Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.1

DELIVERY AND PERFORMANCE COMMITTEE	**Date of Meeting: 23 June 2022**
Subject:	**Update on the Implementation of Value-based Healthcare Approach**
Approved and presented by:	**Director of Finance & ICT** **Medical Director**
Prepared by:	**Assistant Director of Transformation & Value** **Transformation Programme Manager** **Service Transformation Manager**
Other Committees and meetings considered at:	This paper draws on content considered at the last Value Based Healthcare Programme Board meeting held on 24th May 2022.

PURPOSE:

The purpose of this paper is to provide the Delivery and Performance Committee with an update on the implementation of the value-based healthcare approach within Powys Teaching Health Board (PTHB).

RECOMMENDATION(S):

The Delivery and Performance Committee is asked to NOTE and DISCUSS the report.

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

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

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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 implementation of value-based healthcare forms a key part of the health board's Integrated Medium-Term Plan and governance arrangements have been established to embed a value-based healthcare approach in the organisation's operating model.

Posts have been created and appointments made to strengthen the Transformation & Value Team, although some roles remain more challenging to recruit to. Analysis of low value interventions as well as opportunities to improve value through clinical pathways is underway. A consistent approach to patient reported outcome measures and patient reported experience measures is being developed, linked to national work and with liaison underway to incorporate data for Powys patients treated in England. Engagement activities to embed value-based healthcare have commenced. Proposals aligned to the health board's priorities have been submitted to for additional Welsh Government funding targeted to support high-value interventions.

DETAILED BACKGROUND AND ASSESSMENT:

The Strategic Priorities within the Powys Teaching Health Board (PTHB) Integrated Medium Term Plan (IMTP) for 2022/23 – 2024/25 include *implementing value-based*

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healthcare to deliver improved outcomes and experience, including effective deployment and management of resources.

Understanding the outcomes and experience of the Powys population, the evidence base and comparative costs will enable PTHB to increase value. The health board is working to allocate resources to the right place to deliver the best outcomes that matter for the population of Powys at the least cost.

The health board is embedding a value-based healthcare approach within its way of working, spanning its whole operating model, with the aim of improving outcomes, reducing clinical variation, and improving efficiency through the system. Key to this will be the development and implementation of a Value Based Healthcare strategy and approach defined around the following themes:

➢ Strategy
➢ People & skills
➢ Culture
➢ Process
➢ Structures

The 2022/23-2024/25 Financial Plan is designed to effectively deploy resources to deliver improved outcomes and meet the needs of the resident population. It is a significant driver of the value-based healthcare approach which is being embedded throughout the organisation and supported by a core and expert team focused on renewal and transformation.

Value based healthcare will support ongoing access to good quality health services with a focus on recovery and renewal from the pandemic whilst meeting the statutory duty to breakeven over the three-year period. It will be important for the organisation to maintain a clear focus to support transformation and value-based healthcare to support medium- and longer-term sustainability whilst improving patient outcomes for our population.

As set out in the IMTP, a value-based healthcare approach is also being used to underpin the renewal programmes including 'the Big Four', so that the health board allocates its resources to the right places to deliver the best outcomes that matter.

The principles of 'doing what matters' and 'doing what works', and our values are key to improving outcomes working with our patients. The health board will embed this approach in its operating model to ensure it has the right people, culture, skills, processes, and structures in place for this.

The health board has recognised the scale of the challenge will not be met by existing approaches and will require new, radical solutions bounded in a value-based healthcare approach locally, regionally, and nationally.

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A Programme Initiation Document (PID) for Value Based Healthcare was approved by the Renewal Strategic Portfolio Board (RSPB) in September 2021.

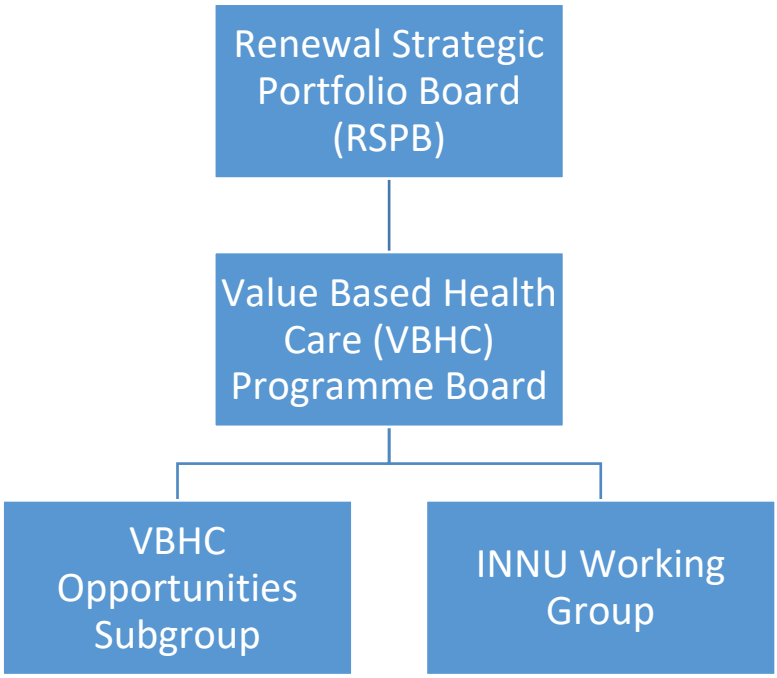
PTHB has defined Value Based Healthcare as:

> PTHB recognises Value as allocating resources to the right place to deliver the best outcomes that matter for the population of Powys at the least cost.

This work is taking forward the vision for A Healthy, Caring Powys and ensuring that the guiding principles, such as doing what matters, doing what works, being prudent and offering fair access, lies at the heart of the programme of work. The programme will ensure the right people and skills, processes, structures, and culture are in place for Value Based Healthcare.

Establishing programme governance arrangements

PTHB has established the Value Based Healthcare (VBHC) Programme Board, which is co-chaired by the Medical Director and Director of Finance & ICT, and reports to the RSPB to embed VBHC approaches within the organisation's operating framework and, in particular, the health board's Renewal Priority areas.



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The specific actions that have to be achieved in 2022-23 in relation to VBHC are set out in the PTHB annual delivery plan 2022/23 as summarised below:

24 - Implement value-based healthcare, to deliver improved outcomes and experience, including the effective deployment and management of resources *Executive Lead - Various*		
Delivery of the value based healthcare programme *Renewal Portfolio*	Further strengthen the Transformation and Value team, including research assistants, Masters and PHD Students	Q1 – Q3
	Analysis of low value interventions Q1, Review with BCUHB Q2, update Interventions Not Normally Undertaken (INNU) Policy Q3	Q1 – Q4
	Develop and implement consistent approach to PROMs and PREMs Linking with the OD Framework, implement a range of engagement activity that helps embed Value Based Healthcare	Q1 – Q4

Further strengthen the Transformation & Value Team

The VBHC Team has been strengthened over the last ten months including programme co-ordination, an analyst and costing accountant. Unfortunately, the first attempt to secure master's level students in Q1 2022 was not successful but there will be further work in the year to attempt to secure research assistants, master's, and PhD students.

Several attempts have been made to secure Value Based Medicines Optimisation Pharmacists which have been unsuccessful, and support is currently being provided by members of the PTHB Chief Pharmacist's team. The Executive Committee has agreed to approve the investment into a joint Professor in Health Economics post and team as part of the Value in rural Wales Group, appointments are currently being progressed.

Analysis of low value interventions

The VBHC Programme has established an Interventions Not Normally Undertaken (INNU) Working Group to review and update the PTHB INNU Policy. However, there has been recent correspondence from Welsh Government to inform PTHB of the intention to develop an all-Wales INNU policy. PTHB has an extant INNU policy in place but is supportive of an update being provided on a 'Once for Wales' basis. PTHB has a process in place within the Commissioning Department for identifying INNU activity within commissioned providers. The VBHC Analyst is examining closed pathways to identify the extent of any INNU activity that has been undertaken.

A VBHC Opportunities Subgroup has been established, chaired by the Director of Clinical Strategy, to identify and analyse data across PTHB and provider organisations in order to recognise opportunities for value creation within pathways. It will seek to improve value via cost containment, cost reduction (through substitution) and/or redesign focusing on improved deployment of resources in clinical pathways. The VBHC Opportunities Subgroup reports to the VBHC Programme Board.

The VBHC Opportunities Subgroup is examining data and activity around wet age-related macular degeneration as eye care is one of the priority areas that has been identified within the approved VBHC programme. The Subgroup is also examining the data and activity around cataracts and opportunities for value creation.

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Develop a consistent approach to Patient Reported Outcome Measures and Patient Reported Experience Measures

The VBHC Programme Board received a presentation from the Welsh Value in Health Centre on the Patient Reported Outcomes Measures Standard Operating Model (PSOM) on 17th March 2022. PTHB also provided input and feedback to Welsh Value in Health Team on the PSOM service specification.

A survey has been developed and approved by the VBHC Programme Board to understand the existing use of Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs) across PTHB. Data gathered from the survey will inform the approach to PROMs and PREMs in Powys. Links with the Welsh Value in Health Centre and other health boards will ensure alignment with the national work. Contact has also been made with neighbouring English Integrated Care Systems to discuss how PROMs and PREMs captured for Powys patients accessing services in English NHS trusts can be fed into Welsh system.

Implement a range of engagement activity that helps embed VBHC

"Bringing Value to Life" Education Programme was held in March 2022 in collaboration with Betsi Cadwaladr University Health Board, Hywel Dda University Health Board and PTHB. The event was attended by 14 clinicians and non-clinicians from PTHB to support understanding with VBHC across the region. Further engagement activities for PTHB will be developed.

