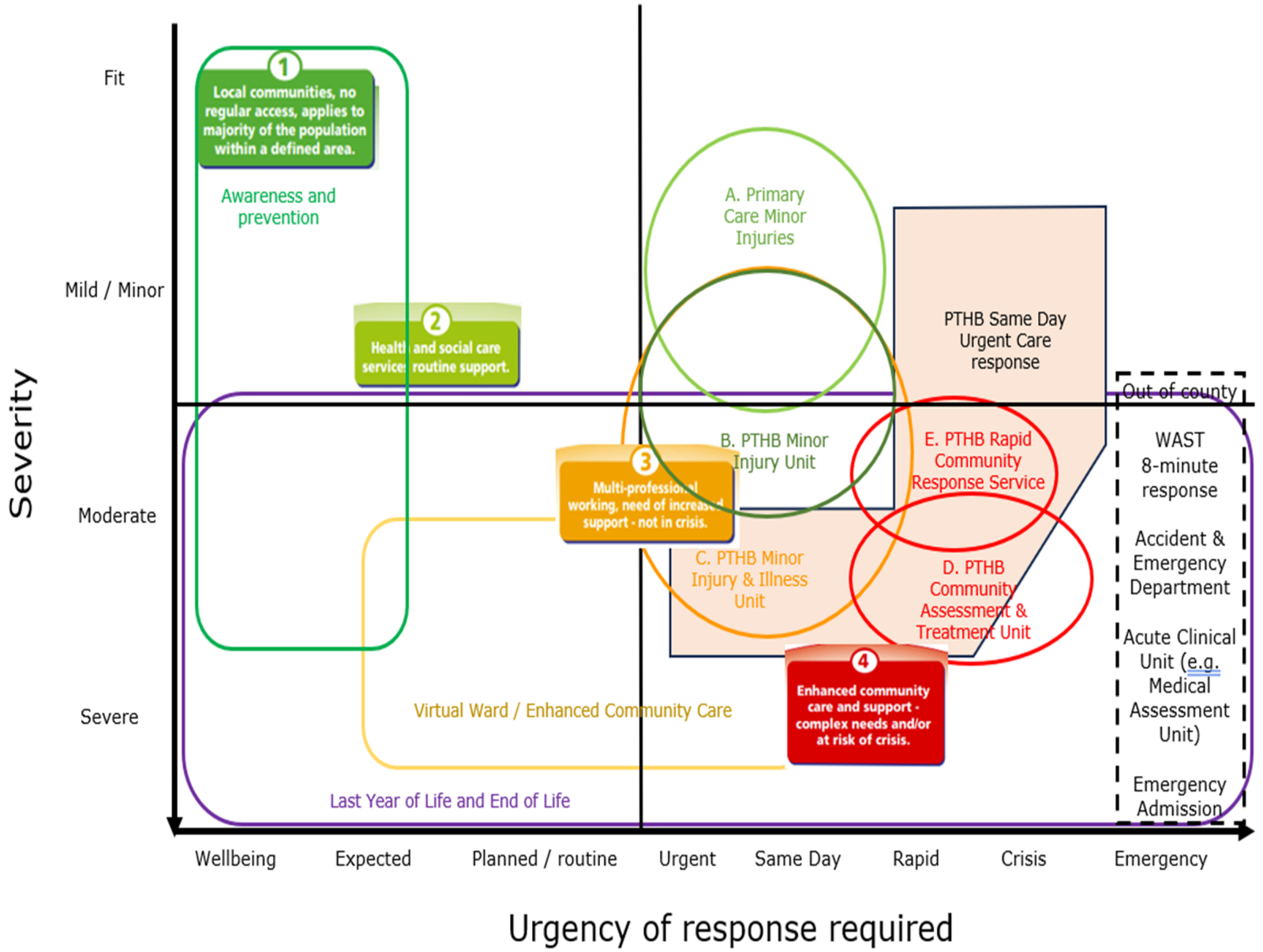




Extended role of Powys MIU's – **Potential** Future Model (ASM)

Same Day Urgent Care (SDUC)

Same Day Urgent Care spans rapid responses in the community – and the backup/step-up needed for this; Minor Injury and Illness Units; and same day attendances for assessment and treatment. The diagram attempts to show where these developments sit within the continuum of urgency and severity.



N.B. the scale of severity is intended to be interpreted differently between the Planned and Unscheduled sections of the diagrams, e.g. a patient may be severely frail from a planned care perspective, but not severely unwell from an Unscheduled perspective.

Extended role of Powys MIU's – **Potential** Future Model (ASM)

Same Day Urgent Care (SDUC) – potential conditions that could be managed

The services would be led by Advanced Practitioner nurses or Allied Health Professionals (such as paramedics) and could involve newly developed dual roles such as Nurse/Paramedics or Nurse/Social Workers.

Such professionals can assess, diagnose and treat walk-in patients who are then able to return home the same day, with a plan of care involving referral to other services if necessary.

This includes support for admission to Same Day Emergency Care (SDEC) or swift transfer to A&E in the most urgent cases. The MIIU- SDUC would have access to virtual consultant advice through [Consultant Connect].

The services would be linked to enhanced diagnostics.
The service would provide:

- the ability for patients to be assessed, diagnosed and start treatment on the same day, improving patient experience and reducing hospital admissions.
- avoiding unplanned and longer than necessary stays in hospitals, resulting in lower risk of infections and de-conditioning for patients
- financial benefits and cost savings for hospitals, and often for patients too.

- Chest Infections (which would require illness module training for non complex cases & access to chest x-ray)
- Wound Infections (opportunity to further develop)
- Urinary Tract Infections (would require illness module training for non complex cases)
- Ear Infections (as above)
- Minor Chest/Hip/Pelvic/Back injuries – Patient must be able to mobilise [Unable to x-ray hip/pelvis at present]
- Minor Head Injury
- Non-cardiac chest pain
- Skin complaints including rashes, infections, and sunburn [would require illness module training for non complex cases]
- Sprains, strains & soft tissue injuries
- Hay fever, Mild allergic reactions
- Minor injuries - cuts, wounds
- Minor eye injuries, complaints and irritations requiring irrigation, and Chemical eye injury
- Emergency contraception
- Suspected fractures and injuries to knee, lower leg, ankle, and feet
- Suspected fractures and injuries to arms ➢ Animal, insect, or human bites
- Minor burns & scalds
- Removal of foreign bodies from eyes, ears, nose & skin

Extended role of Admission Avoidance - **Potential** Future Model (ASM)

Same Day Urgent Care: Community Assessment and Treatment Unit (CATU)

This service is a continuum of the same day urgent care approach described above but enables short-term admission (preventing admission to DGHs or longer-term community hospital admission). In particular, it helps to provide a step-up unit for frailty and back-up for virtual wards/enhanced community care

The unit would help to provide:

- ➢ Rapid assessment
- ➢ Enhanced therapy
- ➢ Backup for virtual wards/enhanced community care
- ➢ IV Electrolyte imbalance correction
- ➢ IV fluids
- ➢ IV antibiotics
- ➢ IV infusions
- ➢ Blood transfusions
- ➢ Management of exacerbations of long-term conditions (chronic heart failure and COPD)
- ➢ End of life if symptom palliation
- ➢ Link to on-site diagnostics (community cardiology, ultrasound, x-ray)
- ➢ WAST direct access
- ➢ Admission could be up to 48 hours if required
- ➢ Most patients would return home on pathway 0 under D2RA
- ➢ Post DGH Urgent Assessment & treatment

Both SDUC & CATU services require further development as part of our 5 year plan including intended benefits (financial & non financial, quantitative & qualitative)

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 2.5

Delivery and Performance Committee	**Date of Meeting: 13 December 2023**
Subject:	**Information Governance Key Performance Metrics Report**
Approved and presented by:	Pete Hopgood, Executive Director of Finance, Informatics, and Information Services
Prepared by:	Amanda Smart, Head of Information Governance, Records and DPO and Rhiannon Hughes Information Governance Manager
Other Committees and meetings considered at:	Executive Committee – 13 December 2023

PURPOSE:

The purpose of this paper is to inform the Delivery and Performance Committee of the Health Board's performance against the NHS Wales Information Governance Toolkit for Health Boards and Trusts 2022-2023.

An IG Toolkit Improvement Plan has been developed highlighting areas of work required to improve the current compliance in readiness for the 2023-24 submission.

The Committee are asked to note that there has been a significant delay in reporting the 2022-23 assessment due to national delays within the central Welsh IG Toolkit Team at Digital Health and Care Wales (DHCW) developing and deploying the latest version of the assessment to participating organisations to complete.

RECOMMENDATION(S):

The Committee is asked to:

1. **REVIEW** the contents of this report and take **ASSURANCE** the management actions identified in the Improvement Plan to support the 2023-24 submission.
2. **NOTE** due to the change in the platform and additional categorisation the scoring for 2023-24 out-turn report may show a drop in compliance.
3. Take **ASSURANCE** from the significant improvement in records management compliance from 0% in previous years submissions to exceeding expectations for 2022-2023.
4. **NOTE** the publication of the Toolkit scores and final out-turn report in accordance with requirements of the Wales Information Governance Board (WIGB)

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:

For this reporting period the IG Team have continued to generate an estimated percentage overall score using the average level score reached on each category. While this will not be as accurate as scoring aligned to each question, this will provide a high-level indication on compliance reached for this reporting period. These are below:

Level 0 – 25%
Level 1 – 50%
Level 2 – 75%
Level 3 – 100%

Current Position (2022-2023)
The health board performed well in the 2022-2023 assessment equalling that of the estimated score for 2021-2022 (**92%**).

The IG Toolkit moved to a new platform this year, with significant changes being made to the sections and supporting questions. Future compliance scoring will also look different and has been replaced with a compliance percentage per new sub-category. Confirmation has been received from the national team at DHCW the

scoring functionality on the new platform is still not yet live with no given timeframe for completion which may result in manual completion by the IG Team if not available in readiness for the next report. The NHS Wales Information Governance Managers Advisory Group have raised this issue.

DETAILED BACKGROUND AND ASSESSMENT:

The Welsh Information Governance Toolkit is a self-assessment tool enabling organisations to measure their level of compliance against national Information Governance standards and legislation. The aim of the assessment is to demonstrate that the Health Board can be trusted to maintain the confidentiality and security of both personal and business information. This in turn provides re-assurance to staff and patients that their information is processed securely and appropriately, and assure other organisations where sharing is made that appropriate IG arrangements are in place.

While the toolkit demonstrates IG and records management compliance, some aspects are also assessed under the biennial Welsh Cyber Assurance Process (WCAP).

The assessment assists in identifying areas which require improvement, and these informs the IG Toolkit Improvement Plan.

Since March 2023, the IG Toolkit assessment now consists of a range of updated categorised questions based on legal requirements, guidance, and codes of practice. These are broken down into twelve sections each with their own sub-sections:

- Accountability
- Leadership and Oversight
- Policies and Procedures
- Individuals Rights
- Records of Processing and Lawful Basis
- Contracts and Information Sharing
- Risks and Data Protection Impact Assessments (DPIAs)
- Records Management and Security
- Breach Response and Monitoring
- Freedom of Information (FOI) and Environmental Information (EIR)
- Information Security Measures
- Business Continuity

The latest release of the IG toolkit was delayed this year by DHCW central team with submissions not opening until March 2023 and closing on 30 June 2023.

The table below highlights PTHB's estimated scoring for the previous two years submission:

Category	Level Average 2020-21	Estimated Average percentage 2020-21	Level Average 2021-22	Estimated Average percentage 2021-22
Business Responsibilities	2	82%	3	96%
Business Management	3	100%	3	100%
Individuals Rights and Obligations	2	88%	3	94%
Technical, Physical and Organisational Measures	2	56%	2	69%
Reporting Data Breaches	3	100%	3	100%
Total	**2**	**85 %**	**3**	**92%**

How is Compliance Measured?

Compliance is measured by positively answering assessment questions within each of the categories. Supporting evidence is uploaded or text descriptors inserted to detail the Organisation's position with regards to relevant legal requirements, guidance, and codes of practice.

Measures:

"Minimum Expectations" sets out the minimum requirements which form the backbone of the organisation's IG compliance, it includes questions which are either legal requirements or are set out within the Information Commissioner's Office Accountability Framework.

"Expectations Exceeded" allows organisations to demonstrate that they are working above the minimum requirements in that topic area and contains an additional question set which is only available once the minimum expectations have been achieved (e.g., 100% completion).

Each category will have a varying number of questions depending on the requirement, and to complete a section all questions for that category must be sufficiently answered. Partial responses demonstrate that the health board is "working towards" compliance. Following completion and submission of the toolkit, results are reviewed by each organisation and DHCW, and an improvement plan is locally developed for approval. The IG Improvement Plan 2023 - 2024 has been included with this paper.

Assurance for 2022-2023:

Where the health board can demonstrate full compliance (100%), work should and always will continue to ensure that the high level of assurance is maintained to demonstrate compliance with data protection and records management obligations, provide assurance to key stakeholders such as provider organisations, our service users and the Information Commissioner's Office (ICO).

Any areas requiring action for improvement to increase compliance are documented within the IG Toolkit Improvement Plan 2023-24.

NEXT STEPS:

Work will commence on completion of the 2023/24 submission as well as addressing the identified areas of IG and Records Management from the IG Improvement Plan 2023-2024 to support overall compliance.

Assurance reports will be submitted to the Delivery and Performance Committee annually.

Information Governance Toolkit Actions from Improvement Plan 2023-2024

The table below outlines the actions required to improve on the current PTHB IG assurance compliance score from the NHS Wales IG Toolkit for Health Boards and Trusts 2023-2024.

As noted on the Out-turn report, compliance is measured in % based on questions completed for each section. An organisation can achieve full compliance for "Expectations Met" when they complete and upload relevant evidence up to 100%. When 100% is achieved and expectations are met, PTHB is then able to score compliance against "Expectations Exceeded" up to a further 100%.

This current submission has highlighted **8** actions from Appendix 1 of the Out-turn Report for improvement that either did not meet expectations or score 100% in exceeded expectations:

Action no.	Category and reference	Subsection	Level working towards	% Achieved	Issue/Requirement	Action required to Improve %	Responsible Director
1	Accountability 1.1	Leadership and Oversight	Expectations Met	**93%**	Staff resource	Ensure job descriptions include key roles and responsibilities e.g. SIRO, Caldicott Guardian Awareness raising of these key roles throughout the organisation	Deputy Chief Executive/ Exec Director of Finance, IT & Information Services Medical Director

2	Accountability 1.2	Policies and Procedures	Exceeded Expectations	**80%**	Policies and procedures are in place to ensure IG and data protection issues are considered prior to new processing of personal information commencing	Embed a robust process to support the design and implementation of new systems, services and business practices in relation to IG and Data Protection issues.	Deputy Chief Executive/ Exec Director of Finance, IT & Information Services
3	Accountability 1.2	Policies and Procedures	As above	As above	Does the organisation keep a record to positively confirm staff and have read and understand relevant policies and procedures?	Explore options on possible systems to meet this requirement e.g. the Net Consent solution	Director of Corporate Governance/Board Secretary
4	Accountability 1.5	Transparency	Exceeded Expectations	**88%**	Privacy Notice	Develop a standard Privacy Notice for Children and make available on the PTHB website	Deputy Chief Executive/ Exec Director of Finance, IT & Information Services
5	Accountability 1.5	Transparency	As above	As above	Record of Processing Activities (ROPA)	Continue to work with local Business Intelligence and Informatics lead to explore options around the	Deputy Chief Executive/ Exec Director of Finance, IT & Information Services

						development of a system to act as a central ROPA to register existing processing activities for transparency and Business Continuity. This will link with the Health Boards Information Asset Register (IAR) and current on-going work.	
6	Accountability 1.9	Records of Processing and Lawful Basis	Expectations Met	**77%**	Record of Processing Activities (ROPA)	As above. This should be based on data mapping exercises in line with action 5.	Deputy Chief Executive/ Exec Director of Finance, IT & Information Services
7	Accountability 1.9	Records Management & Security	Exceeded Expectations	**90%**	Spot checks and monitoring to ensure procedures regarding security of information are followed across the organisation	Same as action 3	Director of Corporate Governance/Board Secretary

						Audit Programme developed and implemented across all services	Deputy Chief Executive/ Exec Director of Finance, IT & Information Services and Director of estates
8	Accountability 1.4	Individual's Rights	Exceeded Expectations	**100%**	Subject Access Requests (SARs)	While this is included in our Access to Information Procedure, we are required to draft a clear separate guidance document for the inaccurate disclosure of data and how we inform the individual affected.	Deputy Chief Executive/ Exec Director of Finance, IT & Information Services

Progress made from Information Governance Toolkit Actions from 2022-2023 Improvement Plan

The table below outlines the progress made in the identified areas from the previous IG Toolkit Submission submission (2021/2022)

Category. Ref no.	Category	Area of Responsibility	% achieved 2022/23	Action required to Improve %	Responsible Director	Progress made / updates for 2022/2023
2.3	Business Responsibilities	Information Sharing	2	Need to ensure agreements are kept up to date. Any changes or updates are reflected in the Information Sharing Register – this has not been practicable due to Covid-19/ Staffing resources	Exec Director of Finance, IT & Information Services	Completed under Section 1.7 Accountability (Contracts and Information Sharing)
2.7	Business Responsibilities	Privacy and Electronic Communications Regulations	0	1. Ensure that there are privacy and electronic communications regulation related policies and procedure and any relevant guidance outlining high level responsibilities 2. Identify appropriate individuals to undergo PECR training 3. Provide details of how staff members are informed of the procedures and policies and how these are made accessible	Exec Director of Finance, IT & Information Services	Completed - This is no longer a requirement on the Welsh Information Governance Toolkit 2022-2023. Our regulator, the ICO consulted on a draft Regulatory Action Policy (RAP) in line with the Data Protection Act 2018, in January 2022. The results of this consultation are yet to be published.

