Bundle Digital Intelligence and Health Committee 3 December 2019

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6 Review of the Meeting

7 Date and Time of Next Meeting

7.1 4th February 2020, Woodland House

Digital & Health Intelligence Committee
Agenda
3rd December 2019
Cefn Mably, Ground Floor, Woodlands House

1.	**Preliminaries**	
1.1	Welcome & Introductions	Eileen Brandreth
1.2	Apologies for Absence	Eileen Brandreth
1.3	Declarations of Interest	Eileen Brandreth
1.4	Minutes of the Committee Meeting held on 15th August 2019	Eileen Brandreth
1.5	Action Log	Eileen Brandreth
1.6	Chairs Action taken since last meeting	Eileen Brandreth
2.	**Items for Review and Assurance**	
	Strategic Issues	
2.1	Digital Strategy – Update on Progress	David Thomas – Verbal
2.2	Strategic Transformation – Programme Update	David Thomas
	Risk & Audit Assurance	
2.3	Joint IMT Risk Register	David Thomas
2.4	IMT Audit Assurance	David Thomas
2.5	Information Governance Audit Assurance (Joint GDPR & other IG action plan summary of progress)	James Webb
	Information Governance	
2.6	Clinical Coding – Performance Data	David Thomas
	IMT	
2.7	Work Plan Exception Report	David Thomas
3.	**Items for Approval/Ratification**	
3.1	Information Governance Policy	James Webb
3.2	SAR Procedure	James Webb
3.3	FOI 2000 & EIR 2004 Procedure	James Webb
4.	**Items for Noting and Information**	
4.1	Information Governance Compliance	James Webb
4.2	CDF Schedule (Policies & Procedures)	David Thomas
	Minutes for Noting	
4.3	Capital Management Group	David Thomas
4.4	NIMB	David Thomas
5.	**Items to bring to the attention of the Board**	Eileen Brandreth
6.	**Review of the Meeting**	Eileen Brandreth
7.	**Date and time of next Meeting**	
7.1	4th February 2020, Woodland House	

Unconfirmed Minutes of the Digital Health & Intelligence Committee
Thursday 15th August – 8:30am – 11:30am
Nant Fawr 1 & 2, Woodland House

Chair:		
Eileen Brandeth	EB	Committee Chair & Independent Member
Members:		
Michael Imperato	MI	Committee Vice Chair & Independent Member
Charles Janczewski	CJ	UHB Interim Chair & Independent Member
In Attendance:		
Nicola Foreman	NF	Director of Corporate Governance
Christopher Lewis	CL	Deputy Executive Director of Finance
David Thomas	DT	Director of Digital & Health Intelligence
Allan Wardaugh	AW	Assistant Medical Director
James Webb	JW	Information Governance Manager
Len Richards	LR	Chief Executive Officer
Secretariat:		
Laura Tolley	LT	Corporate Governance Officer
Apologies:		
Dr Stuart Walker	SW	Medical Director
Dr Sharon Hopkins	SH	Deputy Chief Executive Officer

DHIC 19/08/001	**Welcome & Introductions** The Committee Chair welcomed everyone to the public meeting.	**Action**
DHIC 19/08/002	**Quorum** The Committee Chair confirmed the meeting was quorate.	
DHIC 19/08/003	**Apologies for Absence** Apologies for absence were noted.	
DHIC 19/08/004	**Declarations of Interest** Michael Imperato declared his interest as a Legal Representative for the ongoing Blood Inquiry. The Committee Chair confirmed that there was no relevant conflict for the Digital & Health Intelligence Committee therefore no action was taken.	
DHIC 19/08/005	**Minutes of the Committee Meeting held on 29th January 2019** **Resolved – that:** (a) The Committee approved the minutes of the meeting held on 29th January 2019	

DHIC 19/08/006	**Action Log following the Meeting held on 29th January 2019** **Resolved – that:** (a) The Committee reviewed and noted the Action Log from the meeting held on 29th January 2019 (b) In response to a questions raised at the Board, in relation to the Lightfoot contract, DDHI confirmed that, although no additional IT infrastructure was required (as UHB data was being shared with Lightfoot who subsequently provide reports via their own platform), there is a need to ensure adequate, on-going investment in providing desk-top PCs and mobile devices to a minimum specification and that there is reliable wi-fi access for clinicians to view and use the data effectively.	
DHIC 19/08/007	**Chairs Action taken since last meeting** There had been no Chairs actions taken since the last meeting.	
DHIC 19/08/008	**Digital Strategy Presentation** The Director of Digital Health Intelligence (DDHI) introduced the presentation and confirmed the following: • The Cardiff & Vale Digital Team is responsible for IT, business analytics and information, information governance, specific IT project teams (e.g. PARIS team and WCP team) and clinical coding. • Their aim was to provide enabling services across the Health Board to support delivery of clinical services. The Digital Team works closely with the Transformation Board and focus on continuing service improvement. The Committee Chair asked if the Digital Team were also responsible for digital innovation. The DDHI confirmed that this was a key focus for the team and that they encourage and welcome all staff and service users across the UHB to bring ideas for innovation to the Digital Team for discussion and consideration. The UHB Interim Chair asked how clinical coding was monitored as this was not seen by the Committee. In response, the Chief Executive Officer confirmed that the Director of Digital Health & Intelligence monitored the information and that this information was reported into Management Executive Meetings. The Committee Chair noted that Board receive performance data relating to clinical coding as part of the KPI's that it monitors but noted that it would be helpful for this committee to receive more detailed assurance in this area. DDHI to prepare a relevant update for the next committee. The PICU Consultant provided an explanation to the Committee about the Informatics Plan 2019/22 and emphasised that Data Repository at its heart	**DT**