Plan on a page to build VBHC into PTHB operating model focusing on the following areas, guided by PTHB principles

STRATEGY	PEOPLE & SKILLS	CULTURE	PROCESS	STRUCTURES
YR1: Embedded in annual plan ✓ Embedded in delivery plan 2022-23 ✓ Embedded in PTHB IMTP 2022-25 Agreed Programme Initiation Document✓ Agreed Programme Plan ✓ Agreed Programme Risk Register ✓ YR1: Agree organisational approach	Exec level leadership ✓ YR 1: Capacity and skills to support programme [analyst, cost accountant, project manager] Explore Shared access to Health Economist✓ YR1: Website (materials / methods / links) YR1: Training those leading & supporting the programme YR1: Identify development & training needs of clinical leaders in value, shared decision making	Promote the new language: System, Programme, Network, Pathway, Value, Outcomes. Create clinicians who own the whole pathway (YR1: First focus orthopaedics (Including pre-hab and virtual MDT) ophthalmology, respiratory, cancer, diabetes, cardiac care and frailty)	Consistent approach & methods (Needs assessment, evidence appraisal, gap analysis (variation, activity and costs) clinical prioritisation, option appraisal, pathway redesign (Including patient involvement), financial, workforce, engagement Outcome's measurement, PROMS, PREMS Performance, quality, Benefits Realisation etc) Updated INNU policy ✓ (In place) IPFR and Prior approval processes in place✓ YR1: focus on assurance around specific low clinical effectiveness interventions. Biosimilars, oxygen, diabetes,	Exec Renewal Strategic Portfolio Board (Governance structure) ✓ YR1: Establish VBHC Steering Group ✓ YR1: Establish VBHC Programme to i) embed VBHC organisational approach across the operating model and ii) to support focused work within renewal priorities ✓ YR1: establish VBHC Drugs and Medication (Opportunities) Group. Link into national support and leadership groups. (DoFs VBHC Group; Rural Value Group, Welsh Value in Health Centre✓

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	& outcomes measurement. Agree an approach to securing clinical leaders from outside PTHB and within.		Aromatase inhibitors silver dressings/ Incontinence aids / catheter usage	

Welsh Government additional funding for 2022-23

Welsh Government wrote to Welsh health boards and trusts on 14th April 2022 outlining that £5million was available to provide targeted support to high-value interventions which can demonstrate improved outcomes, with proposals invited to be submitted by 30th May 2022.

PTHB developed three proposals, which align with the priorities in the IMTP, and these were considered by Senior Clinical and Financial colleagues within the health board before being submitted to the PTHB VBHC Programme Board. The proposals were:

- Frailty: A multi-agency Value based approach to falls prevention and the response to falls,
- Embedding early intervention in care homes to prevent falls,
- A Value based approach to the use of Kardia Mobile devices in Atrial Fibrillation and Supraventricular Tachycardias.

In addition to the above, there was also a further proposal developed through our GP Cluster process relating to Dermatology, which was considered by the PTHB Investment Benefits Group and recommended to go forward by the Executive Director of Finance & ICT.

All four proposals were subsequently approved by the PTHB Chief Executive Officer and submitted by the 30th of May 2022 deadline. Confirmation of whether the proposals have been successful is anticipated in the coming weeks.

NEXT STEPS:

To continue to implement the actions for VBHC as set out in the PTHB IMTP Delivery Plan 2022/23.

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

IMPACT ASSESSMENT
Equality Act 2010, Protected Characteristics:

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

Risk Assessment:

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

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Powys Teaching Health Board

Agenda item: 3.2

Delivery and Performance Committee	**Date of Meeting: 23 June 2022**
Subject:	**Records Management Improvement Plan Progress Update**
Approved and presented by:	**Pete Hopgood, Executive Director of Finance, Informatics and Information Services**
Prepared by:	**Vicki Cooper Assistant Director of Digital & Informatics /Amanda Smart Head of Information Governance**
Other Committees and meetings considered at:	

PURPOSE:

The purpose of this report is to provide an update and to detail the progress and performance against the Records Management Improvement Plan

RECOMMENDATION(S):

The report is for information purposes and to note the following:

- An options paper will be presented to IBG and Executive Committee during August 2022 for the digitisation of health records.

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	✓

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	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 report details current delivery against the Records Management Improvement Plan following the 2019 Internal Audit and outcome of 'no assurance given.'

DETAILED BACKGROUND AND ASSESSMENT:

In August 2019, Internal Audit undertook a review of records management within the health board. Conclusion of the review was that the level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with records management was 'No Assurance.' The report recommended six high rated recommendations for action. On 11 November 2019, the Audit, Risk & Assurance Committee approved the Records Management Improvement Plan that was developed in response to this audit. **See Appendix 1**

Resource Update

In January 2020, an Interim Service Improvement Manager was appointed to support the implementation plan and has since subsequently been appointed to another role within the organisation. The two posts approved in July 2021 were appointed to this year; a Documents & Records Manager, post was filled in February 2022, and Project Manager, post holder is due to commence end of June 2022.

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Key areas for Development

- A full Risk review in relation to records management and reporting. There is an opportunity and requirement to strengthen the process for Records related risks to ensure they are visible to the Information Governance function to ensure the level of severity is known and to ensure this is accurately reflected where applicable on related Risk Register.

- Records Management policies, procedures, and guidance. Additional procedures and guidance have been identified within the plan to ensure Powys THB are fully compliant in response to recommendations made.

- Safe and secure storage of Records including identification and tracking will be scoped within the digitisation of records project and will assist the organisation in meeting several outstanding actions.

- A scoping exercise started in March 2022 will assist in the development of a business case that will be presented to the Investment Benefits Group, August 2022 required for the Digitalisation of Records.

- Re-alignment of the Information Governance and Records management function to the Directorate of Finance and Informatics. The transition of the function will provide best practice support and guidance under the direction of Powys THB Senior Information Responsible Owner (SIRO).

The table below (table 1) details progress made to date for each of the six high rated audit recommendations:

Table 1:

Recommendation no	Progress %	RAG Status	Start Date	End Date
1. Accountability, leadership, and coordination of records management	100			
2. Strategies, Policies and Procedures	50		May 2022	Dec 2022
3. Identification and Tracking of Records	40		Mar 2022	Mar 2023
4. Security of Records	30		Mar 2022	Dec 2022
5. Storage of records	30		Mar 2022	Dec 2022
6. Risk Management	60		May 2022	Dec 2022

As there is significant progress to be made to meet the overall 100% compliance against the improvement plan, consideration may need to be given to reinstate

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records onto the corporate risk register whilst work is underway to progress these areas, this is under constant review and assessment.

NEXT STEPS:

- Work will continue to progress the actions and performance against the plan
- The Digitalisation of Records business case will be presented to Investments Benefits Group
- An options paper will be presented to the Executive Committee.

Appendices

1. 2019 Internal Audit Review of Records Management

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Powys Teaching Health Board

Agenda item: 3.3

Delivery and Performance Committee	**Date of Meeting: 23 June 2022**
Subject:	**Out of Hours Performance 2021/2022**
Approved and Presented by:	**Executive Director of Primary Care, Community and Mental Health, Hayley Thomas**
Prepared by:	**Assistant Director of Primary Care, Jayne Lawrence**
Other Committees and meetings considered at:	

PURPOSE:

The purpose of this paper is to provide the PTHB Delivery and Performance Committee with assurance around the Out of Hours (OOH) service provision for Powys patients during 2021/2022.

RECOMMENDATION(S):

The Delivery and Performance Committee is asked to

1) Note OOH performance during 2021/2022 and the other assurance metrics provided.

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

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[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 health board continues to contract with three providers to deliver its OOH services, namely 111, Shropdoc Co-operative Ltd and Swansea Bay University Health Board (SBUHB). This paper summarises the performance of the service provided in 2021/22.

The all-Wales OOH standards are the national metric used to quality measure 111 and OOH services across Wales and were introduced in April 2019. During 2021/2022 the monthly reporting requirement to Welsh Government against the standards has not been formally required due to the on-going COVID-19 pandemic and Welsh Government have advocated a 'light touch' approach throughout the year.

The health board OOH Performance Management Group monitors the performance management of OOH services for all three providers supporting the Powys service. Interaction from the providers in the Performance Management Forum varies.

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

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The health board holds a contract with Shropdoc for the provision of Out of Hours General Medical Services and OOH medical cover at the health board's community hospitals, excluding Ystradgynlais. Shropdoc provides the health board with monthly reports detailing contract achievement against the All-Wales OOH standards. Shropdoc performance against the standards is consistently very good, however an ongoing challenge is meeting the standard around completing home visits within 1 hour and 2 hours. Due to the geography of Powys and the achievement of both these standards will always prove to be challenging.

Rota and shift fill rate in Shropdoc have always been good, achieving fill rates over and above all Wales average. The current Shropdoc contract terminates in June 2022.

Following recent Executive approval the PTHB Board will shortly be considering the approval to a Direct Award with use of a VEAT notice to extend the Shropdoc contract for a period of 24 Months from 01/07/22 to 30/06/24**.**

The health board commissions an annual contract with SBUHB for the continuation of the OOH service for the Powys Ystradgynlais community including the community hospital. Ystradgynlais patients are seen at SBUHB OOH Centres during weekdays and offer access at Ystradgynlais Community Hospital on weekends, when shift cover allows. SBUHB reporting on the relevant standard measures for the Powys element of the service is limited due to the inability of extracting Powys specific data; therefore, no data is available regarding assurance around timely patient access for Powys patients.

The new national reporting IT system SALUS, will resolve this issue when implemented. The SBUHB fill rate for weekend cover is poor. SBUHB have not yet committed to sign the 2022/2023 contract due to the lack of PTHB OOH District Nursing cover, options continue to be scoped and discussions continue with SBUHB. An escalated meeting has been organised with SBUHB to resolve the issue.

DETAILED BACKGROUND AND ASSESSMENT:

Since 2004, Health Boards became responsible for the provision of out of hours general medical services as per the National Health Service (General Medical Services Contracts) (Wales) Regulations 2004.

The Out of Hours is defined as:

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

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

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

Contractual Arrangements:

111

Since October 2018, the national NHS Wales 111 service (hosted by the SBUHB OOH Service) has been used as the first point of contact to access PTHB GMS OOH services. The 111 offer to PTHB includes call handling and first line triage only. Patients requiring further clinical triage are passed either to the Shropdoc service, or for Ystradgynlais patients to SBUHB Clinical Assessment Team and also the SBUHB OOH service.

The contractual arrangement between the health board and 111 forms part of the national service provision.

Shropdoc

The health board holds a contract with Shropdoc for the provision of Powys Out of Hours General Medical Services (excluding Ystradgynlais patients), Minor Injury Unit cover at Welshpool, Llandrindod Wells and Brecon Community Hospital; and OOH medical cover at PTHB community hospitals.

In addition to this as part of the contract agreement Shropdoc also provides the health board with a service for Care Coordination Centre, Violent Patient Line, Powys Urgent Response Service at Home (PURSH), 10 Protected Learning Time cover Days and other adhoc cover required, outside of the contract e.g., Flu clinic protected time. This paper solely refers to the performance management of the Shropdoc GMS OOH service and not the other services commissioned from Shropdoc.