5.1	Managing and Securing Records	Management of Records (Acute, Community, Mental Health and Corporate)	0	Section not completed while service improvement work is being undertaken	Exec Director of Finance, IT & Information Services	Improvements made under Section 1.9 Accountability (Records Management and Security). Further action required (Action 7) See Records Management Improvement Plan.
5.2	Managing and Securing Records	Information Asset Register	2	Need to report IAR performance to the Committee/Board	Exec Director of Finance, IT & Information Services	Improvements made under Section 1.9 Accountability (Records Management and Security). Further action required (Action 5) See Records Management Improvement Plan.
5.3	Managing and Securing Records	Data Accuracy	0	Section not completed while service improvement work is being undertaken	ALL	Improvements made under Section 1.9 Accountability (Records Management and Security). IG to liaise with Data and Business Intelligence team to further progress this.

5.4	Managing and Securing Records	Retention Schedules, Secure Destruction and Disposal	0	Section not completed while service improvement work is being undertaken	Exec Director of Finance, IT & Information Services	Completed - Improvements made under Section 1.9 Accountability (Records Management and Security). Remaining actions required are included under Action 3.
6.1	Technical, Physical and Organisational Security Measures	Physical Security Measures	2	Need to liaise with Estates for further information - consider audits including date of last security audit for health board premises.	Exec Director of Finance, IT & Information Services and Director of Workforce & Organisational Development & Support Services	Completed - Improvements made. Work continues to progress updates as required. IG to continue liaising with Estates Support Services Manager. This is covered in Section 3.0
6.6	Technical, Physical and Organisational Security Measures	Technical Security Measures	2	1.All reasonable steps have been taken to ensure technical measures provide sufficient security by undertaking regular risk assessment. Any improvements are considered and	Exec Director of Finance, IT & Information Services	Completed - Improvements made under Section 1.9 Accountability (Records Management and Security) and Section 3.0 (Information Security).

				implemented where necessary. 2. The health board carries out regular auditing of their IT systems to monitor activity. 3. All staff are informed that their activities on IT systems will be monitored		

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda Item: 2.7

Delivery and Performance Committee	**Date of Meeting: 19 December 2023**
Subject:	**Commissioning Assurance Framework – Primary Care General Dental Services 2022/2023**
Approved and presented by:	Director of Finance & IT and Interim Executive Director of Primary Care
Prepared by:	Jayne Lawrence, Assistant Director of Primary Care
Other Committees and meetings considered at:	Executive Committee – 15 November 2023

PURPOSE:		
The purpose of this paper is to provide assurance to the PTHB Executive Committee on the General Dental Services Commissioning Assurance Framework process applied to the 2022/2023 contract year.		
RECOMMENDATION(S):		
The Committee is requested to 1. **NOTE** the update provided. 2. Take **ASSURANCE** that the General Dental Services Commissioning Assurance Framework monitoring process is in place and providing the required assurance to PTHB on dental contract management.		
Approval/Ratification/Decision[1]	**Discussion**	**Information**
	✓	✓

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

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

EXECUTIVE SUMMARY:

The General Dental Services (GDS) Commissioning Assurance Framework (CAF) reporting is updated monthly and internal assurance is delivered through the monthly General Dental Services Monitoring Meetings. The GDS CAF monitors general dental services contracts only and during 2022/23 PTHB had 20 GDS providers, two of which were managed practices

The assurance on the delivery of GDS is summative and takes place throughout the year as ongoing data is reviewed and regular dialogue takes place with the contractors, as necessary. If a problem is found, the General Dental Services Monitoring Group is clear on the consequences and subsequent actions that need to be taken.

GDS Contract Reform restarted in 2022/23 and the dental providers had the option to either continue working under the UDA contract arrangement or to take up the opportunity to take part in Contract Reform. In 2022/23 the PTHB uptake of Contract Reform was 85% (17) with 15% (3) of practices choosing to continue working under the UDA contract.

Monitoring the delivery of dental services throughout 2022/23 was a complex process as two types of contracts were monitored with each having different target metrics to work towards. This was reflected in the CAF with the various metrics included for both contract types. GDS Contract Reform is not enforced via updated legislation and practice participation was in place through a contract variation notice to the provider's substantive contract. In addition to the national Contract Reform measures, PTHB introduced a local measure to enable urgent access for patients which offered 50 urgent slots per week. This metric was deducted from the national new patient measure.

2022/23 continued to be a learning year for Contract Reform providers and UDA providers reverted back to how they worked before the pandemic.

Practice compliance with the measures were linked to financial reward and sanctions were placed on practices that didn't meet their targets.

Welsh Government supported the year end process by releasing End of Year flexibilities for Health Boards to reduce practices financial sanctions and also introduced a number of national mitigations. This applied to both Contract Reform and UDA contracts. In addition to this Health Boards had discretion to apply additional local mitigation. As agreed by PTHB Executives, PTHB did not apply local mitigation. Across Wales some Health Boards applied local mitigation, however the local mitigation was determined at individual Health Board level, therefore there has been no consistency across Wales regarding mitigations applied at year end to calculate contract sanctions. This has caused difficulties for the dental contract management team with year-end discussions with dental providers.

During 2022/23 the end CAF position resulted in the following Escalation Levels in line with contractual requirements as follows:

Assurance monitoring	No: of practices
Routine Monitoring	3
Enhanced monitoring	17
Breach Notice issued	1

17 practices had an underperformance recorded against their contract.

The Welsh Government year-end flexibilities guidance has enabled each practice to consider whether they want to carry forward their underperformance into 2023/24. Providers that had an underperformance in value over £20k were asked to provide PTHB with a business plan regarding contract delivery for 2023/2024 to include the 2022/23 carry forward and the 2023/24 metrics. This was put in place to offer assurance to PTHB that a practice could absorb the carry forward. This was an appropriate request as per the Welsh Government flexibilities guidance approach.

Some providers are still working through their underperformance by reviewing financial stability along with workforce requirements to deliver both the 2022/23 underperformance and their current contract within 2023/24. Many of these discussions are taking place at the 2023/2024 mid-year review meetings which are currently taking place.

The underperformance total is £876k. Currently the minimum clawback that PTHB will be receiving stands at £609,840.30, with the potential of £266,100.74 underperformance to be carried forward into 2023/24. However, these values may change as the providers continue to work through the implications of their underperformance.

Access:
Access to general dental services continues to be a local and national challenge. Supporting patients to access appropriate GDS provision continues to be a high priority for PTHB. The dedicated Dental Help line supports and signposts patients to access a dentist. Patients requiring urgent treatment are signposted to a dentist with urgent slot capacity and additional support is provided from the PTHB Community Dental Service when required, to meet patient demand. Patients who do not have access to a dentist are added to the PTHB centralised waiting list. The waiting list has been in place since September 2021. As of October 2023, there are approximately 5,000 patients on the waiting list and 2,000 patients have been secured access with a dentist. Welsh Government are now requiring all Health Boards to implement a waiting list and are pleased with the PTHB proactive approach to this.

2022/2023 Contract changes:

- The Powell Main Dental Practice in Newtown terminated their contract, on 31st of August 2022.
- The re-tendering of the above contract was successful with a new practice in Newtown opening its doors on 1st May 2023 to NHS patients.
- The Dental Practice in Llandrindod Wells was taken over by a new provider who was also awarded an extra NHS contract increasing the capacity of the contract thereby enabling increased patient throughput and access.

- The My Dentist Brecon Practice was taken over by a new provider who currently holds three contracts in Brecon. Access has been variable across the three contracts due to recruitment challenges, however the current workforce plan shared with PTHB offers assurance around contract delivery in 2023/24. This is being closely monitored.

DETAILED BACKGROUND AND ASSESSMENT:

Currently PTHB delivers primary care dental services through three types of contractual arrangements: General Dental Services Contracts, Personal Dental Service contracts and Managed Practice contracts.

The Personal Dental Service arrangements have different contracts, and some are managed separately due to fixed expiry dates and relate to specialist or individual service arrangements, for example emergency access, orthodontics and out of hours. The GDS CAF monitors General Dental Services contracts only including the two managed practice contracts at Machynlleth and Builth Wells.

Dental Services contracts between Health Boards and general dental service providers are delivered within the National Health Service (General Dental Services Contracts) (Wales) Regulations 2006. During 2022/23 PTHB had 20 GDS providers/contracts in place, two of which are managed practices.

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

- final GDS contract achievement data is not published until June
- CAF dashboards are in place for all GDS contracts.
- exceptions linking to the agreed CAF RAG rating are actioned appropriately in year along with a final reconciliation at year end.
- the GDS Monitoring Group identifies areas of concern and agrees whether to 'step up' or 'step down' escalation.
- there are two pivotal reporting timelines within the GDS CAF, linked to the regulations which can enable contract sanctions to be progressed if appropriate, namely the mid-year (30th September) and end of year (30th June) review process.
- other measures within the CAF provide assurance on the delivery of services, as opposed to contract levers.
- only CAF indicators linked to the regulations are enforceable. Parameters within the CAF not covered within the regulations are not enforceable.

The Contract Reform principle of moving away from the % of UDAs being generated continued throughout 2022/23 and the focus on addressing prioritising patient needs and inequalities and stepping up preventive intervention and care continued. This change in contract approach has not been enforced via updated legislation and the current Contract Reform measures have been developed by Welsh Government Dental Branch.

Dental providers had the option to either continue working under the UDA contract arrangement or to take up the opportunity to take part in Contract Reform. In 2022/23, the PTHB uptake of Contract Reform was 85% with 15% of practices choosing to continue working under the UDA contract.

Monitoring the delivery of dental services throughout 2022/23 was a complex process as two types of contracts were monitored with each having different target metrics to work towards. This was reflected in the CAF with the various metrics included for both contract types. Participation in Contract Reform was put in place through a Contract Variation Notice to the provider's substantive contract.

The ongoing learning from Contract Reform is helping Welsh Government to inform the New Dental contract due to be implemented in 2024/25.

The national performance measures were altered by Welsh Government as part of the restart of the Contract Reform programme for 2022/2023 and the CAF metrics were altered to take this into account:

- national performance measure
- local performance measures. PTHB introduced a local measure to enable urgent access for patients. This metric was deducted from the national new patient target.
- opening hours/access
- Quality Assurance Self-Assessment (clinical governance framework) Mid-Year and End of Year reviews
- External audit by NHS Business Services Authority (NHSBSA)

Appendix 1 (provided to Committee Members as background papers) details the full Contract Reform national measures. The measures included access for New and Historical patients, Fluoride Varnish targets and a Recall Interval target.

The locally introduced measure to support urgent patient access was taken up by 71% of the Contract Reform providers. This provided the Health Board with 50 urgent slots per week.

Mid-year review

The mid-year review legislation is linked to performance of completed UDAs and practices who have achieved <30% of their contracted allocation as of 30th September require a mid-year review. In relation to the Contract Reform all practices were required to have a Mid- Year review. 70% (16) practices took up the offer of a mid-year review. In addition to this the two managed practices received a mid-year review however this was undertaken through a different format.

The visits provided an opportunity to provide support and advice to the contract holders. Many Contract Reform providers were unclear on various aspects of the contract and welcomed the visit to gain clarification. Monthly spreadsheets were shared with the practices to inform them of their ongoing achievement of the metrics.

End of Year Review

The regulations state that a Health Board must arrange with the contractor an annual review of its performance in relation to the contract. This applied to both the UDA and Contract Reform providers. In 2022/23, 100% of End of Year Reviews were completed.

To support End of Year, the Welsh Government released End of Year flexibilities for Health Boards to implement to reduce practices financial sanctions. This applied to both Contract Reform and UDA contracts. This included the following three measures:

1) Underperformance, up to 20% of the annual contract value, could be carried into 2023/24 providing that the Health Board was assured that the contract holder had sufficient workforce in place to absorb additional activity.

   This was a very generous offer, compared to the 5% carried forward allowance detailed in legislation. This applied to Contract Reform and UDA providers.

2) The contract holder could elect to repay part of the value of the 2022/23 underperformance and carry the remaining value over into the 2023/24 contract.

3) The contract holder could elect to pay the financial sanctions in full.

In addition to this, Welsh Government supported the year end process by introducing a number of mitigations. This applied to both Contract Reform and UDA contracts. The mitigations had to be applied to all practices that underperformed on their contract. Mitigation could only be applied to underperforming contracts if they had reached the Health Board or National average for laboratory-based work such as crowns and dentures.

Health Boards had discretion to apply additional local mitigation. As agreed by PTHB Executives, PTHB did not apply local mitigation. Across Wales some Health Boards applied local mitigation, however the local mitigation was determined at individual Health Board level, therefore there has been no consistency across Wales regarding mitigations applied at year end to calculate contract sanctions. This has caused difficulties for the dental contract management team with year-end discussions with dental providers.

Appendix 2 details the Welsh Government mitigation measures for 2022/23.

Appendix 3 (provided to Committee Members as background papers) details the End of Year Flexibilities for 2022/23

CAF summary:

- 100% of practices met the required access arrangements and remained open (contractual requirement)
- 80% (16) practices took up the offer of a mid-year review. The two managed practices received a mid-year review however this was undertaken through a different format.
- 100% (20) practices received an end of year review.
- 95% (19) completed the Quality Assurance Self-Assessment. A Breach notice issued to provider who did not complete.
- 1 practice were subject to external audit scrutiny completed by the NHS Business Services Authority. No issues or concerns raised.

Contract Reform Achievement:

Measure (adults & children combined)	Target	Achievement
New patients	7,519	5,406 (72%)
Historical Patients	36,714	23,537 (64%)
Fluoride varnish application	>80%	86%
Recall intervals	<20% (with 5% tolerance) should not be seen in 12 months:	100%
UDA	UDA Target made up of 25% of ACV	88%
Local measure: urgent slots	2078	1705 (82%)

UDA Achievement:

Measure (adults & children combined)	Target	Achievement
UDA	23,788	22,491 (95%)

Application of the Welsh Government Year End flexibilities and mitigation resulted in the following year end position:

17 practices had an underperformance recorded against their contract.

Whilst clawback and carry forward values were estimated following the year-end flexibilities guidance, each practice needed to consider whether they were able to carry forward any underperformance into 2023/24. Providers that had an underperformance in value over £20k were asked to provide PTHB with a business plan regarding contract delivery for 2023/2024 to include the 2022/23 carry forward and the 2023/24 metrics. This was put in place to offer assurance to PTHB that a practice could absorb the carry forward. This was an appropriate request as per the Welsh Government flexibilities guidance approach.

Some providers are still working through their underperformance by reviewing financial stability along with workforce requirements to deliver both the 2022/23 underperformance and their current contract within 2023/24. Many of these discussions are taking place at the 2023/2024 mid-year review meetings which are currently taking place.

The underperformance total is £876k. Currently the minimum clawback that PTHB will be receiving stands at £609,840.30, with the potential of £266,100.74 underperformance to be carried forward into 2023/24. However, these values may change as the providers continue to work through the implications of their underperformance.

During 2022/23 the end CAF position resulted in the following Escalation Levels in line with contractual requirements as follows:

Assurance monitoring	No: of practices
Routine Monitoring	3
Enhanced monitoring	17
Breach Notice issued	1

Appendix 4 details the end of year 2022/23 CAF dashboard.

Access:

On the 6th of September 2021, PTHB implemented a dedicated Dental Helpline for Powys residents and offers a 9am – 5pm service, five days per week. The line also has the ability for the patient to leave their details should they call outside of these hours. The helpline supports patients to access general dental services. Patients requiring urgent treatment are signposted to a dentist with urgent slot capacity and additional support provided from the PTHB Community Dental Service when required, to meet patient demand. Patients who do not have access to a dentist are added to the PTHB centralised waiting list.

Dental Helpline statistics (as of 20th October 2023):

	Number
Total No. of Calls received	12,236
Queries/Concerns	4,846 Out of which 2,233 have been advised to call 111
Referred to a dental practice	2,081
Declined Referral to a Dental Practice	191

Added to the centralised waiting list	5,143

PTHB Centralised Waiting List breakdown:

Cluster:	Number
North Cluster Total	**1,724**
Mid Cluster Total	**2,976**
South Cluster Total	**443**
PTHB Total	**5,143**

The Dental team are currently undertaking a cleansing list exercise and sending out letters to patients on the waiting list to check whether they still need a place with an NHS Dentist.

2022/23 Contract changes:

- The Powell Main Dental Practice in Newtown terminated their contract, with their last day of service being the 31st of August 2022, this created a large influx of patients in the North Cluster being added to the waiting list. The re-tendering of this contract was successful with a new practice in Newtown opening its doors on 1st May 2023 to NHS patients. There is temporarily reduced access with this new contract as the new provider opted to fulfil 50% of the contract for 2023/24 due to being a new business owner, however it is expected that from 24/25 onwards full access will be in place.
- During 2022/23 the Dental Practice in Llandrindod Wells was taken over by a new provider who was also awarded an extra NHS contract increasing the capacity of the contract thereby enabling increased patient throughput and access.
- On the 1st of November 2023, the My Dentist Brecon Practice was taken over by a new provider who currently holds three contracts in Brecon. Access has been variable across the three contracts due to recruitment challenges, however the current workforce plan shared with PTHB offers assurance around contract delivery in 2023/24. This is being closely monitored.

2023/2024 Contract Changes:

- My Dentist Hay on Wye has informed the Health Board of their resignation of their contract, effective from 30th November 2023. Alternative provision for GDS access to the area is currently being scoped by the dental contracts team. Urgent access will be offered via the dental helpline.

NEXT STEPS:

1. To continue contract management monitoring and year end forecasting aligned to the 2023/2024 GDS Contract Variation.
2. To continue to revise and align the PTHB Commissioning Assurance Framework to the 2023/2024 Contract Variation.
3. To undertake mid-year review visits (currently ongoing)

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

IMPACT ASSESSMENT

Equality Act 2010, Protected Characteristics:

	No impact	Adverse	Differential	Positive	Statement
Age	x				***Please provide supporting narrative for any adverse, differential or positive impact that may arise from a decision being taken***
Disability	x				
Gender reassignment	x				
Pregnancy and maternity	x				
Race	x				
Religion/ Belief	x				
Sex	x				
Sexual Orientation	x				
Marriage and civil partnership	x				
Welsh Language	x				

Risk Assessment:

	Level of risk identified				Statement
	None	Low	Moderate	High	***Please provide supporting narrative for any risks identified that may occur if a decision is taken***
Clinical		x			
Financial		x			
Corporate	x				
Operational			X		
Reputational			x		

End of Year review and performance management of practices participating in the GDS Reform Programme: All-Wales approach

Background:

The Units of Dental Activity (UDA) system, while simple in terms of administration, solely measured a practices performance according to the clinical activity undertaken. It is widely acknowledged that delivery against the UDA target is not an indicator of overall performance of a practice, as it does not consider the needs and risks of a defined local population or encourage a preventive approach to patient care. In addition, the current UDA system encourages NHS practices to re-circulate a high volume of low risk/need patients. This approach to healthcare delivery is unique in the NHS, where patients with the lowest need are prioritised. Contract reform aims to redress this inequality in access by re-directing care to those with the greatest clinical risk and need.

Practices that opted into a primary care contract variation in 2022/23 have been working under a non-UDA measured system, focussing on delivery of preventive dental care for an annual number of new and existing patients.

During 2022/23 several qualitative methods have been employed to gain feedback from practices, health boards and principal stakeholders. Data held by NHSBSA has been and will continue to be analysed to further develop our understanding of practice performance against the metrics. The insight from this data analyses have been invaluable in informing this guidance. We appreciate that the complete picture of delivery against 2022/23 metrics will not be available until full year data is available (summer 2023).

One of the key themes within the feedback, from both practices and health boards, has been the variation between practices regarding the need and risk profile of their specific patient population and the impact this has on the practice's capacity to deliver against the volume metrics. In simple terms practices want to be rewarded for doing the right thing and accepting patients with high treatment need. This aligns with Dental Reform principles, requiring re-orientation of primary dental care to encourage delivery of prevention based on need. This approach is more likely to achieve improved oral health for those patient populations using NHS dental services. Currently the Reform Programme, through the various workstreams, is analysing patient-level ACORN data to inform the design of the new dental contract, primarily one that will incentivise a risk- and needs-based approach. Robust clinical monitoring will be needed to ensure high quality care is provided, as the UDA activity targets will have been removed.

2022/23 and 2023/24 will be interim years leading to the introduction of a new GDS dental contract in 2024. This is the initial stage of an overarching dental system reform for Wales. This guidance outlines the first step in taking account the variation in patient need between dental practices. There will be further learning and insights available from stakeholder groups when the 2022/23 full year data is available. This will inform next year's end of year contract management guidance and the future dental contract.

For the two years before 2022-23 financial sanctions were either suspended or limited to the fluoride varnish metric. Understandably the value of sanctions was very low in

those years. This approach cannot continue indefinitely as there must be mechanisms in place to demonstrate value for money when using public funds.

Ultimately any decision on financial sanction rests with the commissioning Health Board and this guidance does not seek to remove their autonomy or their local flexibility. Before any consideration is given to financial sanctions it is imperative that the practice and health board have an open conversation to understand the reasons why the volume metrics have not been achieved; this should be the starting point before any formula for mitigation is applied. Under performance is multifactorial and cannot be understood just by looking at “the numbers”.

This guidance seeks to ensure that a practice is not disadvantaged for seeing a disproportionate or above the health board average of red ACORN patients. While the following guidance is designed to ensure that such practices are supported and not disadvantaged, there will be scenarios where a financial sanction is appropriate, when Health Boards will have to decide when to apply that course of action. This guidance cannot cover all possible scenarios.

The guidance is intended for contract variation practices only. The guidance will assume that the fluoride and recall metrics have been achieved. Failure to meet this element of the contract variation has been clearly defined when setting out the contract variation offer in March 2022.

1. Practices that have met 2022/23 metrics

It is expected that all practices have delivered personalised prevention using the ACORN and DBOH (Delivering Better Oral Health Prevention: an evidence-based toolkit) principles. As such, it is also expected that all practices will meet the delivery of fluoride varnish applications as outlined in the Welsh Government communication on 3 March 2022 setting out the arrangements for the 2022/23 contract variation offer. It is understood that there will be variation even between the practices that have met the expected metrics. These variations provide learning opportunities for Health Boards in setting up monitoring mechanisms for 2023/24 and beyond.

The ACORN profile for practices will be available in eDen and should be reviewed to determine how the volume metrics have been met. Health Boards should capture successful case studies in their areas and share with other Health Boards for learning and to inform the reform programme.

Health Board Primary Care teams should ask themselves several questions such as:

- Is a practice’s ACORN profile and treatment delivery (eg; proportion of Band 1, Band 2 and Band 3) profile similar or different to Health Board’s average?
- Are the number of FP17Ws ie; Courses of Treatment delivered on patients with one or more Red on ACORN, within the 12 month timeframe, similar to the Health Board average?

Nationally there will be important learning that will inform the new dental contract, especially further refinement, or development of key performance indicators (quality indicators and monitoring mechanisms required once a new contact is introduced).

2. Historic Patient (HP) and New Patients (NP)

The target of 1280 HP and 260 NP for 177.65K ACV are interchangeable providing the NP metric has been met. For example, if a practice has seen 270 NP and 1270 HP then the practice can be assumed to have achieved the metrics.

3. Mitigation Formula

For every 1% increase above the HB median average for red ACORN with 4 or more interventions, the annual patient target (HP+NP) can be decreased by 2%.

For example: If the HB median average for Red ACORN with 4 or more interventions is 50% and a contract's mean average for Red ACORN with 4 or more interventions is 51%, the annual number of patients to be seen by the practice can be reduced by 31 patients for every 177.65k ACV (2% of 1540 total for every 177.65k ACV).

The mitigation formula should be applied first and then the 5% tolerance can be applied to this new target calculation if needed.

The mitigation formula will remove the need to factor in staffing levels directly. However, HBs should record the staffing levels to identify contracts which have obvious workforce issues. Lack of workforce will confirm why a practice has failed to meet the volume metrics confirming the need for a financial sanction for under delivery. A reduced or inappropriate workforce is not a reason for mitigation.

Additional Notes

The definition of a high needs red ACORN patient is currently assumed to be 4 interventions and above. This is calculated by adding 1 to the average of 2.8 (the average number of interventions per patient that require an intervention) and then rounding up. The final, end of year, data report could change this figure but based on the current forecast, it is the best estimate to date. Interventions for the purpose of this guidance are defined as the following items:

- endodontic_treatment_-_number_of_teeth
- permanent_fillings_&_sealant_restorations_-_number_of_teeth
- extractions_(general)_-_number_of_teeth
- crowns/onlays_provided_-_number_of_teeth
- upper_denture_(acrylic)_-_number_of_teeth
- lower_denture_(acrylic)_-_number_of_teeth
- upper_denture_(metal)_-_number_of_teeth
- lower_denture_(metal)_-_number_of_teeth
- veneers_applied_-_number_of_teeth
- bridges_fitted_-_number_of_teeth
- advanced_perio_rsd_-_number_of_sextants
- onlay_with_cusp_-_number_of_teeth
- pre_formed_crowns_-_number_of_crowns

- upper_and_or_lower_metal_denture_-_number_of_dentures
- prevention_and_stabilisation_-_number_of_teeth
- non-surgical_extraction_-_number_of_teeth
- surgical_removal_-_number_of_teeth

The NHSBSA eDen dashboard will, at year end, display the average Red ACORN high needs patient data (4 plus interventions) and the contract holder's Red ACORN high needs patient data (4 plus interventions) making it easier for contracting teams to apply mitigation if required.

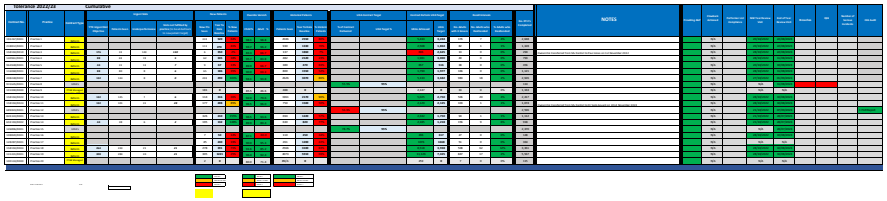
In addition, mitigation will only be applied if a practice is reaching the Health Board or National average (whichever is higher) for laboratory-based work such as crowns and dentures. This figure will be made available at year end. This will prevent mitigation being applied to practices who have not provided a full range of NHS care.

Foundation Dentists Activity and Contract Year-End Management

The notional historic 1820 training UDA's is NOT to be converted into contract variation metrics and added to the main contract.

New patients seen by the FD working in a contract variation practice over the total of 69, will count towards the main contract new patient metrics. This is a threshold not a target and no sanctions are relevant if not reached.

Practices remaining on UDA's will have the notional target reduced by 5% in line with main contracts on UDA's, thus any in excess of 1729 will count towards practice main contract.



Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 2.8

Delivery and Performance Committee	**Date of Meeting: 19 December 2023**
Subject:	**Update on the Cross Border pathways project to support treating Powys patients more safely and effectively**
Approved and Presented by:	Director of Finance, IT and Information
Prepared by:	Vicki Cooper CDO/AD Digital Transformation & Informatics, Sue Hamer, Head of Digital Programmes
Other Committees and meetings considered at:	Executive Committee – 13 December 2023

PURPOSE:

The purpose of this report is to provide a Digital First update on progress in relation to:

- To consolidate the access to information required in Cross Border pathways to be available in Welsh Clinical Systems.

RECOMMENDATION(S):

The Delivery and Performance Committee are asked to:

a) **NOTE** the current position against the cross-border programme.
b) **NOTE** the current challenges.
c) Take **ASSURANCE** from the next steps in the project and timelines.

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

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	û
	2. Provide Early Help and Support	û
	3. Tackle the Big Four	ü
	4. Enable Joined up Care	ü
	5. Develop Workforce Futures	û
	6. Promote Innovative Environments	ü
	7. Put Digital First	ü
	8. Transforming in Partnership	û
Health and Care Standards:	1. Staying Healthy	û
	2. Safe Care	ü
	3. Effective Care	ü
	4. Dignified Care	û
	5. Timely Care	ü
	6. Individual Care	û
	7. Staff and Resources	ü
	8. Governance, Leadership & Accountability	ü

EXECUTIVE SUMMARY:

With more than 50% of Powys Teaching Health Board's Secondary Care provided by neighbouring Welsh Health Boards or by Trusts across the border in England, such as Shrewsbury and Telford Hospital Trust (SaTH), Wye Valley NHS Trust (WVT) and Robert Jones Agnus Hunt (RJAH), having the ability for our local and visiting consultants to access their patient records in a more digitised way has become a necessity in Powys to avoid any unnecessary delays in direct patient care.

In 2021 a business case was submitted and approved by Welsh Government (WG) under the Digital Priorities Investment Fund (DPIF) to develop six workstreams within a 2- year period, with a focus to help treat patients more safely and effectively. The workstreams supported the following:

1. Diagnostics results processed in England for Welsh patients, to be available from the Welsh Results Reporting Service (WRRS)
2. Patient Referrals to NHS hospitals in England for Welsh patients to be processed in the Welsh Patient Referral Service (WPRS) and made available for viewing in the Welsh Clinical Portal (WCP) by storing a copy of the referral document in the Welsh Care Record Service (WCRS)
3. Discharges letters from English hospitals back to Wales, to be added to WCRS.
4. Outpatient clinic letters from English hospitals back to Wales, to be added to WCRS.
5. Images from English hospitals, to be stored in the Welsh Imaging Archive Service (WIAS)
6. The Welsh GP record to be available to NHS clinicians in England, treating Welsh patients.

The programme is due to close June 2024 with the remaining project focussed on testing and completing system integration, however noting there are challenges with engagement with SaTH, who support care for North Powys patients.

DETAILED BACKGROUND AND ASSESSMENT:

Background

Powys has the inability to maximise the All-Wales architecture as over 50% of acute care is provided in England, so it relies on 3rd party systems to support clinicians which is very fragmented. The joint project between Powys Teaching Health Board (PTHB) and Digital Health and Care Wales (DHCW) has been worked up as a permanent solution which will use existing national architecture.

The project will give Powys patients and professionals access to the same type of data regardless of where they are receiving care; ensuring patient safety, efficiency and joined up care is paramount when aligning digital technology. This is a solution that won't just benefit Powys but can be rolled out across neighbouring health boards where the same benefits can be achieved.

Within the current architecture, there are several systems and processes that are in use which no integration or data sharing. These range from end-of-life systems, such as Clinisys ICE used for pathology results, to the use of paper for discharges. There is also limited electronic access to picture archiving and communication system (PACS) images and Clinicians in England have no access to Welsh GP systems. Overall, the systems and processes used for cross border Welsh Patients are ineffective and inefficient with the potential to impact patient safety and access to care within appropriate timescales.

In February 2022, the Powys Cross Border Pathways Programme commenced which brought a new team together with the skill set and expertise to drive the requirements forward as shown in **diagram 1**.

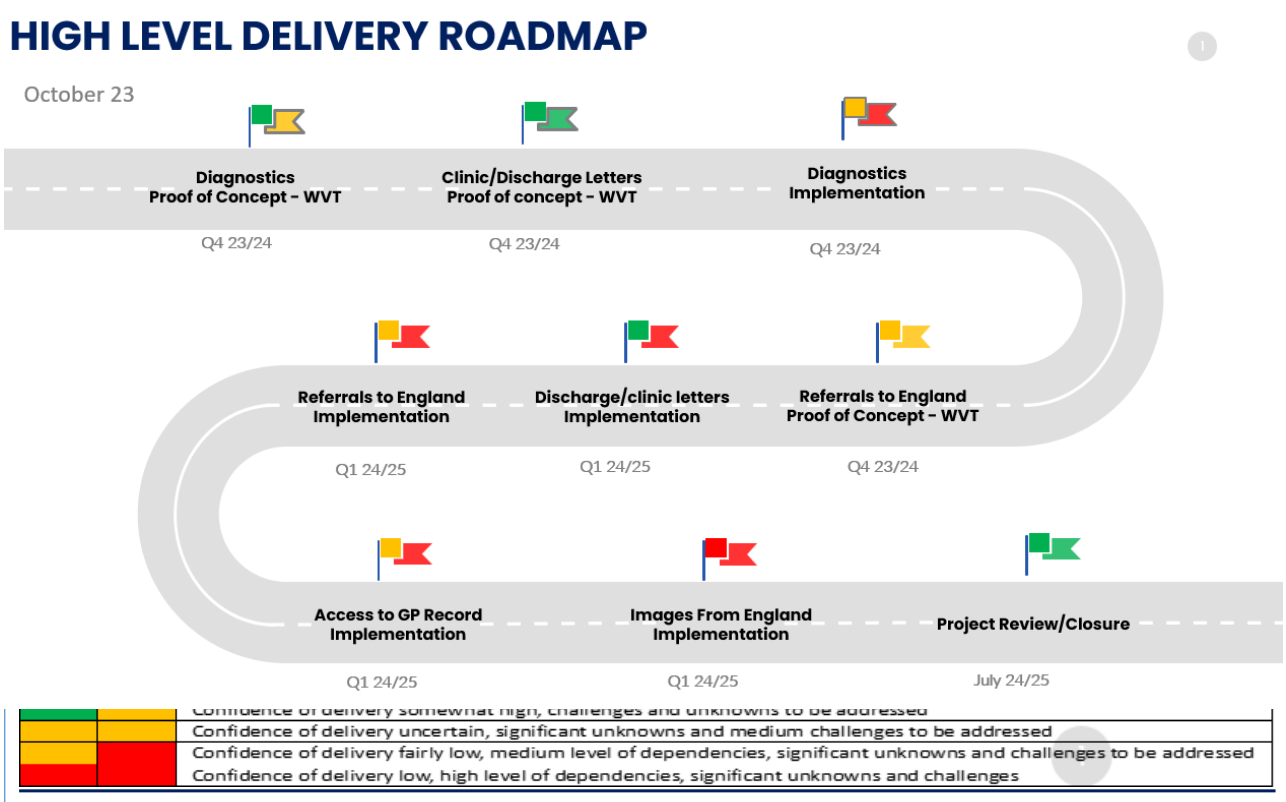


Diagram 1 - High level roadmap of the six workstreams

The diagram shows the progress to date and the order in which the workstreams are being deployed. The low confidence relates to slow progress with SaTH which is detailed under 'challenges.