The current contract in place with Shropdoc ends on 30/06/22. Following recent Executive approval, the PTHB Board will shortly be considering the approval to a Direct Award with use of a VEAT notice to extend the Shropdoc contract for a period of 24 Months from 01/07/22 to 30/06/24.

Below is a summary of the OOH patient pathway for 111 and Shropdoc. The Shropdoc element of the pathway detailed below can similarly be applied to the SBUHB service also.

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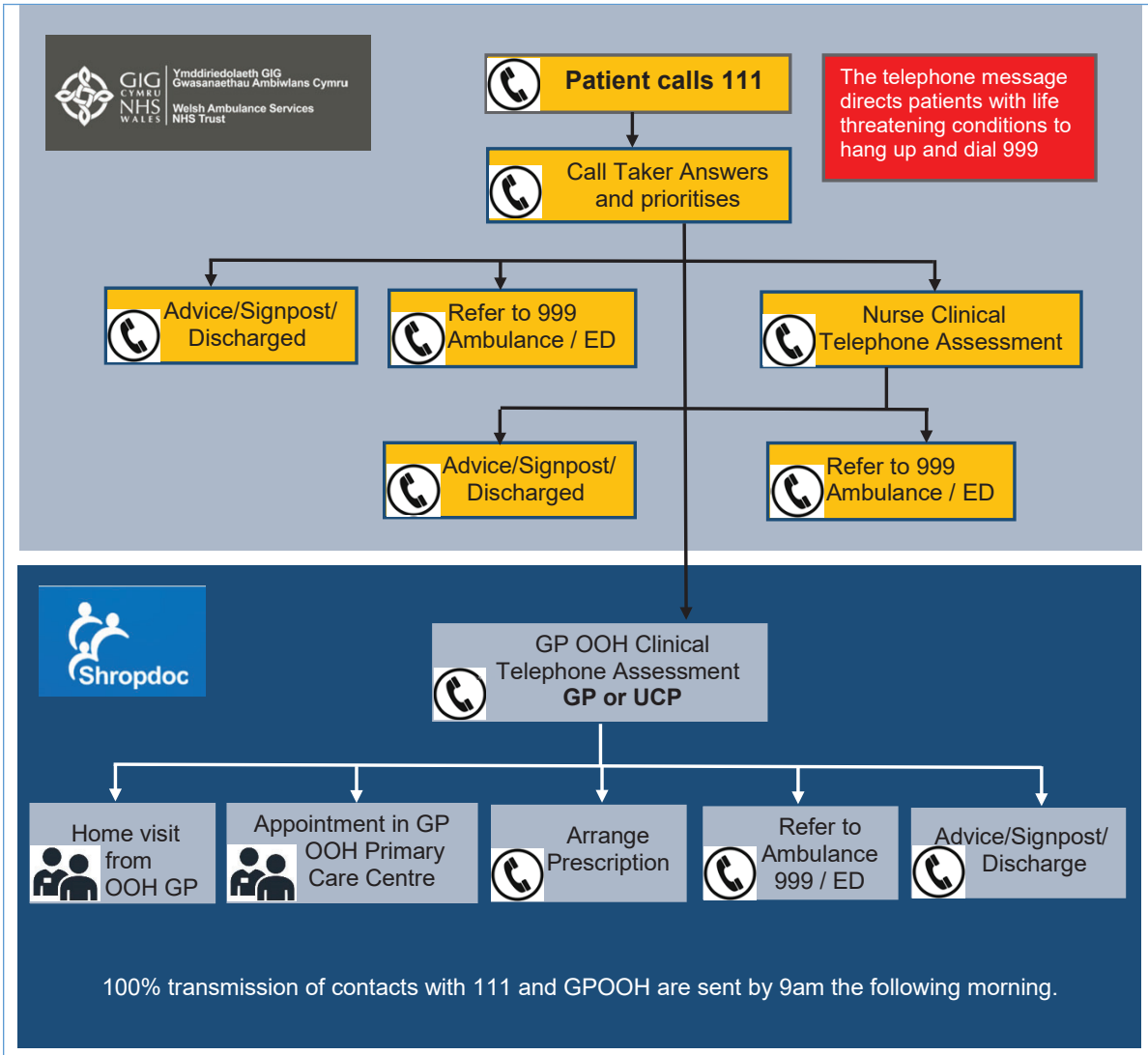

Swansea Bay University Health Board:

The health board has an annual contract with SBUHB to provide OOH GMS services to Ystradgynlais patients registered with the Pengorof Medical Practice, Ystradgynlais and also OOH medical cover at Ystradgynlais Community Hospital (YCH).

The contract for 2022/2023 has not yet been agreed and is currently being progressed. SBUHB are currently refusing to sign the contract until PTHB puts in place district nursing cover during the OOH period to mainly support with catheter management and palliative care support. The activity relating to both these areas is significantly small – 14 incidents in a 12-month period. However, the care required impacts significantly on the SBUHB shift cover. PTHB continues to scope options and liaise with SBUHB over this matter.

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Performance against OOH standards:
The all-Wales OOH standards are the national metric used to quality measure 111 and OOH services across Wales (introduced in April 2019 and further refined in September 2020). The standards are split into two separate areas; National Measures (Part A) and Local Measures (Part B). National Measures are public facing and reported to Welsh Government on a monthly basis. The Local Measures are for local reporting purposes only.

During 2021/22 the monthly reporting requirement to Welsh Government against the standards has not been formally required due to the on-going COVID-19 pandemic and Welsh Government continue to advocate a 'light touch' approach. Welsh Government have requested an Annual Report 'Light' for 2021/22 as a risk-based approach. The health board is currently in the process of preparing the report as per the detail in this report, for submission by 30th June 2022. This mirrors the 2020/21 approach by Welsh Government.

The PTHB OOH Performance Management Group, chaired by the Assistant Director of Primary Care monitors the performance management of OOH services across Powys for all three providers supporting the Powys service and provides assurance to the PTHB Executive. An OOH Commissioning Assurance Framework (CAF) has been developed during 2021/22 to support monitoring OOH services. Utilisation of the OOH CAF will be strengthened in 2022/2023.

111
In terms of OOH Standards compliance, the 111-service performance is measured against the following two indicators.

KPI ref	NATIONAL STANDARDS (PART A) 2021/2022 achievement
1a	% Calls abandoned >60 seconds (Target <5%)
1b	% Answered in 60 seconds (Target >95%)

The 111 system is not able to report at this level of detail, however 111 can confirm that in total 36,112 Powys calls were received into 111 during 2021/2022. Telephone connectivity to a call handler is as follows

Calls abandoned	Calls answered
20%	80%

The achievement in these two areas continues to prove difficult for 111 to achieve. As the service is an All-Wales service the compliance across Powys mirrors the Wales position.

111 challenges continue to relate to:

- 111's ability to respond to the demand during demand spikes

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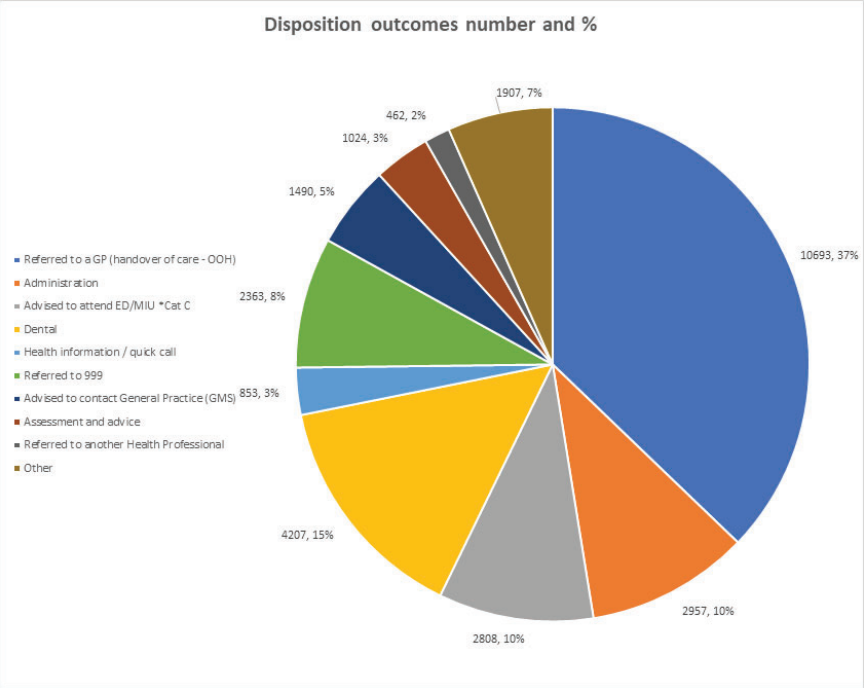
- the weekday demand is fairly static; however, the weekend demand is variable which impacts the capacity to manage and this is confirmed in demand variation data.
- more complex patients are accessing the service and therefore call handlers are transferring an increased level of calls to nurse led clinical response.
- A 'reception' model is in place to support call handling demand by providing the patient with a 'holding' call back to inform patients of delays and to give assurance to patients they are in the system.

The pie chart below depicts the Powys 111 calls and their dispositions (number & %):



Shropdoc

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

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The table below summarises the overall annual performance for 2021/2022 and provides comparison against the 2020/2021 achievement.

KPI Ref	Standard description	2020/2021 Total Calls	2020/2021 % Achieved	2021/2022 Total Calls	2021/2022 % Achieved
2	% Cases passed to 999 within 3 minutes	388	100 %	TBC	100%
3a	% Cases triaged within 60 mins (P1CT)	9223	94%	9897	90%
3b	% Cases triaged within 120 mins (P2CT)	3597	93%	3345	88%
3c	% Cases triaged within 240 mins (P3CT)	1426	98%	1571	94%
4a	F2F Base - 1 hour	65	100%	43	99%
4b	F2F Base- 2 hours	522	100%	787	97%
4c	F2F Base - 8 hours	2348	100%	2702	95%
5a	F2F Home - 1 hour	200	68%	47	46%
5b	F2F Home- 2 hours	890	87%	567	78%
5c	F2F Home - 8 hours	1186	98%	752	98%

Due to pandemic spikes, lock down variation, patient confidence in accessing services, staff sickness etc a true like for like comparison is not achievable against the two years. However, the data does offer assurance on the continued service delivery provided by Shropdoc during the pandemic and the various challenges it has brought with it.