Progress

Start up / foundation stage

The first 6 months of the project focused on primarily recruitment and establishing the team which took longer than anticipated due to the majority being new roles and no existing job descriptions in place. The team is evidenced in **table 1**.

Position PTHB	Position DHCW	WTE
Project Manager	Project Manager	1.0
Business Change Analyst	Solution Architect	1.0
Product Specialist	Developer	1.0
IG Support	Implementation lead	1.0
Digital Integration Developer	Tester	1.0
Cyber Security Analyst	IT Support	1.0

Table 1 - High level roadmap of the six workstreams

The project board and methodology were established and approved, and during the first year the project team achieved the following deliverables.

- Developed the stakeholder list
- Engaged with colleagues across PTHB and NHS England to establish stakeholder networks
- Delivered stakeholder requirement workshops to elicit user stories with PTHB and NHS England colleagues
- 80 end users attending the workshops and 48 user stories were created
- Developed a prioritised requirements list of the must have, should have, could have, wont have (MoSCoW).
- High level solution design work was undertaken with a review of the existing historical solution architecture design document and discovery activities with key technical resources within DHCW
- The solution development team commenced work on the development approach, which provided a high-level definition of the tools, techniques, customs, practices, and standards that need to be applied.

Development

With the discover work completed in year one (2022/23), year two (2023/24) has focused on:

- Developing testing documentation in readiness for formal testing.
- Process maps for Diagnostic test results (Primary and secondary care) as well as Discharge letters have been drafted ready for assurance.
- Developed a message transformation for national systems (DHCW Integration engine (Fiorano) to GP links) which will facilitate quicker uplift of primary care result viewing once English diagnostic result messages are received.
- Reporting template developed by the Solution Development Team at DHCW
- Solution Architecture document for Diagnostic results from England drafted and reviewed by DHCW Technical Design Authority, also shared with bordering trusts for agreement it is a viable design.
- An analysis of systems being used in England NHS Trusts and how information is received into Wales from England continues to be sought to allow the team to build a process map of the "as is" which will be used by the Solution Developers at DHCW, but also support the overall drivers for change looking at the "now" and "future state". This work is currently 75% complete.
- The systems currently used in SaTH and RJAH us shown in **diagram 2.**

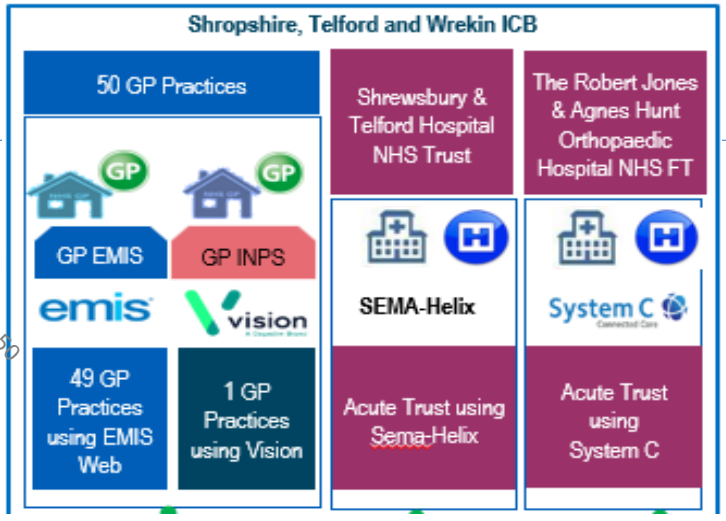


Diagram 2 - Systems currently used in SaTH and RJAH

Engagement

Engagement and sharing of information have taken a considerable amount of time with the four neighbouring English NHS Trusts. Discussions with Wye Valley Trust (WVT) have been extremely positive, and they will be the first Trust to commence testing during December 2023. Robert Jones Agnes Hunt and St Michaels will then be next to test and deploy. Discussions with SaTH have been more difficult, however there has been progress from linking with members of the Integrated Care Board (ICB) at SaTH to raise the profile of the project.

Deliverables

The delivery plan shown in **diagram 3** highlights the stages that have been completed since the start of the project and the increments outstanding.

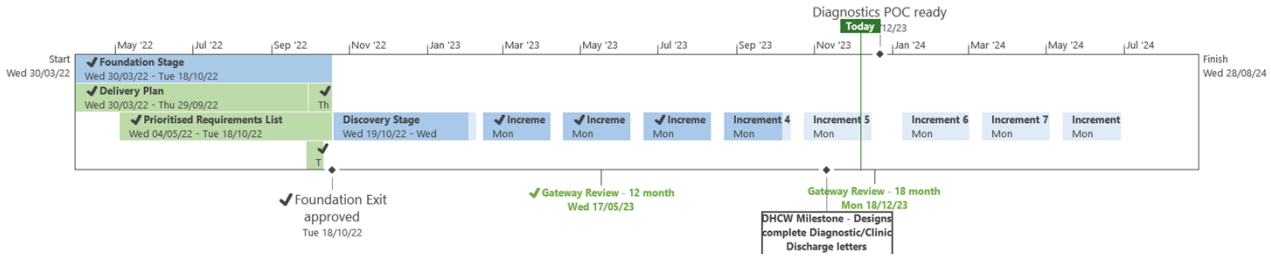


Diagram 3 - High level delivery plan

Plans are currently being confirmed between WVT and DHCW for delivery of both the diagnostic test results and letters workstreams. Testing has been scheduled for the 11 December 2023. Once assurances are in place with DHCW and WVT that the information is feeding into the Welsh Clinical Portal correctly, work will commence to work with the remaining trusts.

Challenges

Description	Progress

Engagement with SaTH has been difficult due to the Trust having their own priorities by introducing an electronic patient record.	This has been escalated to DHCW and WG where there has been email exchanges between DHCW and senior managers at the Trust. Engagement continues via the ICB
NHS England system landscape assessment. For example. • What systems are currently utilised for each workstream? • What messaging standards are in place	The project team have consulted with the 4 Trusts to obtain the level of detail required by DHCW which has taken a considerable amount of time to collect. SaTH is the only Trust outstanding which has been recorded as an issue.

Nest Steps

Appendix 1 provides a plan of the required deliverables within increment five (eight increments in total following agile methodology). In summary the focus in this increment will be to:

- Complete system integration with Wye Valley Trust for Pathology and Clinic Letters
- Continue to work with RJAH and St Michaels to gain landscape assessment and work up a solution for clinic letters and pathology.
- Continue to engage with SaTH ICB colleagues.
- Confirm PM replacement at DHCW.
- Gateway review workshop on the 20th of December to discuss progress, scope of work for the next six months and any gaps. This will include representation from PTHB and DHCW.
- Confirm arrangements for the RISP project (Images) and any dependencies / gaps with the cross-border deliverables.
- With the current integrated health system Platform due to expire in March 2025, a pilot is due to take place in quarter 4 with EMIS community which will support the ability to share information across primary and community care.

Drivers

The proposal, which has been a requirment by PTHB for a number of years will aim to:

- Improve Patient Treatment through the introduction of electronic processes.
- Remove delays in patient access to treatment through the introduction of electronic process.
- Improve patient safety through the introduction of electronic processes.
- Improve digital access to patient information and ensure successful outcome measures scalable for NHS Wales where patient pathways involve commissioned English NHS Trust.

Identified Benefits

Ref.	Workstream	Expected Benefits
1	**Diagnostic results from England**	Having all the diagnostic results in a single system supports safer patient care. It removes the need for tests to be repeated due to results not being available and should avoid clinics having to be re-located from Powys to England.
2	**Discharge Letters from England**	Having electronic copies of letters available in the WCRS makes them available in a hospital setting and provides a more complete patient record which in turn supports clinical assessment and decision making.
3	**Referrals to England**	Providing Welsh Admin Portal (WAP) to those Cross-Border hospitals would give the hospital admin teams' additional functionality including the ability to save referrals as PDFs for storing in their own EPR systems. Moving to electronic grading is more efficient, saves clinical time and will highly likely improve RTT times.
4	**Clinic Letters from England**	Having electronic copies of Clinic Letters available in the WCRS makes them available in a hospital setting and provides a more complete patient record which in turn supports clinical assessment and decision making.
5	**WGPR for English clinicians**	Providing English clinicians with access to the WGPR improves patient safety and saves both clinical and admin time.
6	**Images from England**	Having copies of Cross Border PACS images in the WIAS system would make them readily available in Powys Outpatient Clinics.

Current High Issues

Issue	Impact	Mitigation	RAG
Shrewsbury and Telford Hospital required input and support for the project has not delivered against expectations	Engagement and project support with SaTH has not progressed. Delivery of solutions with SaTH are highly unlikely	**Treat** Senior engagement with SaTH leadership to confirm expectations. **Accept** Review project scope and priorities to focus on viable outputs	

Supporting Documents

Appendix A Increment five Plan	
Appendix B Overall Project Plan	

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

IMPACT ASSESSMENT					
Equality Act 2010, Protected Characteristics:					
	No impact	**Adverse**	**Differential**	**Positive**	**Statement** ***Please provide supporting narrative for any adverse, differential, or positive impact that may arise from a decision being taken.***
Age	✓				
Disability	✓				
Gender reassignment	✓				
Pregnancy and maternity	✓				
Race	✓				

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

Risk Assessment:

	Level of risk identified				
	None	**Low**	**Moderate**	**High**	**Statement** ***Please provide supporting narrative for any risks identified that may occur if a decision is taken***
Clinical					
Financial					
Corporate					
Operational					
Reputational					

No.	Description	Start	Finish
1	Increment Five Duration	11/13/2023	12/22/2023
2	**Increment Five**	**11/13/2023**	**2/2/2024**
2.1	**Increment Four carry over**	**11/13/2023**	**2/2/2024**
2.1.1	WVT - Seek additional landscape info for Diagnostics, Radiology, GP Records and Discharge Letters	11/13/2023	12/22/2023
2.1.2	RJAH - Confirm opportunities for Electronic Letters receipt with RJAH	11/24/2023	12/15/2023
2.1.3	RJAH - Confirm opportunities for Pathology results using RJAH SATH solution	11/24/2023	12/21/2023
2.1.4	St. Michael's - Organise Meeting with Key stakeholders to obtain additional info on landscape	11/13/2023	11/13/2023
2.1.5	Draw/complete process map for Clinic letters	11/13/2023	12/22/2023
2.1.6	Get assurance on completed Clinic letters process map	12/25/2023	2/2/2024
2.1.7	Arrange monthly meetings with Masood Ahmed and ST&W ICB Programme Director	11/13/2023	11/27/2023
2.1.8	Confirm DHCW Replacement PM	11/20/2023	12/1/2023
2.2	**Solution Development**	**11/13/2023**	**1/1/2024**
2.2.1	**Wye Valley Trust Diagnostics (Pathology) - Confirm work package/timeframe**	**11/20/2023**	**1/1/2024**
2.2.1.1	Confirm WVT Pathology lead agreement on Hoople proposal	11/20/2023	12/1/2023
2.2.1.2	Impact assessment of Diagnostic design solution - coding and service mgmt	12/4/2023	12/29/2023
2.2.1.3	Confirm Work package acceptance	1/1/2024	1/1/2024
2.2.2	**Wye Valley Trust Letters**	**11/13/2023**	**12/29/2023**
2.2.2.1	Confirm Testing timeframes with WVT	11/13/2023	12/1/2023
2.2.2.2	Complete System Integration Testing	12/11/2023	12/29/2023
2.2.2.3	Draft Assurance Quality Plan for WVT letters to WCP/WCRS	11/27/2023	12/8/2023
2.2.2.4	Assurance Process undertaken for WVT letters	12/4/2023	12/29/2023

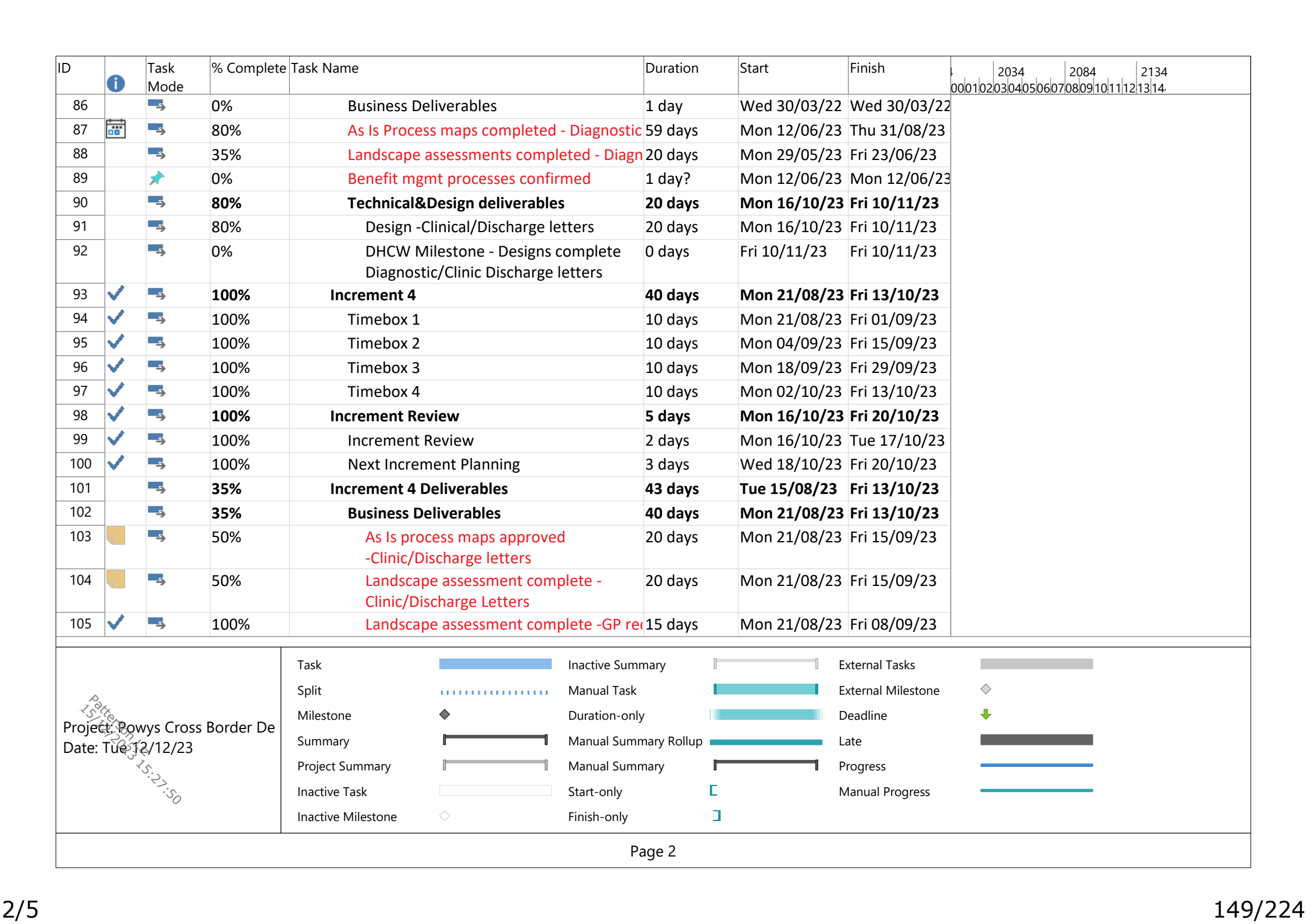
ID	Task Mode	% Complete	Task Name	Duration	Start	Finish
1		**59%**	**Powys Cross Border**	**603 days?**	**Wed 30/03/22**	**Wed 28/08/24**
2		**100%**	**Foundation Stage**	**142 days**	**Wed 30/03/22**	**Tue 18/10/22**
39		**55%**	**Evolutionary Development Stage**	**603 days?**	**Wed 30/03/22**	**Wed 28/08/24**
40		**95%**	**Discovery Stage**	**66 days**	**Wed 19/10/22**	**Wed 08/02/23**
47		**100%**	**Next Stage resources**	**8 days**	**Thu 02/02/23**	**Mon 13/02/23**
56		**100%**	**Increment 1**	**40 days**	**Mon 13/02/23**	**Fri 07/04/23**
61		**100%**	**Increment Review**	**5 days**	**Mon 10/04/23**	**Fri 14/04/23**
64		**100%**	**Increment 2**	**40 days**	**Mon 17/04/23**	**Fri 09/06/23**
69		**100%**	**Increment Review**	**23 days**	**Wed 17/05/23**	**Fri 16/06/23**
73		**0%**	**Increment 2 Deliverables**	**295 days**	**Wed 30/03/22**	**Mon 12/06/23**
74		0%	Business Deliverables	1 day	Wed 30/03/22	Wed 30/03/22
75		**100%**	**Technical&Design deliverables**	**0 days**	**Mon 12/06/23**	**Mon 12/06/23**
76		100%	Design - Diagnostics SAD drafted	0 days	Mon 12/06/23	Mon 12/06/23
77		**100%**	**Increment 3**	**40 days**	**Mon 19/06/23**	**Fri 11/08/23**
78		100%	Timebox 1	10 days	Mon 19/06/23	Fri 30/06/23
79		100%	Timebox 2	10 days	Mon 03/07/23	Fri 14/07/23
80		100%	Timebox 3	10 days	Mon 17/07/23	Fri 28/07/23
81		100%	Timebox 4	10 days	Mon 31/07/23	Fri 11/08/23
82		**100%**	**Increment Review**	**5 days**	**Mon 14/08/23**	**Fri 18/08/23**
83		100%	Increment Review	2 days	Mon 14/08/23	Tue 15/08/23
84		100%	Next Increment Planning	3 days	Wed 16/08/23	Fri 18/08/23
85		**69%**	**Increment 3 Deliverables**	**405 days?**	**Wed 30/03/22**	**Fri 10/11/23**

Project: Powys Cross Border De
Date: Tue 12/12/23

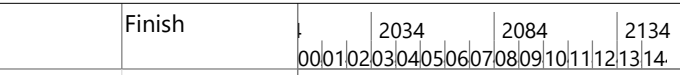
Pattern in: 15/12/2023 15:27:50

Task	Inactive Summary	External Tasks
Split	Manual Task	External Milestone
Milestone	Duration-only	Deadline
Summary	Manual Summary Rollup	Late
Project Summary	Manual Summary	Progress
Inactive Task	Start-only	Manual Progress
Inactive Milestone	Finish-only	

ID	Task Mode	% Complete	Task Name	Duration	Start	Finish
86		0%	Business Deliverables	1 day	Wed 30/03/22	Wed 30/03/22
87		80%	As Is Process maps completed - Diagnostic	59 days	Mon 12/06/23	Thu 31/08/23
88		35%	Landscape assessments completed - Diagn	20 days	Mon 29/05/23	Fri 23/06/23
89		0%	Benefit mgmt processes confirmed	1 day?	Mon 12/06/23	Mon 12/06/23
90		**80%**	**Technical&Design deliverables**	**20 days**	**Mon 16/10/23**	**Fri 10/11/23**
91		80%	Design -Clinical/Discharge letters	20 days	Mon 16/10/23	Fri 10/11/23
92		0%	DHCW Milestone - Designs complete Diagnostic/Clinic Discharge letters	0 days	Fri 10/11/23	Fri 10/11/23
93		**100%**	**Increment 4**	**40 days**	**Mon 21/08/23**	**Fri 13/10/23**
94		100%	Timebox 1	10 days	Mon 21/08/23	Fri 01/09/23
95		100%	Timebox 2	10 days	Mon 04/09/23	Fri 15/09/23
96		100%	Timebox 3	10 days	Mon 18/09/23	Fri 29/09/23
97		100%	Timebox 4	10 days	Mon 02/10/23	Fri 13/10/23
98		**100%**	**Increment Review**	**5 days**	**Mon 16/10/23**	**Fri 20/10/23**
99		100%	Increment Review	2 days	Mon 16/10/23	Tue 17/10/23
100		100%	Next Increment Planning	3 days	Wed 18/10/23	Fri 20/10/23
101		**35%**	**Increment 4 Deliverables**	**43 days**	**Tue 15/08/23**	**Fri 13/10/23**
102		**35%**	**Business Deliverables**	**40 days**	**Mon 21/08/23**	**Fri 13/10/23**
103		50%	As Is process maps approved -Clinic/Discharge letters	20 days	Mon 21/08/23	Fri 15/09/23
104		50%	Landscape assessment complete - Clinic/Discharge Letters	20 days	Mon 21/08/23	Fri 15/09/23
105		100%	Landscape assessment complete -GP re	15 days	Mon 21/08/23	Fri 08/09/23



ID	Task Mode	% Complete	Task Name	Duration	Start	Finish
106		0%	Landscape assessment complete -Referr	40 days	Mon 21/08/23	Fri 13/10/23
107		0%	As Is process maps approved - Referrals	5 days	Mon 04/09/23	Fri 08/09/23
108		**0%**	**Technical&Design deliverables**	**0 days**	**Tue 15/08/23**	**Tue 15/08/23**
109		0%	Build/develop - Diagnostic Prototype	0 days	Tue 15/08/23	Tue 15/08/23
110		0%	Diagnostic Prototype tested	0 days	Tue 15/08/23	Tue 15/08/23
111		**88%**	**Increment 5**	**40 days**	**Mon 23/10/23**	**Fri 15/12/23**
112	✓	100%	Timebox 1	10 days	Mon 23/10/23	Fri 03/11/23
113	✓	100%	Timebox 2	10 days	Mon 06/11/23	Fri 17/11/23
114	✓	100%	Timebox 3	10 days	Mon 20/11/23	Fri 01/12/23
115		50%	Timebox 4	10 days	Mon 04/12/23	Fri 15/12/23
116		**0%**	**Increment Review**	**5 days**	**Mon 18/12/23**	**Fri 22/12/23**
117		0%	Increment Review	2 days	Mon 18/12/23	Tue 19/12/23
118		0%	Next Increment Planning	3 days	Wed 20/12/23	Fri 22/12/23
119		**0%**	**Increment 5 deliverables**	**0 days**	**Wed 30/03/22**	**Wed 30/03/22**
120		0%	Business Deliverables			
121		**0%**	**Technical&Design deliverables**	**50 days**	**Mon 16/10/23**	**Fri 22/12/23**
122		0%	Design complete - Referrals	25 days	Mon 16/10/23	Fri 17/11/23
123		0%	Diagnostics POC ready	0 days	Fri 22/12/23	Fri 22/12/23
124		0%	Build/Develop - Clinic/Discharge letters prototype	0 days	Fri 10/11/23	Fri 10/11/23
125		0%	Design - Access to GP Record complete			
126		0%	Gateway Review - 18 month	1 day	Mon 18/12/23	Mon 18/12/23
127		**0%**	**Increment 6**	**40 days**	**Mon 08/01/24**	**Fri 01/03/24**



Project: Powys Cross Border De
Date: Tue 12/12/23

Pattern in: 15/12/2023 15:27:50

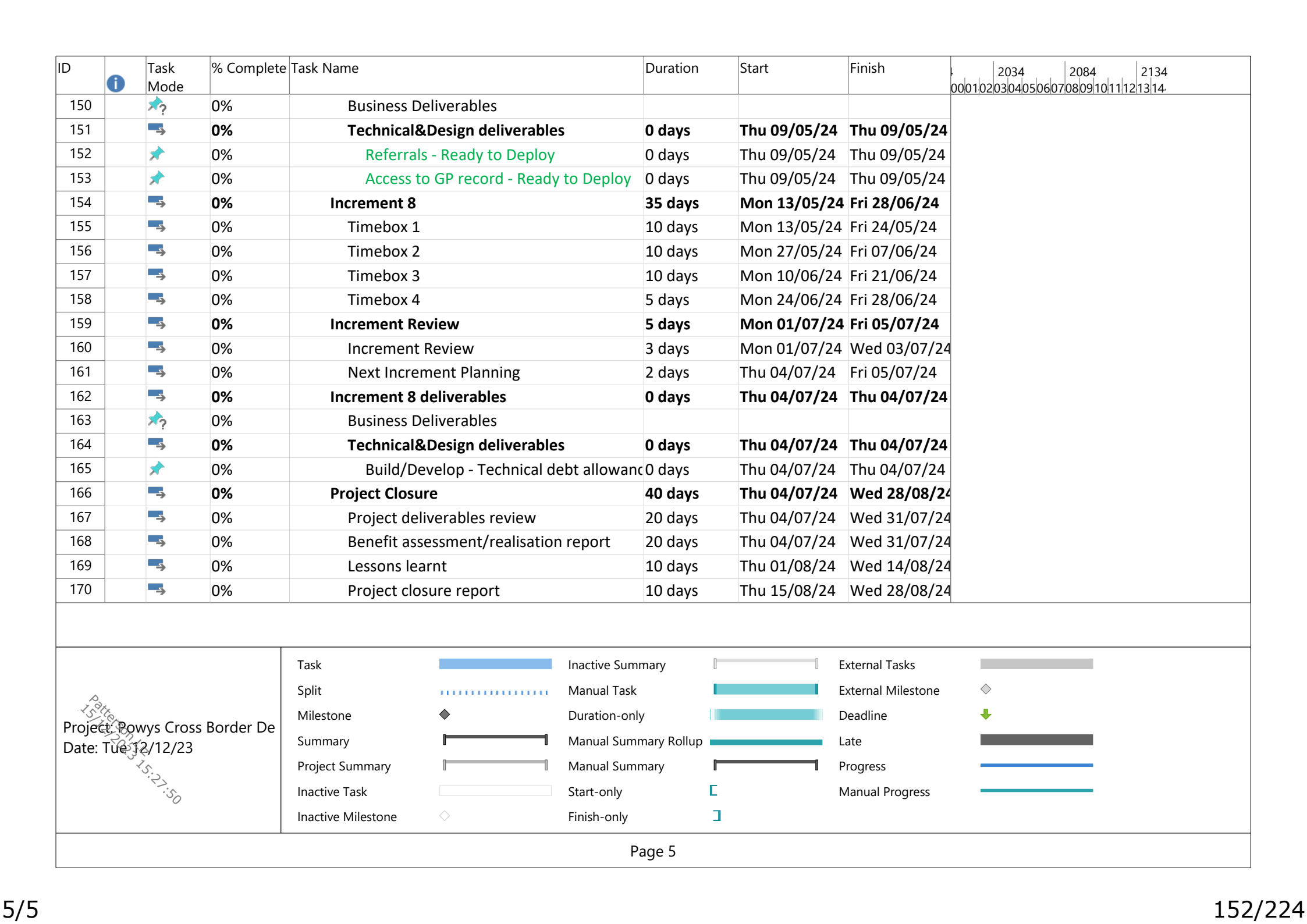
Task	Inactive Summary	External Tasks
Split	Manual Task	External Milestone
Milestone	Duration-only	Deadline
Summary	Manual Summary Rollup	Late
Project Summary	Manual Summary	Progress
Inactive Task	Start-only	Manual Progress
Inactive Milestone	Finish-only	

ID	Task Mode	% Complete	Task Name	Duration	Start	Finish
128		0%	Timebox 1	10 days	Mon 08/01/24	Fri 19/01/24
129		0%	Timebox 2	10 days	Mon 22/01/24	Fri 02/02/24
130		0%	Timebox 3	10 days	Mon 05/02/24	Fri 16/02/24
131		0%	Timebox 4	10 days	Mon 19/02/24	Fri 01/03/24
132		**0%**	**Increment Review**	**5 days**	**Mon 04/03/24**	**Fri 08/03/24**
133		0%	Increment Review	2 days	Mon 04/03/24	Tue 05/03/24
134		0%	Next Increment Planning	3 days	Wed 06/03/24	Fri 08/03/24
135		**0%**	**Increment 6 Deliverables**	**45 days**	**Wed 20/12/23**	**Wed 06/03/24**
136		0%	Business deliverables			
137		**0%**	**Technical&Design deliverables**	**45 days**	**Wed 20/12/23**	**Wed 06/03/24**
138		0%	Build/develop - Access to GP record	0 days	Wed 06/03/24	Wed 06/03/24
139		0%	Build/Develop - Referrals	0 days	Wed 20/12/23	Wed 20/12/23
140		0%	Clinic/Discharge letters Ready to deploy	0 days	Wed 20/12/23	Wed 20/12/23
141		**0%**	**Increment 7**	**40 days**	**Mon 11/03/24**	**Fri 03/05/24**
142		0%	Timebox 1	10 days	Mon 11/03/24	Fri 22/03/24
143		0%	Timebox 2	10 days	Mon 25/03/24	Fri 05/04/24
144		0%	Timebox 3	10 days	Mon 08/04/24	Fri 19/04/24
145		0%	Timebox 4	10 days	Mon 22/04/24	Fri 03/05/24
146		**0%**	**Increment Review**	**5 days**	**Mon 06/05/24**	**Fri 10/05/24**
147		0%	Increment Review	3 days	Mon 06/05/24	Wed 08/05/24
148		0%	Next Increment Planning	2 days	Thu 09/05/24	Fri 10/05/24
149		**0%**	**Increment 7 Deliverables**	**0 days**	**Thu 09/05/24**	**Thu 09/05/24**

Project: Powys Cross Border De
Date: Tue 12/12/23

Task	Inactive Summary	External Tasks
Split	Manual Task	External Milestone
Milestone	Duration-only	Deadline
Summary	Manual Summary Rollup	Late
Project Summary	Manual Summary	Progress
Inactive Task	Start-only	Manual Progress
Inactive Milestone	Finish-only	

ID	Task Mode	% Complete	Task Name	Duration	Start	Finish
150		0%	Business Deliverables			
151		**0%**	**Technical&Design deliverables**	**0 days**	**Thu 09/05/24**	**Thu 09/05/24**
152		0%	Referrals - Ready to Deploy	0 days	Thu 09/05/24	Thu 09/05/24
153		0%	Access to GP record - Ready to Deploy	0 days	Thu 09/05/24	Thu 09/05/24
154		**0%**	**Increment 8**	**35 days**	**Mon 13/05/24**	**Fri 28/06/24**
155		0%	Timebox 1	10 days	Mon 13/05/24	Fri 24/05/24
156		0%	Timebox 2	10 days	Mon 27/05/24	Fri 07/06/24
157		0%	Timebox 3	10 days	Mon 10/06/24	Fri 21/06/24
158		0%	Timebox 4	5 days	Mon 24/06/24	Fri 28/06/24
159		**0%**	**Increment Review**	**5 days**	**Mon 01/07/24**	**Fri 05/07/24**
160		0%	Increment Review	3 days	Mon 01/07/24	Wed 03/07/24
161		0%	Next Increment Planning	2 days	Thu 04/07/24	Fri 05/07/24
162		**0%**	**Increment 8 deliverables**	**0 days**	**Thu 04/07/24**	**Thu 04/07/24**
163		0%	Business Deliverables			
164		**0%**	**Technical&Design deliverables**	**0 days**	**Thu 04/07/24**	**Thu 04/07/24**
165		0%	Build/Develop - Technical debt allowanc	0 days	Thu 04/07/24	Thu 04/07/24
166		**0%**	**Project Closure**	**40 days**	**Thu 04/07/24**	**Wed 28/08/24**
167		0%	Project deliverables review	20 days	Thu 04/07/24	Wed 31/07/24
168		0%	Benefit assessment/realisation report	20 days	Thu 04/07/24	Wed 31/07/24
169		0%	Lessons learnt	10 days	Thu 01/08/24	Wed 14/08/24
170		0%	Project closure report	10 days	Thu 15/08/24	Wed 28/08/24



Project: Powys Cross Border De
Date: Tue 12/12/23

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 2.9

Delivery and Performance Committee	**Date of Meeting: 19 December 2023**
Subject:	**Infrastructure and Asset Audit Update**
Approved and Presented by:	Pete Hopgood, Director Finance, Information and IT
Prepared by:	Vicki Cooper Assistant Director of Digital Transformation and Informatics
Other Committees and meetings considered at:	Executive Committee – 15 November 2023

PURPOSE:
The purpose of this paper is to note the updates against actions from the Infrastructure and Asset Audit recommendations.
RECOMMENDATION(S):
The Committee is asked to: • Take **ASSURANCE** from the updates provided on the progress to date on actions taken in relation to the Infrastructure and Asset Audit.

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

[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:

Following an internal audit review of the management of the IT Infrastructure and Assets undertaken, recommendations are being progressed as per Infrastructure and Assets Internal Audit action tracker.

DETAILED BACKGROUND AND ASSESSMENT:

The internal audit scope was to evaluate and determine the adequacy of the systems and controls in place for the management of the IT Infrastructure assets and network.

The purpose of the review (2021/2022) was to provide assurance to the Audit Committee that a process is in place for ensuring that the infrastructure hardware is tracked, maintained, supported and that the network is managed sufficiently to provide services for the organisation.

Objectives of the area under review:

1. The IT infrastructure is maintained with appropriate monitoring, support and risk management in place.
2. The use of the network is managed to ensure stability and capacity is appropriate for the organisation.

This was to mitigate the risk of loss of key processing or network services.

An action tracker progressing the recommendations is updated and presented.