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

Swansea Bay University Health Board

Reporting on the relevant standard measures for the Powys element of the service is limited due to the inability of SBUHB being able to extract Powys specific data; therefore, monitoring the service against the standards is currently not achievable. SBUHB are only able to quantify the number of Ystradgynlais patients accessing the service and the patient outcomes/management. There is no data available regarding assurance around timely patient access against the OOH standards. The new national reporting IT system SALUS, will resolve this issue when implemented.

During 2021/22 an average of 123 calls per month were transferred from the 111 Clinical Assessment, Hub/Pharmacist Service into the SBUHB OOH service, a total of 1472 OOH contacts during 2021/22, relating to Ystradgynlais patients, of which

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- 52% received GP advice (770 patients)
- 16% received a prescription (230 patients)
- 27% visited a treatment centre, (400 patients, an average of 33 patients per month)
- 5% received a home visit, (72 patients, an average of 6 visits per month)

Other assurance metrics:

111

111 carries out patient experience surveys to make sure patient callers receive the most appropriate advice, care, and high-quality service. Surveys are carried out over the telephone or by post and participation is voluntary. Survey results are shared at the All Wales 111 Joint Operational Forum. Powys specific results are not available.

PTHB is represented at the All-Wales Joint Operational Forum and the 111/OOH Urgent Primary Care Quality and Safety Forum. Shropdoc also attend the forum and various operational subgroups.

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

In addition to this Shropdoc provide quarterly reporting on

- clinical risk – Risk register and risk management processes in place with clear accountability
- Incidents – 100% of reporting serious incidents is within agreed timescales.
- Complaints/concerns – 11 received in 21/22. All concerns and complaints are responded to promptly and within agreed time limits.
- Compliments – 9 compliments received in the reporting period.
- 111 Health Profession Feedback – good communication channels are in place between Shropdoc and 111 to resolve issues.
- Safeguarding – in conjunction with PTHB Safeguarding team and general practice a new process has been put in place to ensure the timely flagging of at-risk patients are notified to Shropdoc
- Undertake a weekly clinical audit (CFEP survey) on 1% of all services
- Prescribing formulary in place

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Shift fill rate in Shropdoc has always been good, achieving fill rates over and above the all Wales average. Fill rates from October 2021 to March 2022 are as follows:

Shropdoc % Cover by Month 2021/22	% Unfilled Slots by month	% Filled Slots by month
OCT	0	100%
NOV	3%	97%
DEC	10%	90%
JAN	11%	89%
FEB	2%	98%
MAR	5%	95%

Shift fill during the year has been challenging due to covid spikes impacting on the available workforce. Base shifts not filled are cross covered from the neighbouring base. Additional triage hours are often put on at Longbow to further support base activity.

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

Unfilled shifts are recorded on the PTHB Datix system.

Shift cover is shared at the twice weekly PTHB Operational Delivery Group.

Swansea Bay University Health Board (SBUHB) OOH service

Shift fill rate:
During weekdays patients access SBUHB Primary Care Centres, mainly at Morriston Hospital.

SBUHB notifies the health board every Friday of the cover for the forthcoming weekend at Ystradgynlais Community Hospital (YCH), however they continue to source cover up until a shift commences. During 2020/2021 the Powys shift fill rate for weekend base cover at YCH dramatically improved, however in 2021/2022 this has declined back to pre-pandemic levels.

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SBHB% Cover by Month 2021/2022	% Unfilled Slots by month	% Filled Slots by month
APR	50%	50%
MAY	56%	44%
JUN	50%	50%
JUL	80%	20%
AUG	100%	0%
SEP	100%	0%
OCT	90%	10%
NOV	100%	0%
DEC	100%	0%
JAN	100%	0%
FEB	100%	0%
MAR	100%	0%

Unfilled shifts are recorded on the PTHB Datix system. When there is no weekend cover at YCH, Ystradgynlais patients are directed to Morriston Hospital. During this reporting period no patient concerns have been raised regarding access.

OOH end to end reporting:

PTHB now has access to the full data feed in a patient OOH contact, irrespective of the provider of the service.

The PTHB Information Team are progressing extracting the relevant data to develop PTHB reports on the total patient journey and final patient outcomes to inform future robust reporting against the OOH standards. The Data can be used to inform future modelling and service developments also.

Accurate national reporting is not solely a Powys issue and given the need for accurate national reporting a replacement IT system for 111 / Out of Hours, called SALUS will be the national OOH reporting system. Unfortunately, national delays continue around the readiness of the system. PTHB and Shropdoc feed into the SALUS development project to articulate the future PTHB reporting requirements.

NEXT STEPS:

1) Finalise the SBUHB OOH contract

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2) Continue to feed into the national SALUS new system development to improve reporting.

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Information Governance Toolkit Actions from Improvement Plan 2022-2023

The table below outlines the actions required to improve on the current PTHB IG assurance compliance score from the IG Toolkit 2021-2022. Levels are scored 0 (lowest) – 3 (highest)

Category. Ref no.	Category	Area of Responsibility	Level achieved 2021/2022	Action required to reach next level	Responsible Director	Progress made / updates for
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	
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	Exec Director of Finance, IT & Information Services	Does anyone in ICT have/need this?

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				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		
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	
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	
5.3	Managing and Securing Records	Data Accuracy	0	Section not completed while service improvement work is being undertaken	ALL	

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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	
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 Director of Environment	
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 implemented where necessary. 2. The health board carries out regular auditing of their IT	Exec Director of Finance, IT & Information Services	

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				systems to monitor activity. 3. All staff are informed that their activities on IT systems will be monitored		

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Powys Teaching Health Board

Agenda item: 6.1

Delivery and Performance Committee	**Date of Meeting: 23 June 2022**
Subject:	**Information Governance Key Performance Metrics Report**
Approved and presented by:	Kate Wright, Medical Director
Prepared by:	Rhiannon Hughes IG Manager
Other Committees and meetings considered at:	Executive Committee

PURPOSE:

The purpose of this paper is to provide assurance and to inform the Delivery and Performance Committee of the health board performance as assessed by the NHS Wales Information Governance Toolkit for Health Boards and Trusts 2021-2022.

An IG Toolkit Improvement Plan has been developed which highlights those areas of work required to improve the current score and assurance level in readiness for the 2022-23 submission.

The Committee are asked to NOTE that there has been a delay in reporting the 2020-21 assessment due to re-prioritisation of resources for Covid-19. The results from 2020-2021 are also included below for comparison, but an improvement plan is not included as this is now outdated and has been superseded by the 2021-22 submission.

RECOMMENDATION(S):

1. The Delivery and Performance Committee is asked to NOTE the contents of this report.
2. The Committee is asked to AGREE the IG toolkit Improvement Plan for 2022/23
3. The Committee APPROVES the publication of the Toolkit scores and final out-turn report in accordance with requirements of the Wales Information Governance Board (WIGB) and to aid in providing assurances to other organisations.

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

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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 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 assessment assists in identifying areas which require improvement and informs an organisations' IG Improvement Plan. The aim is to demonstrate that organisations can be trusted to maintain the confidentiality and security of both personal and business information.

This will provide 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.

The toolkit contains assessed categories that determine the level of assurance achieved. Each category is scored from Level 0 (lowest compliance) to Level 3 (highest compliance). An explanation of the scoring is included in the assessment section of this paper.

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When developing the toolkit assessment, it was agreed across NHS Wales that a Level "0" should be put in place to demonstrate that Level 1 requirements have not yet been met but work is underway to meet this level. The proportion of risk at Level 0 is determined by the area of responsibility being assessed (category of question within the Toolkit), the purpose of the processing, and/or frequency of processing we are carrying out. The IG team specifically prioritise the areas for improvement that cover the most likely high-risk processing e.g. meeting (UK) GDPR requirements over the areas which will be of less relevance due to the nature of processing the health board undertakes e.g. marketing (PEC regulations). Those areas of responsibility at the lower levels of assurance are lower risk to the organisation but will still require improvement to meet health board obligations.

It should be NOTED that while the toolkit demonstrates IG performance, some aspects are also assessed under the biennial Welsh Cyber Assurance Process (WCAP). These areas will be outlined below.

The Committee is asked to NOTE the reporting period is 1 April 2021 to 31 March 2022.

DETAILED BACKGROUND AND ASSESSMENT:

The toolkit submission coincides with the financial year and consists of a range of rudimental categorised questions based on legal requirements. The categories covered are:

Business Responsibilities

- IG Management Structure
- Policies and Procedures
- Information Sharing
- Contracts, and Agreements
- Data Protection Impact Assessments
- Freedom of Information Act and Environmental Information Regulations
- Privacy Electronic Communication Regulations

Business Management

- Business Continuity Plan (via WCAP)
- Risk Assessing
- Auditing

Individual's Rights and Obligations

- Right of Access (Subject Access Requests)

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- Right to be informed
- Right to Object, Rectification, Erasure and Portability
- Rights related to Profiling and automated decision making that has a significant impact on the data subject

Records Management

- Management of Records to include: Health Records (Acute, Community and Mental Health) and Corporate Records
- Information Asset Register
- Data Accuracy
- Retention Schedules, Secure Destruction and Disposal

Please note it was agreed that the Records Management section would not be completed for this submission. Service improvement work due to be undertaken by a 12 month fixed term Service Improvement Manager (SIM) for Records was put on hold due to the pandemic and redeployment.

A Documents and Records Manager permanent role within the IG team was approved and appointed to in February 2022, the post holder will pick up the improvement work as part of their role. A statement has been included in the toolkit to highlight this position. Progress and updates will be reviewed and included in the forthcoming 2022-2023 submission.

Technical, Physical and Organisational Measures

- Physical Security Measures
- Technical Security Measures
- Organisational Measures (Training and Awareness)
- Mobile Working and Remote Access (via WCAP)
- Secure Destruction and Disposal of IT Equipment (via WCAP)
- Surveillance Systems

Cyber Security

- Cyber Security (via WCAP)

As detailed above, while the toolkit assesses aspects of Cyber Security, health boards formally assess their Cyber Security requirements and responsibilities under the biennial Welsh Cyber Assurance Process (WCAP). It was agreed by the Information Governance Management Advisory Group (IGMAG) that to avoid duplication, a more formal assessment would not be expected as part of the toolkit at this time.

Reporting Data breaches

This section assesses internal reporting processes, use of Once for Wales Concerns Management System (Datix), staff training, and communication/awareness.