NEXT STEPS:

To continue to progress the recommended actions with updates presented to the Delivery and Performance Committee

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

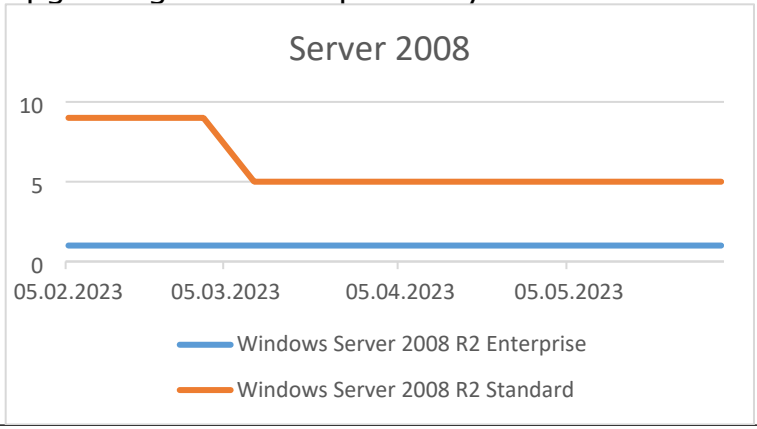
IMPACT ASSESSMENT					
Equality Act 2010, Protected Characteristics:					
	No impact	**Adverse**	**Differential**	**Positive**	**The proposal will not disproportionally affect any of the protected characteristics.**
Age	X				
Disability	X				
Gender reassignment	X				
Pregnancy and maternity	X				
Race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

Key:

Completed
Not yet due
Due
Overdue

Infrastructure Audit Management Action Plan 2022/23 (Oct 2023)

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Matter Arising	Priority	Action	Responsible	Progress Position	Status
1.1	High	A plan to replace all the Windows 2008 servers should be developed and enacted. A funded, rolling replacement programme for infrastructure equipment should be developed	Assistant Director of Digital Transformation/Head of Infrastructure and Cyber	Original replacement plan within S33 was delayed during the pandemic and the Digital Transformation team is now leading on taking this forward. Progress has been made on decommissioning Server 2008 Operating systems with only five systems remaining. Operating system usage is now being tracked and trended over time. Two remaining Server 2008 operating systems are dependent on upgrading the PTHB phone system. 	Complete (with exception of a dependency on the Telephony Upgrade)
2.1	Medium	The risk associated with old equipment should be fully	Assistant Director of Digital Transformation/Head of Infrastructure and Cyber	As Above 1.1 and regular updates are provided to the Exec Director of Finance, and as part of the Digital First updates to D&P committee. Recognising the investment made and how this has helped to improve the position	Due Dec 2022 (Complete with the exception

		explained at the corporate level. The failure to utilise the end of year funding to remove old network devices should be stated to the Delivery and Performance Committee.		(replacement kit / solar winds etc) however not all issues are fully resolved. There is a required plan and action will be across a number of years. This is also reported in the delivery against plan as part of the Digital First objective 'Digital Infrastructure' on the IMTP KPI's will be introduced to measure the movement in old equipment and report upon the current asset estate. There is further work identified in the reporting of assets, particularly physical assets that may be stored in cupboards, not returned etc however PTHB have procured a full Asset management inventory solution which is being developed to report regularly through robust KPIs the position of the asset estate, with a new asset management inventory solution now fully implemented has led to improvements in the ability to identify old equipment. Network scanning is capturing end user devices and supplier data about assets has also been appended into the database. The estate is being physically audited to ensure all digital assets are noted to improve the data quality. A pilot audit is underway on the Bronllys site, and it is expected all audits will be completed FY 23/24. Improvements have also been made to the process for requesting and returning devices to	of the physical audit)

				make it easier for staff. A self-service form allows staff to arrange the return of unwanted or aged equipment. Further capital bids will be made to replace the assets identified in the asset manager as requiring replacement. Update 04/10/23 There are continued improvements in the quality of data in the IT Service Management solution (ITSM). All assets have been updated with approximate replacement dates based on known values for other assets. This is allowing for better prediction of where assets will need replacement and the costs expected. The integration of the ICT service into the ITSM will allow tickets to be associated with assets and further improve business intelligence on the reliability and efficacy of assets.	
3.1	Medium	Alerts should be configured within devices to enable active management. The thresholds for the alerts should be set accordingly.	Assistant Director of Digital Transformation/Head of Infrastructure and Cyber	Monitoring of the network is led by the Digital Transformation Team (previously under S33 arrangements) and this has been enhanced by further deployment of Solar Winds (secured with DPIF funding in 21/22), with continued action in place to fine tune the configuration to maximise functionality and enable proactive alert management.	Dec 2022 Complete.

		The Health Board should use Solar Winds to manage alerts.		Thresholds are regularly reviewed and improved to allow effective management of alerts and issues as reported. This will be developed further and reported against in monthly KPI's to the Senior Management withing the Digital Transformation Team	
4.1	High	A process for ensuring patching of switches should be established.	Assistant Director of Digital Transformation/Head of Infrastructure and Cyber	Extended lifelong warranties have been procured (reliant on vendor support where devices cannot be patched), that means if there is a fault with the switch the vendor will support resolution. Digital Transformation have put plans in place for replacement of the switches (subject to securing capital funding) and will form part of the re-submitted DPIF bid. Responsibility for patching is within the S33 agreement but with the appointment of a new Head of Infrastructure and Cyber will transition to the PTHB Digital Transformation team. Except for switches that have been replaced, continuing progress is in place ensuring legacy switches have updated firmware. Update 04/10/23 All hardware with a current active warranty has been updated. Hardware without warranty or dependant on limited lifetime warranty will require an active maintenance	August 2023

				agreement to facilitate upgrades. A business case will be developed.	
5.1	High	Fire and water detection should be included at both sites. Consideration should be given to providing a dedicated power supply to the Bronllys room. Fire suppression should be installed at Brecon. The air conditioning within Brecon should be reviewed to ensure it can reduce the temperature appropriately.	Head of Infrastructure and Cyber/Head of Estates and Facilities	Fire detection and suppression are in place at Bronllys, but no water detection. Air conditioning has been serviced and will form part of a regular service and maintenance programme to ensure it is efficient. There are plans to move on premise servers held within the Data Centre to the cloud so this will reduce the risk of on-premises DC's. A plan will be developed with Estates and Facilities to assess the water detection requirements and to test and provide assurance relating to the power requirements (initial meeting already taken place). No further progress in this area, discussions are on-going regarding the financial and resource investment from estates department.	Due March 2023
6.1	Medium	A programme of re-cabling should be undertaken.	Head of Infrastructure and Cyber/Head of Estates and Facilities	Dedicated Project Manager in post to lead on this area and to identify options and develop	August 2023

		Unsupported network devices should be removed from the network. A review and associated upgrade of Wi-Fi provision should be undertaken		a plan over a reasonable timescale to improve. Funding to be secured based on final plan and business case and unsupported network devices will be replaced by managed switches (dependant on procurement and funding constraints). An independent Wi-Fi review has been completed and improvement plan in place including controller configuration and upgrade. Further improvement dependant on business case and funding being secured. Further investment has been made and improvements to wired and wireless infrastructure continue. Risks such as asbestos do impact on acceleration of this work. Update 04/10/23 The project to provide is maintaining progress, with funding approved from capital control group for significant improvement in day hospital and Llewellyn ward.	
7.1 Patterson Liz 15/12/2023 15:27:50	High	The network should be split into Vlans. The firewalls should be deployed.	Head of Infrastructure and Cyber	A network redesign is commissioned to re-architect the network to ensure capacity, bandwidth, resilience, and security measures are in place. The network design plans will then be supported via a business case to	Stage 1 Complete

				commence the technical improvements and upgrades in a phased approach to minimise downtime and disruption to services. This work will take place over a number of years to address all sites within PTHB. The Firewalls have been deployed; however, a rolling refresh programme will be identified. Responsibility and management of the network and firewalls is within the S33, but agreement has been reached for this work to transition to the PTHB Digital Transformation team under the leadership of the PTHB Head of Infrastructure and Cyber Work has started in this area to start segmentation on Bronllys Network. The initial focus will be transitioning infrastructure devices to a dedicated vlan to minimise the impact of transitioning the rest of the site. Further resource is being sourced to support this project. Update 04/10/23 Network redesign in progress. A number of technical challenges have been discovered that are actively being worked on to deliver the level of segmentation required.	November 2023.

				Update 13/11/2023 The first stage of network segmentation is complete. Aligning network segmentation with the operationalisation of a new hosting platform means that we can proceed with separating our server estate from our client estate. Server Migrations are in progress and expected to take up to 6 months to complete.	

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 2.10

Delivery & Performance Committee	**Date of Meeting: 19 December 2023**
Subject:	Bronllys Catering Food Hygiene Inspection Report
Approved and presented by:	Claire Madsen, Executive Director Therapies and Health Sciences
Prepared by:	Jason Crowl, Assistant Director Health and Safety and Support Services
Other Committees and meetings considered at:	This paper was approved at Executive Committee on the 13 December'2023

PURPOSE:

To describe the findings of a Food Hygiene Inspection in Bronllys Hospital and actions taken to improve the rating and provide assurance regarding measures taken to strengthen compliance across all kitchens.

RECOMMENDATION(S):

1. To **NOTE** the findings of the first inspection and subsequent re inspection.
2. To take **ASSURANCE** from the actions taken to rectify the issues identified and to strengthen compliance across all kitchens.

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:

On 30 October 2023, Environmental Health Officers identified several issues during an inspection at Bronllys Hospital, officially communicated through a Food Hygiene Inspection letter on 07 November 2023, outlining areas needing attention. The unannounced inspection at Bronllys Hospital revealed non-conformances leading to a downgrade from a previous 4 out of 5 rating to a 1 out of 5.

A low hygiene score poses greater risks to patients, staff, and the organisation's reputation. Immediate corrective measures were undertaken upon initial feedback, further refined after a follow-up assessment by the Support Services Quality Improvement Manager.

Three main non-conformance categories were identified: Food Hygiene and Safety Procedures, Compliance with Structural Requirements, and Confidence in Management/Control Procedures.

Expired food items, potential pest access due to poorly fitted doors, incorrect food labelling, and staff unawareness of critical limits were highlighted as critical concerns.

A comprehensive action plan was developed by the Support Services Management team which worked in collaboration with the Estates team to conduct the remedial work. This included additional managerial audits which were extended to other PTHB kitchens, confirming their compliance at a high standard.

A re-rating request was submitted, leading to a subsequent unannounced visit by EHOs on November 28, 2023. The visit confirmed the resolution of all previous non-conformities and indicated a forthcoming high rating, confirmed as a 5 out of 5 food hygiene rating.

Bronllys Hospital remains under increased intervention by the Support Services Team who have reassessed all other kitchens. Revisions are being made to the PTHB Food Safety Management System procedures.

DETAILED BACKGROUND AND ASSESSMENT:

SITUATION

Local authorities are responsible for enforcing food hygiene laws and typically inspect PTHB kitchens annually. This is to examine its food production compliance with food law and to ensure that the food produced is safe to eat.

The food hygiene rating scheme gives businesses a rating from 5 to 0 which is displayed at their premises and online so you can make more informed choices about where to buy and eat food. A 1 rating indicates a major improvement is necessary.

The rating in 2022 before the inspection on October 2023 was a 4.
The rating following the inspection was a 1.
The rating for Bronllys Kitchen following the inspection on November 28th is now 5.

All other Kitchens in Powys are rated currently as 5.
All kitchens have been inspected by the Support Services team and found to be at an acceptable standard.

BACKGROUND

Delivering meals to patients and staff is the last part of a complex logistics chain starting with production, transport, storage, cooking and serving. There is long standing food safety legislation and monitoring developed in the United Kingdom with the aim of reducing the risk of and impact of food poisoning also including the risk of death.

In a paper published by the BMJ [1] there are on average 180 deaths per year in the UK caused by foodborne disease based on 11 pathogens. While this is a small fraction of the estimated 2.4 million cases of foodborne illness per year,

it still illustrates the potential severity of these illnesses demonstrating the importance in continuing efforts to reduce these infections.

Examples in the UK of the impact of a breakdown in food standards include:

- A sandwich supplied by to 43 NHS Trusts across England, Wales and Scotland led to an outbreak of listeria which resulted in six deaths in 2019.
- In 2022 a care home in Swansea was reported as being under criminal investigation after several residents became ill with food poisoning.
- In 2021, Tesco Stores Limited was fined £7.56 million at Birmingham Magistrates' Court after pleading guilty to twenty-two out of date food offences which occurred at three of its stores in 2016 and 2017.
- Pret-a- manger was charged in November 2017 with selling food with incorrect allergen information, contrary to section 14 of the Food Safety Act.

The Sentencing Council Guidelines for Health and Safety Offences, Corporate Manslaughter and Food Safety and Hygiene Offences for Wales under Food Hygiene (Wales) Regulations 2006 (regulation 17(1)) The General Food Regulations 2004 (regulation 4) makes organisations liable with an offence penalty range is up to £3m.

Local authorities are responsible for enforcing food hygiene laws and typically inspect PTHB kitchens annually. They may look at the whole service or focus on the main kitchen or the ward kitchens or a particular theme during an inspection. This is to examine its food production compliance with legislation and to ensure that the food produced is safe to eat.

During these unannounced visits, depending on the findings during the inspection, the authorised officers can take enforcement action if deemed necessary.

Local authority Environmental Health Officers attended the Bronllys Hospital site to inspect the catering department on 30th October 2023. During the visit, several non-conformances were found and initial feedback on these was provided at the end of the inspection to kitchen staff.

Apart from a level 2 in 2016 due to issues with the ward kitchen and estates compliance in the main kitchen, Bronllys has hovered between 4 and 5. The previous inspection on 30 November 2022 was evaluated as a 4 out of 5.
The catering team at Bronllys is long standing, have worked in catering for many years and at the time of the incident were all compliant with their Level 2 Food Safety Training.

ASSESSMENT

A food hygiene score below a level 3 'satisfactory' may indicate a greater risk to patients, staff and visitors and is a reputational risk to the organisation. It is therefore imperative that the management of kitchen activity is always maintained through a programme of routine checks and controls to be assured of a good (4) or very good (5) hygiene score. These checks and controls need to be at a frequency that allows errors in practice to be identified and rectified without delay.

During the assessment, the findings that were identified as having the potential to be an immediate threat to maintaining food hygiene were dealt with instantly. On receipt of the initial feedback, the Support Services Management team developed a list of actions for immediate attention to make the kitchen and the food served safe. Assurance to this effect was provided by the Support Services Manager.

Following receipt of the inspection letter on 7th November 2023, the initial action plan was refined and included additional findings from the follow-up assessment conducted by the Support Services Quality Improvement Manager on 8th November 2023. This assessment further confirmed that the food produced in the kitchen posed no immediate risk to patients or staff. The Bronllys Hospital Ward Managers were advised of the EHO visit and assured that there was no risk to patients.

The combined findings reported in the EHO inspection letter can be read under 3 categories of non-conformance: Food Hygiene and Safety Procedures, Compliance with Structural Requirements and Confidence in Management/Control Procedures.

Food Hygiene & Safety Procedures - Seven items of food were found which were past their use-by date. These included six packets of bacon (500g each) which had a use-by date of 27/10/23; and a tub of coleslaw (1kg) which had a use-by date of 26/10/23. The use-by date is the date until which the manufacturer of the food guarantees it is safe to eat. Food stored beyond its use-by date may be of inferior quality or unfit for consumption. It is an offence to hold food with an expired use-by date**.**

The follow-up audit by Support Services Managers identified that the standard of kitchen cleanliness was not at the correct standard and that the cleaning schedule did not adequately cover all areas and equipment.

Compliance with Structural Requirements - At the time of the visit, pest access into the premises was possible via the rear doors at the modified food storage room (which then led directly into the main kitchen). The plastic flaps at the rear doors did not properly fit the door and were in poor condition, as there were holes/gaps on either side. Additionally, the plastic flaps had been left propped open for some time during the visit, which will further allow easy access for pests.

Confidence in Management/Control Procedures - Although a stock control and date coding system had been implemented, it was noted that the system is not being maintained in full. For example, at the time of the visit, several high-risk, ready-to-eat foods were being stored undated, and/or the incorrect date had been applied to the food products. These included: -

- Ready-to-eat salad pots in the kitchen refrigerator had been incorrectly labelled.
- Unlabelled sandwiches were stored in the display chiller.
- The individual cheesecake pots, in the display chiller were unlabelled.
- A ready-to-eat (green) chopping board had been placed on a work surface in the kitchen which was designated and intended for raw meat only.
- Not all staff were aware of all correct critical limits (i.e., the required temperatures for monitoring at critical control points) as stated in the food safety management system.

The management team agreed that the issues identified should be given the highest priority to remedy and to prepare its readiness for submission of a request for a re-rating inspection by the Environmental Health Officers. A "no surprises" report was issued to the Welsh Government and the Support Services Team commenced a weekly incident review meeting to monitor progress against the action plan.

Remedial work was completed with the strong collaboration of the Estates Team and the management and staff of the Support Services Team.

More widely in PTHB, all kitchens have now been subjected to further managerial audits to ensure that these issues have not been replicated elsewhere. It has been confirmed that the remaining kitchens are operating to a very good standard and all currently hold 5 of 5 food hygiene ratings.

Following the satisfactory progress against the action plan an EHO re-evaluation request was submitted and on 28th November 2023, the EHO conducted a further unannounced visit. On completion of the visit, the EHO confirmed that there were no existing or new non-conformities and subsequently provided a new rating of 5.

Food Safety Management System

The PTHB kitchens are staffed by Catering Assistants (band2) who are managed by the Support Services Supervisor (band 3) who are based on the site but also manage porter and domestic services. A Support Services Coordinator (band 5) is responsible for facilities services and the wider support services function across several sites and the Support Services Managers (band 7) cover the north and south locality. They also have additional responsibility for contracts, waste management, linen, security, pest control, budgets, and service management. Service Improvement and Compliance Monitoring is provided by the Service Improvement Manager (band 7).

There are nine main Kitchens and 13 ward kitchens managed by PTHB and subject to EHO inspection. In 2022/23 the main kitchens served 212,463 patient meals. In addition, staff meals added an additional 10%, (21,246 meals).

The Procedure Framework relating to food safety is FTP 010 Catering Services Food Safety Procedures.

Policies & Written Control Documents - FTP 010 Catering Services Food Safety Procedures .pdf - All Documents (sharepoint.com)

There are several established quality controls used in kitchens across Powys.

Training

Level 2 training for all Catering Assistants

The level 2 course informs staff of their legal responsibilities and what constitutes best practice regarding controlling food safety hazards, controlling temperatures, food storage, food preparation, personal hygiene, and premises cleaning. They learn about their responsibilities through a range of interactive exercises, written text, and video content. Upon completion of this training, they should be confident in food hygiene knowledge and have all the skills and tools needed to keep people safe and comply with food hygiene law.

At the time of the inspection all catering staff in Bronllys had their level 2.

Level 3 Training for Supervisors and Coordinators

The Level 3 Food Hygiene Training Course is designed for managers and supervisors in the catering industry to help them understand their essential day-to-day responsibilities, including how to implement the basics of a HACCP food safety management system.

The course provides knowledge of food hygiene practices and legal responsibilities and gives further detail on the controls that can be implemented to ensure that the food handling process is as safe and hygienic as possible. The course uses a variety of written text, interactive exercises, video content and downloadable resources to provide learners with up-to-date knowledge of how to comply with, and uphold, food safety law in their workplace.

At the time of the inspection one of the two supervisors had level 3 with the other Supervisor who had joined the team in 2023 having level 2.

Staffing Levels

Staffing levels are set as part of annual roster reviews. The funded staffing level does not include cover to backfill leave, training, and sickness. To meet the demands for catering for patients and staff at Bronllys, the roster is set at 3 staff on an early and 1 on a late shift (3:1). At weekends when there is minimal staff catering required, the staffing is for 2 on an early and 1(2:1) on a late. In the seven days prior to the inspection the service was staffed between 2:1 and 3:1 and were maintaining a full menu for patients and they reduced the menu for staff. This is standard practice across all kitchens, so the priority can be on maintaining a safe service to patients.

A review of the roster and supervisor responsibilities has been commenced. The Support Services Manager based in Brecon will be relocated to Bronllys Hospital to provide additional oversight and undertake the staffing review.

Food Traceability

PTHB uses 'Cater Cloud' system which has limited function and requires the service to have a part paper and part electronic system. The purpose of digital catering management systems is to provide a quality control and traceability system from supply to serving. All menus, labels, ingredients, activity, and costs are supported by Cater Cloud. The Support Services has evaluated the All Wales Catering Management Information System which is a one stop solution for NHS catering, as it includes improved quality control recording and food traceability, down to individual patient level. This creates a significant improvement is food safety monitoring. A paper is being prepared for a proposal to switch to this system in 2024.

Quality Control

There is a paper-based Food Safety Management Record to be completed daily for monitoring fridge temperature, food cooking temperatures, expiry dates and cleaning schedules. These are completed by the catering assistants and then checked daily by the supervisor. These quality control sheets are key safety documents and reflect the first line of defence in safety procedures.

Inspections and Audit

Coordinators and Managers undertake spot checks on an unannounced ad hoc basis throughout the year and manage compliance issues at the local level, whilst also sharing learning. These inspections and audits represent the second line of defence in safety procedures.

Audits cover:

- Food Inspections, covering areas for compliance with EHO expectations, policy and legislation, undertaken by coordinators and managers.
- Food Waste
- Food Supply
- Food Cost
- There is a comprehensive annual 360 audit undertaken with nursing and reported back to the Nutrition and Hydration Group

There has not been an Internal audit regarding governance and compliance against the current Catering Services Food Safety Procedures.

A revised audit cycle, and assurance monitoring system is being tested currently to be implemented by the end of December 2023.

Reporting

In the governance structure of the Health Board there is no formal group that has in its terms of reference or remit to oversee the compliance to food safety standards across Powys and it is not reported via any formal committee currently as a distinct item. Food Hygiene Ratings are highlighted only for the Directorate Performance Report. The annual 360 audit is reported at the Nutrition and Hydration Group which has a focus on quality and experience and reports to the Patient Experience, Quality and Safety Committee.

A review of reports tabled at other Health Boards notes the use of 'Annual Environmental Health Food Hygiene Report' via the Health and Safety Committee route.

Immediate Action Taken

- On the day of the first EHO inspection and issues identified, the kitchen was made safe and out of date items removed and immediate, direct supervision put in place to ensure procedures were being followed. Safe food preparation, storage and handling were in place with immediate effect.
- Daily supervision was put in place with full inspections twice a week.
- All Catering Assistants and supervisors in Bronllys have undertaken additional training provided by the Compliance and Quality Service Improvement Manager.
- New kitchen cleaning schedule have been introduced and is being monitored.
- The kitchen signage, systems and procedures have all been reviewed and improved.
- Redundant equipment and furniture have been removed.
- All the doors and entrances have been cleaned, painted and pest control measures put into place.
- New safety barriers have been introduced to protect staff using trolleys.

- All staff have been informed in writing of their contractual and legal obligations and risks to public health if these are not followed.
- Inspections to all kitchens have been increased to Weekly by Supervisors and Coordinators and Monthly by Managers
- Bronllys Kitchen is to remain at the highest level of intervention for the next 3 months with weekly inspections.
- A review of the roster and supervisor responsibilities has been commenced and will report back in January.
- The Support Services Manager usually based in Brecon Hospital is to be based in Bronllys to strengthen oversight of the kitchen for the next 6 months.

Key Interim Learning

Support Services has taken a learning and improvement approach to establishing and rectifying immediate findings for the root cause of the failure and contributary findings. It has also taken the approach to support staff and improve performance.

Based on the learning from this incident, there are immediate actions being taken by support services to ensure that all kitchens are maintained to the highest standards:

Root Cause -

- Even though Catering Assistants had signed to indicate the Daily Food Safety Management checks were complete, indicating all food was in date and this was countersigned by the Supervisor, the inspection found several food items out of date and not labelled.
- Staff had not followed established procedures for traceability for 'decanted' foods and 'ready to eat' foods.
- Staff had not followed established procedures for the separation of food types.
- The environment of the facility had deteriorated over time, and this had not been identified by local inspections / audits and placed on the FM system.

Key learning –

1. Operating in a high trust environment without more regular physical checks being undertaking by the supervisor, coordinator and manager had allowed poor practice to go unchecked.
2. More attention during the audits should be devoted to the quality of the estate and steps taken to maintain or improve the estate.
3. All estates requirements should be placed on the FM system and reviewed monthly by the Senior Management Team.

Contributary findings-

- Prior to the inspection there were warning signs that there were issues with the Bronllys kitchen but these were not given enough priority by the management team against other competing risks as assessed at that time.
- In the weeks and days prior to the assessment, the internal assurance process had identified another kitchen in South Powys where the management team were focussed on an improvement workstream involving training, support visits and inspections. This took the capacity and focus away from Bronllys and may explain why the issues were missed?
- A new 'Inspections Training' is being developed as there is no standard level of training and competency check specifically around how food standards inspections should be conducted by Supervisors, Coordinators and Managers.

Key Learning and actions-

1. The current Cater Cloud System is providing a limited patient safety and food traceability offer and the proposal being developed by the service to move to the All Wales Catering Management Information System should be expedited.
2. The Food Safety Management System has increased its focus on preventing poor practice and habits from developing and will now be led by practice focussed highly visible leadership.
3. A Support Services monthly Compliance meeting, similar to that used in Estates will commence in January 2024
4. There is now an increase in the overall frequency of inspections undertaken by managers to monthly and by supervisors and coordinators to weekly.
5. A new inspections monitoring tool is being developed to collate all internal and external inspections, and their findings. This will use a new rating system for internal assurance and will be implemented before the end of December 2023
6. New skills-based training is now compulsory for all staff who will undertake kitchen inspections, to ensure there is a common standard and staff have passed a supervised assessment.
7. Review the reporting arrangements for the management and compliance of the kitchens and food safety with the Board Secretary and ensure governance is correct.
8. The Catering Services Food Safety Procedures are due for review in 2024 and this provides a further opportunity to review, update and amend to reflect changes.
9. Request a review by Internal Audit after the implementation of the revised Food Safety Management System in 2024.
10. Completion of full Serious Incident Review to establish a broader system wide level of learning. This will report in the new year.

CONCLUSION

Whilst a root cause analysis investigation will provide a more detailed explanation for the failures found during the inspection, it can be envisaged at this point that the failures identified were preventable.

Given the scrutiny provided by the Support Services Team to the Bronllys Catering arrangements, the subsequent management inspections, the successful re-evaluation visit by the EHO and the additional management scrutiny at the other HB sites, assurance can be provided to the team that the whole service is currently operating at a "Very Good" hygiene standard. This kitchen and the others will now all be assured by an increased and improved monitoring system.

In response to the outcome of the audit, a high standard of collaboration was established between the Support Services and the Works and Estates team who between them worked through the remedial actions quickly with a strong and professional focus.

NEXT STEPS:

1. To note the findings of the first inspection and subsequent re inspection.
2. To note the actions taken to rectify the issues identified and to strengthen compliance across all kitchens.

References

[1] Holland et al (2020) Estimating deaths from foodborne disease in the UK for 11 key pathogens - PMC (nih.gov) (as accessed 6/12/2023)

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 4.1

Delivery and Performance Committee	**Date of Meeting: 19 December 2023**
Subject :	**Records Management Improvement Plan Update**
Approved and Presented by:	**Pete Hopgood, Executive Director of Finance, Informatics, and Information Services**
Prepared by:	**Vicki Cooper,** AD Digital Transformation & Informatics**, Amanda Smart** Head of Information Governance, Records and Data Protection Officer **Laura Hughes** Document & Records Manager
Other Committees and meetings considered at:	**Executive Committee** **Investment Benefits Group (Full EDM Case)**

PURPOSE:

The purpose of this report is to provide a Digital First on the progress, challenges, and next steps for the Records Management Internal Audit Recommendations.

RECOMMENDATION(S):

The Committee is asked to:

a) **NOTE** the current position with the progress against the 2019 Internal Audit recommendations.
b) **NOTE** the areas requiring immediate attention together with longer-term plan.
c) **NOTE** the challenges and identified risks with mitigation recommendations.
d) **NOTE** the achievements resulting in completion of the Internal Audit actions.
e) Take ASSURANCE on the progress to date on actions taken in relation to the Records Management Improvement Plan.

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:

Following the 2019 Internal Audit and outcome of 'no assurance given', this report details the progress against the Records Management Improvement Plan.

Six recommendations were identified for action (See appendix 1 – Internal Audit Report). An Improvement Plan was created and adopted on the November 2019, by the Audit, Risk & Assurance Committee. The progress plan (appendix 2 – Internal Audit Recommendations Progress Table) provides the current position against each of the six recommendations.

DETAILED BACKGROUND AND ASSESSMENT:

Powys Teaching Health Board (PTHB) has made considerable progress to the actions against the six recommendations summarised as:

1) Accountability, Leadership, and coordination of Records Management

- ✓ Creation of a new structure and recruitment of accountable Heads of Service and Leadership roles within Records Management.
- ✓ Coordination of engagement and activities across services

2) Strategy, Policies and Procedures

- ✓ A full Records Management Policy and Procedure schedule is in place identifying the suite of Policies, Procedures and Guidance required.

3) Identification and Tracking of Records

- ✓ Rollout of Intelligence tracking is complete with guidance and training in place for manual tracking of Records.

4) Security of Records

- ✓ Scoping and location audit completed throughout the Health Board. Local security plans have been developed, in partnership with Estates and Facilities to include CCTV monitoring, and all Datix entries relating to the physical security of records reviewed and managed through IG and Facilities and Estates.

5) Storage of Records

- ✓ All locations have been audited and a business case has been completed to identify the digitalisation of all records via procurement and implementation of a full Electronic Document Management system to mitigate the risk of storage

of records. The investment is substantial and as a result other solutions are being explored. For records requiring storage this exercise to scope suitable locations and procedures is complete.

6) Risk Management

✓ Incidents and risks identified are reviewed, scored, and documented within the incident management solution and escalated as appropriate. Department and Directorate risk registers are managed in line with corporate policy arrangements.

Challenges

National Embargo ruling – There has been an embargo on the destruction of records which has only recently been lifted, meaning Health Boards were not able to destroy records within the normal threshold of destruction. This was due to national investigations in secondary care provision.

Records Storage - It has been identified there are some areas within Powys THB where records being stored are not meeting policy and procedure compliance, such as records that are not catalogued with service ownership and unnecessary storage of records that would meet the threshold for destruction. This is being addressed with Service Leads and through ongoing engagement from the IG service leads.

Service Capacity – Records management activities within Service Areas is a legal requirement and to ensure compliance responsibility and capacity constraints are being considered a challenge to appropriate cataloguing and storage. This is being addressed and is ongoing with service leads via regular engagement, education, and training.

Achievements

Central Records Repository - In partnership with Estates and Facilities, new accommodation has been identified for records storage, mitigating the need to procure additional storage from non PTHB locations and creating a suitably equipped central records repository.

Records Management Strategy – In line with the approved Digital Strategic Framework a Records Management Strategy is in draft to roadmap the next three

years ensuring that we continue to improve our records management processes across all service areas and achieve the overall Strategic objectives.

Records Management Policies & Procedures – A suite of new local Records Management Policies and Procedures have been identified and are currently in development with a clear hierarchy in place. These will be fully implemented by the end of FY 23/24

NHS Wales Health Records Training – This is the first time an external Records Management course has been offered to the health board. This offer was distributed out to all heads of service for nominations and employees have taken up the offer across the organisation. This will give operational staff a recognised qualification and will provide the health board with assurance that staff with records management responsibilities are suitably qualified.

Ongoing Improvement Areas

- **WCCIS** – A Service Improvement Manager has been appointed and three working groups have been established covering Community Service Group, Womens & Children and Mental Health services. The IG team works closely with the Service Improvement Manager to ensure Records Management areas are compliant in all aspects in relation to electronically embedding in WCCIS.

- **Digitisation of Records** – To mitigate the financial investment required to back scan all eligible health records, there are alternative solutions being worked through in a phased approach utilising existing tools and systems. Powys THB leads are also linked in with national conversations relating to an 'All Wales' digitalisation of records pipeline programme.

- **Information Asset Register** – There is a new register in place which will provide the IG team with the function to audit and monitor entries along with providing staff with a much more user-friendly application to use. Once established regular monitoring will be undertaken with any areas of non-compliance highlighted to operational teams via a bi-annual Information Governance Management group chaired by the Head of IG.

- **Appraisal and culling of health records –** The embargo on the culling of health records has been unable to move forward due to national pending resolution to remove the 20-year ruling around patients with long-term health conditions. Once a decision is made the destruction of records programme can commence for those records passed their retention period.

This will not only ensure the health board is adhering to legislation but will support to move to the storage area in the new accommodation.

Service Engagement

Continued support and engagement from operational service leads is ensuring that the IG Team can compile a full picture of the scope of the issues around historic health records such as volumes, resourcing, and locations with a gap analysis near completion. Funding opportunities to support service areas in the destruction of records are being explored for this FY

Identified Risks

Risk	Impact	Mitigation	RAG
No single patient record exists – records are on paper in files held across the estate or held in different clinical systems electronically (or duplicated in both).	• Uncertainty all relevant records retrieved. • Uncertainty all records identified when retention reached	Procuring an EDMS which links with the Welsh Clinical Portal and WCCIS will start to formulise a single patient record.	
Tracking of paper records is not consistent across services	• Records not tracked through WPAS may be missed. • Location of records are not known. • Fails UK GDPR Article 30 – (ROPA) organisations to create and maintain a Record of Processing Activities	Engaging with departments to see who uses using intelligence tracking and establishing a central record inventory	
Paper records are stored at many locations, usually at the place of treatment, many are stored elsewhere to alleviate local capacity issues	• Unaware of all records needed for a patient. • Ownership and process at different sites not clear • Notes go missing	Engaging with departments to establish inventory and moving non-active files to a central storage location.	
Some facilities are not designed to accommodate records	• Security – some areas are not locked, and access is not recorded. • Organisation of records not managed. • H&S issues with paper mite or rodent infestations	Moving non-compliant storage of records to a central location which is then tracked on a central inventory	
Embargo on destruction	• Local storage running out of space adds admin overheads	Contacting the inquiries to ascertain if an end date has been agreed to lift the embargo which will those passed their	

		retention period to be culled and free up space.	
Medical records tracking off site and in stored in areas that are not compliant with Health and Safety and Records Management policies	• Health and Safety risk in some locations where paper records are stored.	Review IG Records Policies and Procedures	

NEXT STEPS:

The Health Board recognises the following drivers to support moving to digital records and having an improved storage solution will:

- improve patient safety.
- improve operational efficiency.
- improve effectiveness and governance.
- streamline information sharing.
- improve compliance with Data Protection legislation.
- require additional space available across the organisation's estate.
- better physical ownership of the records as these will be digital.
- reduce number of records related incidents.
- ensure that information is readily available at the point of clinical decision making.
- facilitate the adoption of technology that will provide more 'time to care'.
- facilitating remote services across a large geographical infrastructure.

As such the Health Board will:

1. Continue to progress actions against the recommendations from the Internal Audit of Records Management

2. Request a further Records Management Audit in 2024/25 noting the impact of Covid since the 2019 audit and the progress made to date.