Measuring Compliance

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Compliance is measured by answering the assessment questions within the categories. Supporting evidence is uploaded or text inserted to detail the Organisation's position with regards to relevant legal requirements. The more compliant an organisation is with a legal requirement, the higher the level achieved. Each category is scored from Level 0 (lowest compliance) to Level 3 (highest compliance). An explanation of the scoring is as follows:

Level 0 – an awareness of the Legal Requirement

Level 1 – initial action around the Legal Requirement (policies and procedures are in place, staff awareness and responsibilities outlined)

Level 2 – Implementation / Good practice in relation to the Legal Requirement (appropriate training provided, job descriptions updated for certain roles, policies and procedures are followed)

Level 3 – Review and Reporting Process (processes are in place to monitor, audit and report on operation and compliance)

Each category will have a varying number of questions depending on the legal requirement, and to complete a level all questions for that category must be sufficiently answered. Partial responses demonstrate that the health board is "working towards" the next level. Following completion and submission of the toolkit, results are reviewed by each organisation and an improvement plan is developed for approval by the Delivery and Performance Committee. The IG Improvement Plan 2022 - 2023 has been included with this paper.

Current Position (2021-2022) and Assurance Level:

The health board performed well in the 2021 - 2022 assessment, increasing the score from 2020-2021 by an estimated **7%,** with an average level score of 3 (highest compliance) and an estimated average of **92%** compliance for the areas completed. The table below shows the average scores achieved per area of responsibility scored for 2021-2022, with 2020-2021 for comparison.

2021-2022 Assurance Level:

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%

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Technical, Physical and Organisational Measures	2	56%	2	69%
Reporting Data Breaches	3	100%	3	100%
Total	**2**	**85 %**	**3**	**92%**

The functionality of the next version of the IG toolkit (2022-23) will include previously requested improvements as the assessment moves onto a new platform. The current version does not include a mechanism to percentage score the results. For this paper, the IG team have generated an estimated percentage score using the average level score reached for each category, as shown below:

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

While this will not be as accurate as scoring aligned to each question, an in-depth review of the responses and the recognised work required to reach the next attainment level has indicated that the level of assurance we can provide will not be lower than the percentage outlined above.

Actions required

Where the health board has achieved the highest level of compliance (level 3 – 100%), work should and will continue to ensure that the high level of assurance is maintained to comply with data sharing obligations and to provide assurance to other organisations and the Information Commissioner's Office (ICO).

Areas that require action for improvement on compliance are outlined on the IG Improvement Plan 2022-23.

NEXT STEPS:

The Committee are asked to NOTE that progress has already been made to address areas of responsibility within the "Managing and Securing Records" section to improve compliance as listed within the Improvement Plan in preparation for the next toolkit assessment (2022-2023).

Continued assurance reports will be submitted to the Delivery and Performance Committee.

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Powys Teaching Health Board

Agenda item: 7.1

Delivery and Performance Committee	**Date of Meeting: 23 June 2022**
Subject:	**COMMITTEE BASED RISKS ON THE CORPORATE RISK REGISTER**
Approved and Presented by:	Interim Board Secretary
Prepared by:	Interim Corporate Governance Manager
Other Committees and meetings considered at:	n/a

PURPOSE:

The purpose of this paper is to provide the Committee with the May 2022 version of the Committee Risk Register for information.

RECOMMENDATION(S):

It is recommended that the Committee CONSIDERS the May 2022 version of the Committee Risk Register, which reflects the risks identified as requiring oversight by this Lead Committee. This iteration of the Committee Risk Register is based upon on the Corporate Risk Register (CRR) considered by the Board on 25 May 2022.

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	

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

EXECUTIVE SUMMARY:

The purpose of the Committee Risk Register is to draw together relevant risks for the Committee from the Corporate Risk Register (CRR), to provide a summary of the significant risks to delivery of the health board's strategic objectives.

BACKGROUND AND ASSESSMENT:

The CRR provides a summary of the significant risks to the delivery of the health board's strategic objectives. Corporate risks also include risks that are widespread beyond the local area, and risks for which the cost of control is significantly beyond the scope of the local budget holder. The CRR is reviewed by the Executive Committee on a bi-monthly basis and is noted by the Board.

The Committee is asked to DISCUSS the risks relating to Delivery and Performance and the risk targets within the Committee Risk Register, and to CONSIDER whether the targets identified are achievable and realistic.

The full Committee Risk Register is attached at **Appendix A.**

NEXT STEPS:

The Risk and Assurance Group will lead the ongoing development of the CRR, escalating any organisational risks for proposal to the CRR, for consideration by the Executive Committee.

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Committee Risk Register
May 2022

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COMMITTEE RISK HEAT MAP: May 2022

There is a risk that…

Impact							
	Catastrophic	5					
	Major	4			▪ Potential adverse impact on business continuity and service delivery arising from a pandemic outbreak of an infectious disease (COVID-19) ▪ The Health Board does not meet its statutory duty to achieve a breakeven position in 2021/22	▪ The care provided in some areas is compromised due to the health board's estate being non-compliant and not fit for purpose ▪ There are delays in accessing treatment in for Primary and Community Care Services in excess of 36 and 52 weeks, and a reduction in levels of enhanced services provided by General Practices under the GMS Contract. ▪ If a cyber-attack is successful then one or more critical systems may be out of use resulting in service downtime, loss of data and/or harm to patients	▪ There are delays in accessing treatment in Secondary and Specialised care services, in excess of 36 and 52 weeks
	Moderate	3				▪ The Health Board has insufficient capacity to lead and manage change effectively	
	Minor	2					
	Negligible	1					
			1	2	3	4	5
			Rare	Unlikely	Possible	Likely	Almost Certain
			Likelihood				

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COMMITTEE RISK DASHBOARD – MAY 2022

Risk Lead	Risk ID	Main Risk Type	Risk Description There is a risk that:	SCORE (Likelihood x Impact)	Trend	Board Risk Appetite	Risk Target	At Target ✓/×	Lead Board Committee	Risk Impacts on
DFIIT	CRR 002	**Finance**	The Health Board does not meet its statutory duty to achieve a breakeven position in future years of the IMTP	**3 x 4 = 12**	↑	Moderate	8	×	Delivery and Performance	Organisational Priorities underpinning WBO 8.2
CEO	CRR 003	**Innovation & Strategic Change**	The Health Board has insufficient capacity to lead and manage change effectively	**4 x 3 = 12**	→	High	9	×	Delivery and Performance	Organisational Priorities underpinning Renewal Portfolio specifically and indirectly all annual plan / wellbeing objectives
DoE	CRR 005	**Quality & Safety of Services**	The care provided in some areas is compromised due to the health board's estate being non-compliant and not fit for purpose	**4 x 4 = 16**	→	Low	9	×	Delivery and Performance	Organisational Priorities Underpinning WBO 1 to 4

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DPP	CRR 007	**Quality & Safety of Services**	There are delays in accessing treatment in Secondary and Specialised care services, in excess of 36 and 52 weeks	**5 x 4 = 20**	→	Low	12	×	Delivery and Performance	Organisational Priorities underpinning WBO 4 – specifically 4.3
DFIIT / DPP	CRR 013	**Quality & Safety of Services**	There are delays in accessing treatment in for Primary and Community Care Services in excess of 36 and 52 weeks, and a reduction in levels of enhanced services provided by General Practices under the GMS Contract.	**4 x 4 = 16**	→	Low	12	×	Delivery and Performance	Organisational Priorities underpinning WBO 1 to 4
DPH	CRR 014	**Quality & Safety of Services**	Potential adverse impact on business continuity and service delivery arising from a pandemic outbreak of an infectious disease (COVID-19)	**3 x 4 = 12**	→	Low	12	✓	Delivery and Performance	Organisational Priorities Underpinning WBO 1 to 8
DFIT	CRR015	**Quality & Safety of Services**	If a cyber-attack is successful then one or more critical systems may be out of use resulting in service downtime, loss of data and/or harm to patients.	**4 x 4 = 16**	↑	Low	8	×	Delivery and Performance	loss of systems and impact to recovery timescales

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KEY:

LIKELIHOOD	IMPACT				
	Insignificant 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
Almost Certain 5	5	10	15	20	25
Likely 4	4	8	12	16	20
Possible 3	3	6	9	12	15
Unlikely 2	2	4	6	8	10
Rare 1	1	2	3	4	5

Very Low	1-3	Low	4-8	Moderate	9-12	High	15-25

Executive Lead:	
CEO	Chief Executive
DPCMH	Director of Primary, Community Mental Health Services
DN	Director of Nursing
DFIIT	Director of Finance, Information and IT
MD	Medical Director
DPH	Director of Public Health
DWODSS	Director of Workforce & OD and Support Services
DTHS	Director of Therapies & Health Sciences
DPP	Director of Planning & Performance
BS	Board Secretary

RISK APPETITE		
Category	**Appetite for Risk**	
Quality & Safety of Services	Low	Risk Score 1-6
Regulation & Compliance	Low	Risk Score 1-6
Reputation & Public Confidence	Moderate	Risk Score 8-10
Finance	Moderate	Risk Score 8-10
Innovation & Strategic Change	High	Risk Score 12-15

Trend	
↑	risk score increased
→	risk score remains static
↓	risk score reduced

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CRR 002 **Risk that:** the Health Board does not meet its statutory duty to achieve a breakeven position in future years of the IMTP	**Executive Lead:** Director of Finance, Information and IT **Assuring Committee:** Delivery and Performance
Risk Impacts on: Organisational Priorities underpinning WBO 8.2	**Date last reviewed:** May 2022

Risk Rating (likelihood x impact): Initial: 4 x 4 = 16 ~~Current: 2 x 4 = 8~~ Current: 3 x 4 = 12 Target: 2 x 4 = 8		**Rationale for current score:** ▪ The IMTP has not yet been approved but includes a balanced core financial plan based on assumptions included (regarding funding and treatment of Exceptional National Cost Pressures and Ongoing Covid response Costs) ▪ Plan requires delivery of £4.6m of efficiencies with action still required to identify full actions to deliver. ▪ Breakeven forecast includes several risks and opportunities that need to be managed to deliver ▪ The impact of Covid-19 and the assumption that WG will fund the ongoing response in full is key. ▪ There are significant pressures in relation to energy and other cost of living increases that are not yet fully known or quantified and this is a risk to the plan.
Date added to the risk register March 2017		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
▪ Balanced Financial Plan included in IMTP Submission. ▪ Monthly Reporting via Governance Structure, includes progress / delivery ▪ Financial Control Procedures and Standing Orders and Standing Financial Instructions and Budgetary Control Framework ▪ Contracting Framework and impact of Block arrangements in 2022/23 and going forward ▪ Savings Plan monitoring and reporting linked to the Efficiency Framework and Investment Benefits Group and supporting the VBHC approach. ▪ Risks and Opportunities – focus and action to maximise opportunities and minimise / mitigate risks ▪ Regular communication and reporting to Welsh Government and Finance Delivery Unit regarding the impact of pressures and ongoing Covid-19 and expectations regarding funding and impact on Financial Plan and underlying position.	Strengthening of the capability and sustainability of the Finance Team and establish a modernisation programme to improve function performance and delivery	DFIIT	In Progress Deputy Director of Finance in post and structure realignment completed
	Increase focus on longer term efficiency and sustainability (value) and balance with in year delivery as needed for plan. New Efficiency Framework approved and live and Value Based Healthcare Board being established in year.	DFIIT / MD	Established

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▪ VBHC the basis of approach to deliver long term sustainability. ▪ Service Reviews / Performance reviews to strengthen financial monitoring of performance and longer-term impact on financial plan (support better decision making). ▪ Task and Finish Groups established for CHC, Variable Pay and Contracting with identified leads and clear expectation re delivery, these groups will have a short- and longer-term focus for delivery.			
Current Risk Rating	**Additional Comments**		
3 x 4 = 12	Risk level increased due to uncertainty re impact of cost pressures as identified. (May 2022)		

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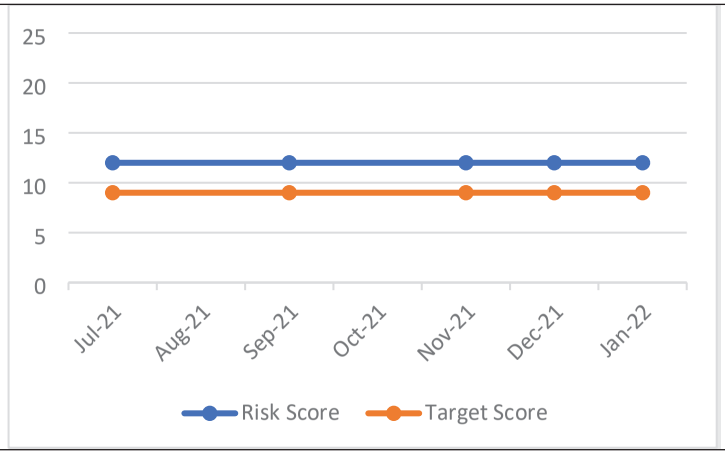
CRR 003 **Risk that:** the health board has insufficient capacity to lead and manage change effectively	**Executive Lead:** Chief Executive **Assuring Committee:** Delivery and Performance
Risk Impacts on: Organisational Priorities underpinning Renewal Portfolio specifically and indirectly all annual plan/wellbeing objectives	**Date last reviewed:** January 2022

Risk Rating (likelihood x impact): Initial: 4 x 3 = 12 Current: 4 x 3 = 12 Target: 3 x 3 = 9		**Rationale for current score:** The Health Board will need to undertake significant recovery and renewal work as a result of the pandemic. This is wide ranging and will need to, in part, take place whilst the further action to manage the pandemic continues. There are other significant change programmes now being aligned to the recovery and renewal work that will also require capacity to progress. Additional Welsh Government funding is assisting the provision of capacity including Integrated Care Fund (ICF), Transformation Fund and the Recovery (planned care and mental health). Whilst these funds are clearly supporting capacity for change, it is important to note they are all non-recurrent.
Date added to the risk register July 2021		

Controls (What are we currently doing about the risk?)

- The Annual Plan focuses on priorities which will be staged in implementation and thus that will extend beyond one year.
- Successful applications for WG funding has secured specific funds within the ICF, Transformation Fund and Recovery (planned care and mental health).
- Alignment of change programmes (Recovery and Renewal and the North Powys Wellbeing Programme) is helping to reduce duplication and waste of expertise/resources.
- Further recruitment into project manager and programme manager posts for the Renewal Programme is underway.
- The emerging approach on value-based healthcare will support increased capability in focusing on priorities for change that could also be cash-releasing. This could support further investment.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Carefully track the investments for change management that are non-recurrently funded; enabling opportunity to access any further funds to support capacity and capability building	DoF / DoP	Review mid-year 2021
Support the work programme of the Research Improvement and Innovation Hub to deliver increased capacity and capability, including the potential for Improvement Cymru to provide additional support	MD	Review Q3
Support the delivery of change management skills as part of the School of Leadership and Management	WOD	Review Q3

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• Clinical leadership posts (Heads of) are near full establishment, these roles play a pivotal part of clinical change. • Project management skills programmes/session are provided to support staff at all levels across the organisation. • Investment made in the Innovation and Improvement Hub – including on a multiagency basis – to support change management. • Development of the School of Leadership within the Health and Care Academy provides a platform for further capacity building for change.	Recruit to project and programme managers for the Renewal Portfolio	CEO via Transformation Team	Review monthly Q2 2021
	Pursue the value-based healthcare approach, enabling a focus on where outcomes improvement/lower unit cost can be achieved; to seek opportunity for re-investment where possible	CEO via Director of Clinical Strategy / Transformation Team	Review end Q2; end Q3.
Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**		
• Allocated resources are identifiable within major change programme arrangements, e.g. Renewal Portfolio, North Powys Wellbeing Programme. • Evidence of training and staff preparation • Dialogue with Trade Unions and other staff engagement mechanisms (e.g. surveys / staff Q & A sessions) to understand impacts • Management and oversight of change programmes by the Executive Committee and Renewal Portfolio Board with clear reporting into Board Committees / Board • Individual Executive Director 1 to 1 and performance review processes	• Development of clear status reports for major programmes to be further developed to assist reporting, visibility and oversight • Measurement approach – including PROMS and PREMS – to be developed to enable measurement of change		
Current Risk Rating	**Additional Comments**		
4 x 3 = 12	This risk is being kept under review in light of the current situation of reprioritising leaders and managers work to deal with the impact of the Omicron variant. This has an understandable impact upon service change work but the development of the IMTP presents is core to the continuing management of this risk.		

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CRR 005 **Risk that:** the care provided in some areas is compromised due to the Health Board's estate being non-compliant and not fit for purpose	**Executive Lead:** Director of Environment **Assuring Committee:** Delivery and Performance
Risk Impacts on: Organisational Priorities underpinning Well-being Objectives 1 to 4	**Date last reviewed:** May 2022

Risk Rating (likelihood x impact): Initial: 4 x 4 = 16 Current: 4 x 4 = 16 Target: 3 x 3 = 9		**Rationale for current score:** **Estates Compliance**: 38% of the estate infrastructure was built pre-1948 and only 5% of the estate post-2005. Significant investment and risk-based programmes of work over several years across the compliance disciplines (fire, water hygiene, electric, medical gases, ventilation, etc.) will be required. **Capital:** the health board has not had the resource or infrastructure in place in recent times to deliver a significant capital programme and this places pressures on systems, capital resource and the wider organisation to fully support major project activity. Furthermore, Discretionary Capital acts as the safety net for overspend on capital projects for the health boards, and with a very limited discretionary allowance in PTHB this is a significant financial risk. Failure to secure funds could impact business continuity in terms of healthcare services. **Environment & Sustainability**: Welsh Government declared a Climate Crisis in April 2019 requiring escalated activity with ambitious targets in terms of decarbonisation of public sector by 2030 and zero waste to landfill by 2050.
Date added to the risk register January 2017		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
ESTATES ▪ Specialist sub-groups for each compliance discipline ▪ Risk-based improvement plans introduced ▪ Specialist leads identified ▪ Estates Compliance Group and Capital Control Group established ▪ Medical Gases Group; Fire Safety Group; Water Safety Group; Health & Safety Group in place. New Ventilation Safety Group set up.	**Action**	**Lead**	**Deadline**
	Implement the Capital Programme and develop the long-term capital programme	AD Estates & Property	In line with Annual Plan for 2022-23
	Continue to seek WG Capital pipeline programme funding continuity: seek alternative capital funding opportunities to mitigate funding reduction for 2022/23 and develop projects in	AD Estates & Property	In line with Annual Plan for 2022-23

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▪ Capital Programme developed for compliance and approved ▪ Capital and Estates set as a specific Organisational Priority in the health board's Annual Plan ▪ Address (on an ongoing basis) maintenance and compliance issues ▪ Address maintenance and compliance improvements to ensure patient environment is safe, appropriate and in line with standards **CAPITAL** ▪ Capital Procedures for project activity ▪ Routine oversight / meetings with NWSSP Procurement ▪ Specialist advice and support from NWSSP Specialist Estates Services ▪ Audit reviews by NWSSP Audit and Assurance ▪ Close liaison with Welsh Government, Capital Function ▪ Reporting routinely to P&R Committee ▪ Capital Programme developed and approved ▪ Detailed Strategic, Outline and Full Business Cases defining risk ▪ Capital and Estates set as a specific Organisational Priority **ENVIRONMENT** ▪ ISO 14001 routine external audit to retain accreditation ▪ Environment & Sustainability Group ▪ NWSSP Specialist Estates Services (Environment) support and oversight ▪ Welsh Government support and advice to identify and fund decarbonisation project initiatives	readiness for any capital slippage in latter part of financial year cycle.		
	Develop capacity and efficiency of the Estates and Capital function	AD Estates & Property	In line with Annual Plan for 2022-23
	Review current structure of capital and estates department – Estates Management and Senior Management Team structure enhancements in place. Second tier of structure review required to address limited establishment staff numbers in Works Team and recruitment challenges.	AD Estates & Property	May 2022
Current Risk Rating	**Additional Comments**		

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4 x 4 = 16	**COVID-19** has introduced risk pressures in respect of the health board's estate and the ability of the Estates & Property team to manage and prioritise risk mitigation in a number of ways. **ESTATES:** Estates compliance – team continues to support core statutory compliance and limited Reactive job requests using risk-based approach due to age of estate. Workforce challenges for recruitment and staff resource establishment level being reviewed at Innovative Environments Group **CAPITAL:** impacts from COVID and BREXIT on cost and time to deliver Capital programme. Major step up in activity in financial year with resource pressure. 2022/23 WG Discretionary Capital cut by circa 25% with overall pressure on All Wales Capital Funding - will limit scope of estates compliance improvement programme and associated risk reduction activity in year. **ENVIRONMENT & SUSTAINABILITY:** NHS Wales Decarbonisation Strategic Delivery Plan published in ~~early~~ 2021 with challenging targets with limited resource. **FIRE:** Work to improve operational fire structure in 2021 has been positive, but significant infrastructure risks related to compartmentation and physical systems remain. Programmes of work implemented to address dependant on funding. **PROPERTY:** COVID moves of staff in uncontrolled manner will need to be addressed to step back up business as usual alongside implementation of new agile working approach.