3. Engage with national discussions relative to an 'All Wales' digitalisation of records solution.

Appendices

1. 2019 Internal Audit Review of Records Management
2. Internal Audit Recommendations Progress Table

PTHB Ref. No.	Report Title	Assurance Rating	Director	Responsible Officer	Recommendation	Management Response	Status	Progress being made to implement recommendation					
								Work completed to meet recommendations	Outstanding actions identified	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	When will implementation be achieved?	If action is complete, can evidence be provided upon request?
1. Accountability, leadership, and coordination of records management	Records Management	Low	DRT	Head of IG, Records & DPO	The health board should strengthen its leadership arrangements and the coordination of its approach to enable effective records management. Individual roles and responsibilities should be reviewed, defined and documented accordingly, either within the most appropriate policy or a separate roles and responsibility document	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	Complete	Document & Records Manager now appointed and in post Head of IG, Records and DPO now in post Project Manager appointed for Digitisation of Records Project All staff Job descriptions have been updated to reflect responsibilities in records management. Records Management section on IG page live on the intranet as at Jan 2023 All policies and procedures are now documented with clear roles and responsibilities relating to records management. Structure in place for records management attendance at meetings such as •Property & Accommodation Group – physical storage concerns •WCCIS Management & Operational groups •HRMAG for national records related issues •PTHB Destruction of Records Task and Finish Group •Digital Transformation & Informatics Onsite Support days •Key roles and responsibilities in IG/Records Management are relayed to staff during bespoke training sessions and included in National IG Mandatory E-Learning	A recent audit, has highlighted further gaps such as the role of Information Asset Owners and Information Asset Administrators should be identified throughout the organisation to support the Information Asset Register. This will be added to the overall improvement plan	IAR database is still currently a work in progress by the Digital team but due to be completed by 31/12/23.	Consider the allocation of IAO and IAA roles to manage all information assets (including health records) and to regularly maintain the IA Register	28/02/2024	
2. Strategies, Policies and Procedures	Records Management	Low	DRT	Head of IG, Records & DPO	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.	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 Publish the updated Policy and Procedures, raising awareness across the organisation Introduce a programme of records management training for clinicians and staff, including management of identified risks	Partially complete	A Records Management Policy & Procedure schedule has been created to identify the suite of Policies, Procedures and Guidance required to meet the internal audit recommendations and those on the wider RM workplan. IGP 014 Records Management Framework IGP 010 Access to Information Procedure IGP 005 Destruction of Records Procedure IGP 008/009 removed and archived as no longer required. IGP 002 FOI and EOI Procedure IGP 017 Records Management Code of Practice for Health & Social Care 2022 highlighted a change to retention periods for various health records. Existing documents that contained retention periods have been updated to reflect this new document. Information Security Policy Development of a Records Management page on the IG intranet site that links to current policies and procedures and guidance. This is regularly updated. Redaction Guidance for staff IG staff leaflet revised to include records management. Regular tailored local training sessions are offered to services on request. The national e-learning IG mandatory module has been updated in line with legislative requirements and also now covers Records Management and Cyber Security	IGP 007 Health Records Procedure review is drafted and currently going through approval process and due to be completed by 31/01/2024 An overarching Records Management Policy was identified as an area of non compliance . This is in draft and due to be completed by 31/12/2023. All associated records management procedures will align within the framework of this policy. A Corporate Records Procedure, not included in initial work, has been identified as an area of non-compliance. This is in draft and due to be completed by 31/12/2023. Adoption guidance Transgender guidance The team have been exploring the possibility of obtaining a new SAR tracker to streamline the access to records process. Work on this is ongoing. A Clinical Record Keeping Procedure was requested by the WCCIS Management group. This has been drafted and sent for comments to the Caldicott Guardian and Chief Clinical Information Officer. This will then go for approval by 30/11/23	Proposed changes to the Adoption process by Welsh Government in Sept 2022 put a hold on progressing with guidance. These changes were then disgarded in Sept 2023 due to lack of funding and resource from Welsh Government. The team has since worked with the WB&C lead to review their SOP and due to a continued lack of national guidance, local procedures will be developed as a priority. There is still no national Transgender Policy. Engagement from other services to develop local guidance has been lacking.	Develop and publish interim supporting procedures. On the HRMAG workplan and being driven by Welsh Government	01/02/2024 Ongoing	
3. Identification and Tracking of Records	Records Management	Low	DRT	Head of IG, Records & DPO	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.	Review and update procedures and guidance to support effective tracking of records Ensure adequate Business Continuity Planning arrangements are in place relating to records management Review and update arrangements for the retrieval and transportation of records, ensuring consistency in approach across the organisation Develop a business case for the digitisation of active records Review Information Sharing Protocols in place for commissioned services	Complete	The business case and rollout of Intelligent Tracking is complete with guidance and training available for all staff. Regular data quality and performance reports are made available to service leads. Health Records Procedure details guidance for manual tracking of records for those not using Intelligent Tracking Confidential waste contract has been renewed and is managed by Support Services. Destruction certificates are provided and confidential waste bags are held in a secure area before collection. A recent scoping exercise identified that all hospitals have a secure location for mail to be picked up/dropped off. Local security plans developed by Facilities & Support Services Manager cover records management elements. The Information Asset Register has been promoted throughout the health board. The link to access is on the Records Management section of the intranet and regular reminders are added to the IG alert issued to staff. A scoping exercise was undertaken by an external consultancy company during March 2022 focussing on the health boards health records. A business case highlighting the outcome from this exercise, risks and next steps was developed. However progress has been stalled due to a lack of funding for the Digitisation of Records Project. A further scoping exercise has been undertaken by the IG team as part of the Destruction of Records T&F group. WCCIS performance improved since server capacity increased. Newly appointed Service Improvement Manager for WCCIS works closely with the Document & Records Manager and has developed a Service Improvement Plan to address issues with system performance and staff engagement. Local SOPs are being reviewed and developed to address issues raised such as merging duplicate records, to ensure good practice and business continuity arrangements. A business case was developed for the Digitisation of Records but progress has not been made due to a lack of available funding. An alternative solution, using an existing system such as WCP, is currently being explored. A number of national projects have been commenced (cross border, Welsh Nurse Care Records WCCIS) to support digitisation of records	A task and finish group with leads from all services, was established to ensure a co-ordinated approach to the destruction of records across the health board. Services were asked to identify all records held, both paper and electronic, and this data has been cross referenced with data sourced from a scoping exercise undertaken by the IG team to ensure accuracy. Work is ongoing to address the issues raised. Scoping exercise needs to be undertaken to assess the volume of corporate records across the health board. Work is ongoing with the Digital team to develop a more user-friendly Information Asset Register, as the current format is not easy to report on. The Digital team are working on developing an App so that Information Asset Administrators/Owners are able to review and update their entries. This will support the Document & Records Manager to regularly audit entries and monitor areas of non compliance. Business Continuity plans are in place for WCCIS however need to identify for all other electronic systems.	Not all health records are tracked using the Intelligent Tracking option with advice given that services do not have the resources to undertake the manual addition of existing records into the Intelligent Tracking system. Any records considered for storing in central repository will be considered to be added to Intelligent Tracking as part of the archiving process.	Any records identified to be moved to Spa Road will be tracked using Intelligent Tracking. As part of the appraisal programme services will be tasked with updating Intelligent Tracking for any records that are still within their retention period in manned and unmanned libraries.	Ongoing Ongoing	
4. Security of Records	Records Management	Low	DRT	Head of IG, Records & DPO	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.	Explore and secure suitable storage spaces (on site or off site) for the storage of active records	Complete	A scoping assessment has been undertaken by the IG team to identify the location of records throughout the health board. All records accommodation requests come through the Property & Accommodation group to ensure records are houses in suitable locations. Local security plans developed by Facilities & Support Services Manager cover records management elements. CCTV Equipment, Policy and procedures have been updated which in turn monitors the security of PTHB premises which in turn will hold records and data. Datix incidents relating to physical security are reviewed by the IG Team and shared with the Facilities and Support Services Manager.	Records Storage Space has been allocated within the newly acquired Welsh Government building at Spa Road in Llanbradach Wells. Work is currently underway to identify the volume of records this area will hold. IG/Records are part of the Spa Road Project Team to facilitate the move of records. An exit strategy will be developed to manage the transfer of paper records to Spa Road.	As part of the Destruction of Records T&F group, confidential waste budget has been highlighted as an issue. Due to current financial pressures across the organisation there is currently a stop on any additional spend on confidential waste which has stalled any services destroying records identified for destruction. This issue will be considered as part of the Spa Road Project Group as this could stall moving any records to the allocated areas as appraisal and destruction will need to take place before the move.	This will need to be considered at Executive Committee.	Ongoing	
5. Storage of records	Records Management	Low	DRT	Head of IG, Records & DPO	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.	Explore and secure suitable storage spaces (on site or off site) for the storage of active records	Complete	Several 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. Further, some existing sites are not fit for purpose e.g., Brindlys creche, the garage at Ynys y Plant, Newtown. Enquiries relating to sites with potential for storage at Mamhilad, Aneurin Bevan UHB, IPS in Newport and a Welsh Government Building at Newtown have been followed up, none of which have been available for PTHB use. A number of services within PTHB currently use PCC archives facility at Dibble Road for offsite storage at a cost to the organisation, however use of this service is service led and there is no standard process on which records are archived. Any requests for in-house records storage go through the Property and Accommodation group for consideration to ensure that any movement of records are being allocated to suitable premises and that the archiving process has been completed correctly. The Documents and Records Manager sits on this Group	A task and finish group with leads from all services, was established to ensure a co-ordinated approach to the destruction of records across the health board. Services were asked to identify all records held, both paper and electronic, and this data has been cross referenced with data sourced from a scoping exercise undertaken by the IG team to ensure accuracy. Work is ongoing to address the issues raised. An exit plan will be developed to coordinate the movement of records from Bro Hafren and PCC Archives to central PTHB repositories.	The lifting of the culling ban has been implemented however with the identification of a 20 year ruling for health records for patients with long term health conditions it has put a stop to the destruction of most records whilst clarity is sought. This has been discussed at an all Wales level and work is ongoing to review the NHS Wales Records Management Code of Practice to clarify this issue. In Jan 23 as part of the Destruction of Records Task & Finish Group, services were asked to complete an audit of the location and volume of paper records held across the organisation. Completion of this from some services has been slow, and we are still awaiting the return of some. The returned audits has highlighted that some services have not been appraising records due to capacity constraints	HRMAG are currently liaising with WG to come to a conclusion. However services have been advised that they can cull those records that do not fit the 20 year ruling retention criteria. Reports will be shared with HoS where there are areas of no/low participation as part of ongoing engagement	Ongoing	
6. Risk Management	Records Management	Low	DRT	Head of IG, Records & DPO	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.	Introduce a programme of records management training for clinicians and staff, including management of identified risks Ensure that risks associated with records management, including those arising from the Internal Audit review, are identified and recorded and managed in line with the Risk Management Framework Review arrangements for the reporting and management of information governance related breaches and incidents	Partially complete	National e-learning module has been updated to include Records Management and Cyber Security elements ABUHB offered employees of PTHB the opportunity to complete IHRIM Foundation in Records Management. 6 PTHB staff are currently undertaking this course. Document & Records Manager sits on various local meetings such as WCCIS & T&F for Destruction of Records, where records related risks are discussed and identified. Information Governance team have their own risk register which sits within the Digital Transformation Directorate risk register. IG and Records related risks are identified within all service areas which are reported through the Risk and Assurance Committee regularly. These are discussed and if deemed necessary are considered for the corporate risk register. All IG (inc Records Management) incidents are reviewed, scored, and scoring is documented within the incident management system and if scoring above the threshold escalated as appropriate. IGP 013 Information Governance Incident Reporting Standard Operational Procedure has been developed to support staff	IG senior staff to attend Risk Management training. Training needs analysis to identify service specific gaps in relation to RM/IG elements still to be undertaken.	ongoing training availability and staff participation	Will need to explore what training is available with the Risk Lead for the organisation. IG will work with WOD, OD, IG&IAG, and HRMAG to develop and implement a suitable training needs analysis for PTHB staff	31/03/2024 31/03/2024	

Agenda Item 3.5a
Appendix 2

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.

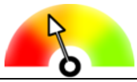
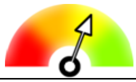
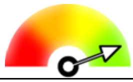
The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with records management is **No** assurance.

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

Patterson,Liz
15/12/2023 15:27:50

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: 'A*imed 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.

In the event that, pursuant to a request which the client has received under the Freedom of Information Act 2000, it is required to disclose any information contained in this report, it will notify the Head of Internal Audit promptly and consult with the Head of Internal Audit and Board Secretary prior to disclosing such report.

The Health Board shall apply any relevant exemptions which may exist under the Act. If, following consultation with the Head of Internal Audit this report or any part thereof is disclosed, management shall ensure that any disclaimer which NHS Wales Audit & Assurance Services has included or may subsequently wish to include in the information is reproduced in full in any copies disclosed.

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.

Office details:

POWYS Office	MAMHILAD Office	SWANSEA Office
Audit and Assurance	Audit and Assurance	Audit and Assurance
Hafren Ward	Cwmbran House (First Floor)	Floor 2, Matrix House
Bronllys Hospital	Mamhilad Park Estate	Matrix Park
Powys	Pontypool, Gwent	Swansea
LD3 0LS	NP4 0XS	SA6 8BX

Contact details:

Helen Higgs (Head of Internal Audit)	– 01495 300846
Osian Lloyd (Deputy Head of Internal Audit)	– 01495 300843
Matthew Smith (Senior Auditor)	– 01792 860598

Delivery and Performance Committee 2023-24

Theme	Item Title	Role of Committee	May 02/05/2023	June 27/06/2023	August 31/08/2023 (Agenda reduced - items due to be reviewed)	October 17/10/2023	December 19/12/2023	February 29/02/2024
Governance	Minutes of previous meeting	Approval	✓	✓	✓	✓	✓	✓
Governance	Declaration of Interests	Compliance	✓	✓	✓	✓	✓	✓
Governance	Action Log	Approval	✓	✓	✓	✓	✓	✓
Governance	Committee Risk Register	Assurance	✓	✓	☒	✓	✓	✓
Governance	Annual Work Programme	Recommend	✓					
Governance	Work Programme (updated through year)	Review		✓	✓	✓	✓	✓
Governance	Annual Assessment of Committee Effectiveness	Review			☒			✓
Governance	Committee Annual Report	Recommend						✓
Governance	Review of Terms of Reference	Recommend						✓
Performance	Integrated Performance Report	Assurance	✓	✓	✓	✓	✓	✓
Performance	Annual Delivery Plan Q2 and reset for rest of year							
Finance	Finance Report	Assurance	✓	✓	✓	✓	✓	✓
Finance	Finance Savings Report	Assurance		✓		✓		✓
Finance	Financial Sustainability In-Committee	Assurance	✓	✓	✓	✓	✓	✓
Finance	Six monthly report on Continuing Heath Care	Assurance			✓			✓
Annual Reporting	Draft Performance Report (invite ARAC)	Assurance	☒					
Health & Safety and Fire Safety	Compliance with regulations and Standards	Assurance						✓
Health & Safety and Fire Safety	Health and Safety Assurance Update	Assurance			✓			
Health & Safety and Fire Safety	Health and Safety Annual Report	Assurance						✓
Information Governance	Annual Report	Assurance	✓					
Information Governance	Monitoring Report	Assurance			✓		✓	
Information Governance	IG Toolkit (National Audit replaces Caldicott	Assurance					✓	
Records Management	Records Management Improvement Plan	Assurance	✓				✓	
Records Management	Records Management Update	Assurance					✓	
Innovative Environments	Capital Programme Delivery	Assurance					✓	
Innovative Environments	Capital and Estates Compliance Report	Assurance						✓
Innovative Environments	Capital and Estates Strategy	Assurance				☒	☒	✓
Innovative Environments	Capital Pipeline Overview	Assurance			☒			
Innovative Environments	Capital Procedures re authorisation of capital	Assurance				✓		
Primary Care	GMS	Assurance						✓
Primary Care	GDS	Assurance					✓	
Primary Care	Out of Hours	Assurance			☒	✓		
Primary Care	Community Pharmacy	Assurance					☒	✓
Digital First	Annual Plan	Assurance	✓					
Digital First	Monitoring Report	Assurance					✓	
Digital First	IT Infrastructure and Asset Management (update	Assurance		✓	☒	✓	✓	✓
Renewal Portfolio Highlight	Renewal Portfolio Closure Report	Assurance		✓				
Accelerated Sustainable Model (ASM)		Assurance						
Audit Rec Monitoring	Cyber security - In Committee	Assurance	✓	✓	☒			✓
Escalated Issue	Variable Pay	Assurance			✓			
requested items	IPC - data assurance lessons learned (via HB)	Assurance			☒			✓
	ISO 14001 Report	Assurance			✓			
	Digital Strategic Framework	Assurance					☒	✓
	Audit Wales report - Orthopaedic Services - Tackling the backlog (action)	Assurance				☒	✓	
	Montoring of the Primary Care Prescribing (action)	Assurance					✓	

Key
- Date to be confirmed
- Item to be confirmed
- Item deferred
- Item brought forward
- Going to Board
- Due to Committee
- Find Exec Cttee date
- Added to draft agenda