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CRR 007 **Risk that:** there are delays in accessing treatment in Secondary and Specialised care services, in excess of 36 and 52 weeks	**Executive Lead:** Director of Planning & Performance **Assuring Committee:** Delivery and Performance
Risk Impacts on: Organisational Priorities underpinning WBO 1 to 4	**Date last reviewed:** May 2022

Risk Rating (likelihood x impact): Initial: 5 x 4 = 20 Current: 5 x 4 = 20 Target: 3 x 4 = 12		**Rationale for current score:** Baseline as at end of February 2022 indicates current aggregated waiting times as follows (including PTHB provided services): 5,048 patients waiting over 36 weeks, of these 2,632 are waiting over 52 weeks of those 777 wait longer than 104 weeks. Historical activity levels cannot currently be delivered due to ongoing Covid-19 related infection prevention and control measures including social distancing of patients and emergency admission pressures. A key constraint currently is available workforce and physical 'green' capacity to operate additional activity. Limitations on ability to both insource and outsource by English and Welsh providers. If urgent and emergency care pressures lead to the invoking of the NHS Local Options Framework, planned care will be reduced/suspended resulting in further delays to treatment.
Date added to the risk register July 2021		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• Key priorities identified to deliver elective treatments within 52 weeks • Commissioning Assurance Framework (across 5 domains) incremental use with 15 NHS organisations, 2 private sector organisations, and embedded in third sector • CAF escalation process • Strategic Commissioning Framework • Fragile services log • Develop funding proposal to WG to support recovery of waiting times for Powys activity in English Providers.	Secure performance improvement trajectories from providers. English providers waiting for H2 planning guidance.	DPP	June 2022
	Develop funding proposal for greater throughput within neighbouring providers in England subject to Welsh Government funding release. Insourcing and outsourcing options being considered (subject to capacity). All providers now expected to agree improvement trajectories in light of	DPP/DOF	October 2021 / Complete

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• Deliver the Renewal Portfolio to ensure planned care performance improvement improves, including establishing an Advice, Support and Prehabilitation service to actively support those awaiting treatment. • Seeking to mobilise additional capacity through insourcing, outsourcing and exploring options via LTA & SLA agreements • Developing better understanding of overall waiting list 'intelligence'.	22/23 guidance published for planned care recovery		
	Develop recovery relationships with revised CCGs & STPs	DPP	Ongoing
	Establish Advice, Support and Prehabilitation Service	DPP	December 2021 / Complete
	Ensure Powys residents needs understood within Strategic Change Programmes	DPP	Ongoing
Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**		
• Monthly waiting time reporting at Delivery Performance Group • Reporting at Delivery and Performance Committee and Board • Bi-monthly meetings with Welsh Government at Quality and Delivery Meetings • More emphasis being place upon long waiting patients and risk management processes at commissioner / provider CQPRM meetings	• All Directorates contributing to CAF		
Current Risk Rating	**Additional Comments**		
5 x 4 = 20			

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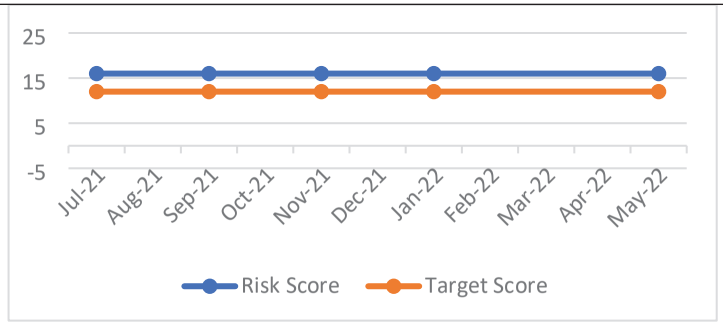
CRR 013 **Risk that:** there are delays in accessing treatment in Primary and Community Care Services in excess of 36 and 52 weeks, and a reduction in levels of enhanced services provided by General Practices under the GMS Contract.	**Executive Lead:** Director of Primary Community Care and Mental Health / Director of Planning and Performance **Assuring Committee:** Delivery and Performance
Risk Impacts on: Organisational Priorities underpinning WBO 1 to 4	**Date last reviewed:** May 2022

Risk Rating
(likelihood x impact):
Initial: 4 x 4 = 16
Current: 4 x 4 = 16
Target: 3 x 4 = 12

Date added to the risk register
July 2021



Rationale for current score:

Baseline as at end of March 2022 indicates current waiting times including diagnostics and therapies as follows: - Provider Position – 41 people waiting over 36 weeks and 9 waiting over 52 weeks.

Prior to the pandemic Powys provided services did not exceed waiting times albeit there was fragility in certain in-reach services which continues to be the case.

Substantial progress has been made to reduce current waiting times.

A key constraint currently is available workforce to operate activity with a specific risk relating to theatres and endoscopy staff.

Pre procedure testing arrangements will be reviewed in light of recent changes in guidance.

In line with national relaxation for Directed Enhanced Services (DES) and local relaxation for Local/National Enhanced Services (LES/NES) General Practice has physically seen less patients under these contracts than at pre-Covid levels.
Given the current pressures and risk of staff absences in primary and community care services, the Health Board has approved the extension to the end of March for the relaxation for Directed Enhanced Services (DES) and local relaxation for Local/National Enhanced Services (LES/NES) at 75%. General Practice has

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		physically seen less patients under these contracts than at pre-Covid levels.

Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
• Insourcing capacity secured to support reduction in waiting times. • As part of the renewal priorities, scoping of the establishment and Advice, Support and Prehabilitation service to actively support those awaiting treatment. • LES and NES activity levels held at 75% of historical levels from Jan 22 to March 22 (extension of the 75% activity threshold in place until 31st December 2021). • LES specifications were temporarily amended to support delivery of enhanced services (in place until 31/03/2022) under the caveat of clinical judgement and responsibility of the clinician to prioritise and manage patient care. • GMS annual return used to gain assurance of continued performance in meeting contractual requirement. • Specific Enhanced Service audits (NPT, Anticoagulation and Diabetes). • Data provided by General Practice across a range of conditions and dialogue with practices and clusters active on next steps. • Renewal Priority "Diagnostics, Ambulatory and Planned Care" developing plan for waiting time recovery including recruitment. Programme Manager appointed to support this work, which is being monitored through the Renewal Programme Board. • Work is ongoing with clusters and practices to develop proposals for any recovery in line with national discussions with additional funding available to support. • Paper completed summarizing the approach taken by General Practice throughout the pandemic in identifying and prioritizing patients for enhanced services. • Review relaxation of LES and NES levels following national position on DES levels, Proposal for rest of the year agreed by Executive Committee.	**Action**	**Lead**	**Deadline**
	Establish Advice, Support and Prehabilitation Service	DPP	Complete
	Insourcing capacity secured and full delivery plan in place for completion by end of May 2022	DPCMH	May 2022
	Seeking support from NHS Wales Delivery Unit for specific demand and capacity tools which can be used operationally to project, implement and monitor activity on a weekly basis. Work ongoing with DU to ensure this model reflects the specific issues of Powys delivery locations.	DPCMH	July 2022
Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**		

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• Monthly waiting time reporting at Delivery Performance Group • Reporting at Performance and Resources Committee and Board • Monthly meeting with Welsh Government at Quality and Delivery Meetings • QAIF clinical indicator achievement • Enhanced Service activity/claims • Review of Q1 Enhanced service activity/claims to monitor practice achievement towards 75% attainment	
Current Risk Rating	**Additional Comments**
4 x 4 = 16	

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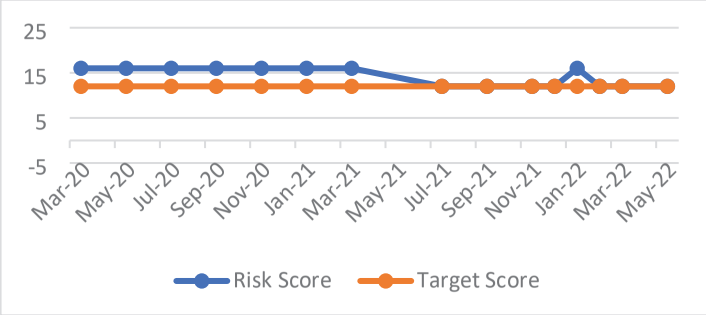
CRR 014 **Risk that:** potential adverse impact on business continuity and service delivery arising from a pandemic outbreak of an infectious disease (COVID-19)	**Executive Lead:** Director of Public Health **Assuring Committee:** Delivery and Performance
Risk Impacts on: Impact on the health and wellbeing of the population, patients and visitors and on the continuity of a range of NHS systems and services, including workforce, support services and supply chain.	**Date last reviewed:** May 2022

Risk Rating (likelihood x impact): Initial: 4 x 4 = 16 Current: 3.x.4.=.12 Target: 3 x 4 = 12		**Rationale for current score:** Likelihood: 'Possible'. Vaccination appears to be weakening the link between cases and admissions to hospital and Wales is now coming out of the recent Omicron wave. Recent estimates indicate that the risk of admission to hospital following infection has reduced from a pre-vaccination level of 10% to 2.8% currently. Recognising that the (direct) risk of Covid-19 overwhelming the NHS has reduced, the likelihood has been adjusted from 'likely' to 'possible' as at February 2022. It should be noted there are still risks: estimates only need to be wrong by a small percentage and admissions will rise significantly, the NHS is already operating at near maximum capacity, and large numbers of staff isolating as contacts in a third wave may impact on some services. The risk score will therefore need to be kept under regular review. Impact: 'Major'. COVID-19 presents four harms to the population: - 1. The direct harm arising from the disease itself; 2. The harm caused by an overwhelmed NHS;
Date added to the risk register February 2020		

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		3. The harm caused by stopping other non-COVID activity; and 4. The wider harm to wellbeing caused by population level measures in response to COVID-19.

Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
1. Test Trace Protect programme currently in transition in line with "Together for a Safer Wales": • LFT testing available for the Powys population with symptoms via the UK online portal; • PCR testing remains in place for target population via Powys CTUs; • Contact tracing service operating; • Regional response cell meeting monthly or as required. 2. Joint management and oversight arrangements remain in place with Powys County Council, including a joint Prevention and Response Strategic Oversight Group. 3. Working as part of the wider system in Wales through participation in regional and national planning and response arrangements. 4. Delivery of "Together for a Safer Future" transition under way. 5. COVID-19 Spring booster programme on track 6. System resilience plan in place to respond to direct and indirect impact of COVID-19 during the second half of 2021/22. 7. Revised our command structures to manage risks. Proportionate governance framework in place (Gold, Silver, Bronze). 8. Reprioritisation work completed to enable business continuity planning and staff moved to support fragile operating areas. 9. All Wales position on HBs invoking the Local Options Framework being considered. 10. Staff testing guidance updated and re-issued in May 2022 11. Non-essential training stood down to enable business continuity measures to be enacted 12. Enhanced rates of pay for staff agreed to improve operational areas 13. FFP3 mask usage – decision on 29th December 2021 to continue to follow UK IP&C guidance supporting risk assessed use.	**Action**	**Lead**	**Deadline**
	• Draft Interim COVID-19 vaccination plan in place and with quarterly review	HT/AO	30/07/22
	• Draft TTP Plan in place and with quarterly review	AO	30/07/22
	• Surge testing plan and surge vaccination plan under development	AO	30/06/22
	• Staff testing guidance and IPC policies kept under review	CR/AO	30/06/22
	• Mass Vaccination Plan to be reviewed based on COVID-19 learning	AO	30/09/22
Current Risk Rating	**Additional Comments**		

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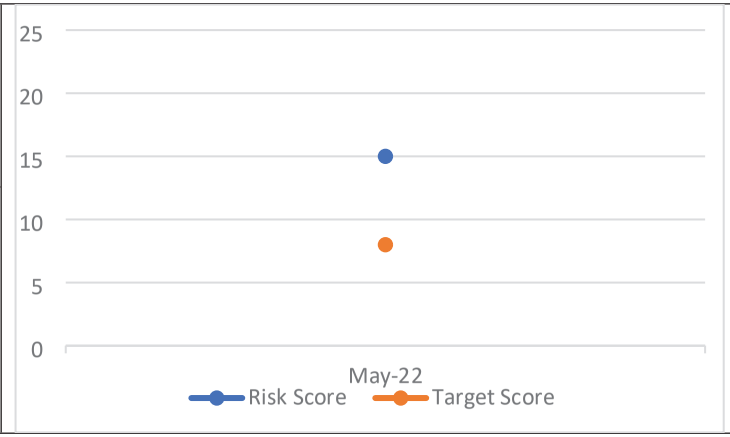
3 x 4 = 12	

CRR015 – NEW RISK **Risk that:** If a cyber-attack is successful then one or more critical systems may be out of use resulting in service downtime, loss of data and/or harm to patients.	**Executive Lead:** Director of Finance, Information, and IT **Assuring Committee:** Delivery and Performance
Risk Impacts on loss of systems and impact to recovery timescales	**Date last reviewed:** May 2022

Risk Rating (Likelihood x impact): Initial: 3 x 5 = 15 Current 4 x 4 = 16 Target:2 x 4 = 8		**Rationale for current score:** ▪ Increased risk of potential Cyber-attack due to current climate and world events. ▪ Several reports have highlighted potential areas for improvement.
Date added to the risk register May 2022		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**

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▪ Recruited a Cyber Security and Compliance Manager lead for the HB. ▪ In the process of recruiting a Senior Cyber Security Officer who will be responsible for IT operational controls and monitoring of the HB systems and Infrastructure. ▪ Cyber Improvement Plan in place linked to National Digital Health Care Wales (DHCW) and Local Actions. ▪ Controls and action in place to strengthen the monitoring of the network, improve anti-virus and Windows defender protection, enhanced end user license to increase protection to mitigate the risk and impact of any attack. ▪ Further action to be taken to test Business Continuity and recovery plans across service areas. ▪ Monthly Reporting via Governance Structure includes progress / delivery against Cyber Assurance Framework (CAF), this monitors performance and alignment to Security of Network and Information System regulations (NIS) Framework. ▪ Procurement and implementation of Solar Winds network monitoring. ▪ Windows Defender deployed and Phishing Campaign in place to increase awareness. ▪ Annual penetration testing programme in place. ▪ Upgraded O365 license to include enhanced E5 Security. ▪ Internal Audit report on NIS rated as Reasonable Assurance.	Increase awareness through the ESR Cyber Security training and make mandatory for all staff to complete. Arrange Board Development Session re Cyber to increase awareness.	DFIIT	Paper to Exec Committee to recommend by end of May - aim to complete all training in 4-6 months Board Session to be arranged by July.
	Develop a Cyber Recovery Response plan in conjunction with Assistant Directors and Heads of Service. Equipment replacement plan and migration from on premise to Cloud.	DFIIT	In Progress Case and timelines being finalised
Current Risk Rating = 16	**Additional Comments**		
4 x 4 = 16	New risk added to CRR due to current climate (May 2022)		

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DELIVERY AND PERFORMANCE COMMITTEE
PROGRAMME OF BUSINESS APRIL 2022- MARCH 2023

In July 2021 the Board established a Delivery and Performance Committee. The purpose of which to provide advice and assurance to the Board on the effectiveness of arrangements in place for securing the achievement of the Board's aims and objectives, in accordance with the standards of good governance determined for the NHS in Wales. The scope of the Committee extends to the full range of PTHB responsibilities. This encompasses the integrated performance oversight of all directly provided and commissioned services.

This Annual Programme of Business has been developed with reference to:

- the Committee's Terms of Reference as agreed by the Board;
- the Board's Assurance Framework;
- key risks identified through the Corporate Risk Register, Commissioning Assurance Framework; and Operational Risk Registers.
- audit and regulatory reports identifying weaknesses in internal control (following consideration by the Audit, Risk and Assurance Committee);
- key statutory, national and best practice requirements and reporting arrangements.

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MATTER TO BE CONSIDERED BY COMMITTEE		EXEC LEAD	SCHEDULED COMMITTEE DATES 2022-23					
			3 May	23 Jun	12 Sep	27 Oct	15 Dec	28 Feb
	Audit and Regulatory Reports	Lead Director	**As and when identified**					
SP4	Primary Care Services Performance Report: - Dental Services (incl. GDS) Performance - GMS (incl. OOH) Performance - Community Pharmacy	DPCCMH			✓			✓
SP4	Out of Hours Update	DPCCMH		✓				
	Overview of Renewal Strategic Portfolio, including: - Value-based Healthcare Progress - Portfolio risks	CEO/DPP	✓	✓		✓		
	Update on Screening Programmes	DPH			✓			
SP5	Diagnostics, Planned and Ambulatory Care Programme Update	DPCCMH				✓		
	Children and Young People (Renewal Portfolio) Highlight Report				✓			✓
SP7	Cancer Programme (Renewal Portfolio) Highlight Report	MD			✓			✓
SP8	Circulatory Programme (Renewal Portfolio) Highlight Report	DPH					✓	
SP10	Mental Health (Renewal Programme) Highlight Report	DPCCMH				✓		

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MATTER TO BE CONSIDERED BY COMMITTEE		EXEC LEAD	SCHEDULED COMMITTEE DATES 2022-23					
			3 May	23 Jun	12 Sep	27 Oct	15 Dec	28 Feb
SP11	Urgent and Emergency Care, incl. Frailty and Community Model Update and Performance Report	DPCCMH				✓		
SP18-19	Digital First Update Report including: - Clinical Digital System Implementation - Infrastructure and Intelligence Implementation - Performance report	DFI&IT		✓			✓	
SP19	Information Governance Performance Report	DFI&IT	✓			✓		
SP19	Information Governance Toolkit Out-turn and Improvement Plan	DFI&IT	✓					
SP19	Records Management Improvement Plan Update (Escalated Issue)	DFI&IT		✓				
SP21	Capital Pipeline Overview	DE		✓				
SP21	Innovative Environments Overview Report: - Delivery of the Discretionary Capital Programme - Capital and Estates Compliance Report (including Health and Safety, Fire Safety etc.) - Discretionary Capital Programme 2023/24 (Feb 2023)	DE			✓			✓

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MATTER TO BE CONSIDERED BY COMMITTEE		EXEC LEAD	SCHEDULED COMMITTEE DATES 2022-23					
			3 May	23 Jun	12 Sep	27 Oct	15 Dec	28 Feb
SP21	Waste Management Procurement (Follow-up issue)	DE					✓	
SP24	Financial Performance Report	DFI&IT	✓	✓	✓	✓	✓	✓
SP24	Strategic Resource Planning, including Efficiencies	DFI&IT			✓			
SP25	Integrated Performance Report	DPP	✓	✓	✓	✓	✓	✓
SP25	Performance Exception Reporting (Commissioned and Provided Services)	DPP & Exec Lead	**As and when identified by Executive Committee**					
SP25	Commissioning Assurance Framework	DPP					✓	
SP25	Annual Performance Report	DPP	✓					
SP25	Performance Report of the NHS Wales Shared Services Partnership, including Procurement Summary	DFI&IT						✓
	Scrutiny of business cases and major capital projects	Lead Director	**As and when identified**					
	Governance Reports							
	Policies Delegated from the Board for Review and Approval	BS	**As and when identified**					
	Committee Programme of Business	BS			✓	✓	✓	
	Committee Risk Register	BS	✓	✓	✓	✓	✓	✓
	Committee Requirements as set out in Standing Orders							
	Development of Committee Annual Programme Business	BS		✓ 22-23				✓ 23-24

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MATTER TO BE CONSIDERED BY COMMITTEE		EXEC LEAD	SCHEDULED COMMITTEE DATES 2022-23					
			3 May	23 Jun	12 Sep	27 Oct	15 Dec	28 Feb
	Annual Review of Committee Terms of Reference 2022-23	BS				✓		
	Total Number of Agenda Items		**7**	**9**	**10**	**10**	**8**	**9**

KEY:

CEO:	Chief Executive
DPP:	Director of Planning and Performance
DFI&IT:	Director of Finance, Information and IT
DPCCMH:	Director of Primary, Community Care and Mental Health
MD:	Medical Director
DoNM:	Director of Nursing and Midwifery
DoTHS:	Director of Therapies and Health Sciences
DWOD:	Director of Workforce & OD
DPH:	Director of Public Health
BS:	Board Secretary
DE	Director of Environment
ADCB:	Associate Director of Corporate Business

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