	was critical to the way the UHB worked. The PICU Consultant confirmed that the data held in the repository, together with data sourced from other systems through the Interoperability Hub could be used to make a single digital picture of a patient's records. The PICU Consultant confirmed the three important user groups of the data repository were: 1. Patients – The UHB wants to give patients easy access to their Health Records 2. Clinicians – The UHB wants to make it easier for Clinicians to see and share data 3. System Leaders – The UHB wants to make better system and care decisions informed by evidence and the appropriate use of data analysis. This would be brought to life through a series of portals. The PICU Consultant explained that the approach to the overall architecture had changed to allow for this to happen, allowing for existing architecture to be utilised whilst solutions appropriate for national implementation are brought to life. The PICU Consultant emphasised the importance around the type of applications that would be used for interaction and advised the Committee that the UHB may want to design the applications in-house or engage with the Life Science Hub to create these. The PICU Consultant mentioned the UHB needed to be skilful in getting applications that patients benefit from, and which are 'plug and play' – whereby the application is quick to implement, but readily replaceable – the enabler being the adoption of standards and the availability (storage) via a 'central' indexed repository. The UHB Interim Chair thanked the PICU Consultant for his constructive explanation. The Committee Chair asked if the Welsh Clinical Portal was still the primary portal within the architecture. The DDHI confirmed that the focus was on open architecture to ensure all Health Boards have systems that they needed as the 'one for all' system was unsuccessful. The DDHI confirmed that he expected a development of the National Data Repository to be ready by the end of 2019. The DDHI confirmed the main focus was gaining real time data across the UHB. The DDHI explained that E–Patient Flow would be funded by the end of 2019 and there was a need to look at how this would fit into the UHB's long term plan. The PCIC Consultant confirmed that if E-Patient Flow was looked at in the correct way it would fit into the new Digital Strategy.	

	The DDHI informed the Committee that Patient Knows Best is now being implemented within Cardiff & Vale and was also being looked at Nationally. The DDHI confirmed that WiFi Services received funding from the Digital Fund 2018/19 but was currently funded mainly by the Health Charity. The UHB Interim Chair emphasised the importance of communities being equipped adequately to become more efficient, maximising the use of systems in place. The DDHI explained that a Mobile Strategy was being developed to look at preferred devices and this would be brought to a future meeting. The PICU Consultant stressed the importance of the UHB investing in devices that Clinicians and Service Users required therefore, it was important for the UHB to involve both Clinicians and Service Users in decision making. The Committee Chair expressed concern that appropriate care with patient data be taken when accessing information in community settings. In response, the DDHI confirmed that work was being carried out in relation to Cyber Security in Cardiff & Vale and nationally to gain this assurance and funding was expected which would support Cyber Security issues. The DDHI confirmed the three key findings from the National Digital Architecture Review were: 1. Current State – Current approach was unsustainable and would not enable the ambition set out in A Healthier Wales to be achieved 2. Opportunity – A significant opportunity for digital transformation 3. Approach – digital transformed NHS in Wales was achievable, but required a fundamental change of approach and focus The DDHI also explained the recommended architectural steps and confirmed they reflect the view of all Health Boards across Wales: 1. Digital Architecture – 3-9 months 2. Open Digital Platform – 1-2 years 3. Stabilisation and Resilience – 2-3 years The DDHI confirmed that he had reviewed the Digital work programme to ensure it reflected the National Architecture Review. There will be a new Digital Design Group implemented from September 2019, in which consideration and decisions relating to digital plan would be made. The Digital Design Group would be made up of Clinical Board Directors, Executives and Clinicians. The DDHI explained that a £50M Digital Investment bid had been submitted to Welsh Government for consideration and the Welsh Government Chief Digital Officer had advised that the Minister would be making decisions on bids submitted in September 2019. The £50M Digital Investment covered the following areas:	**DT**

	• Transforming Digital Services for the Public and Patients • Transforming Digital Services for Professional • Cyber Security and Resilience • Modernising Devices and Moving to Cloud Services • Investing in Data and Intelligent Information • Cross Cutting Activity • Business Case Pipeline (inc. Canisc, Linc – Pathology Services, E-prescribing, Critical Care EHR etc.…) The DDHI confirmed he would provide the Committee with an update on the £50M Digital Investment bid at the next Committee meeting. The Committee Vice Chair thanked the DDHI for the presentation and asked where the patient was in the Digital Strategy. The PICU Consultant confirmed he shared the view of the Committee Vice Chair and emphasised the importance of the patient being at the heart of the Digital Strategy. The PICU Consultant explained that Cardiff & Vale UHB needed to help this evolve and Clinical Engagement User work needed to be carried out. The Committee Chair welcomed the Digital Strategy and confirmed that the DDHI would bring a plan to the next Committee meeting explaining how the Digital Strategy would include all patients. **Resolved – that:** (a) The Committee agreed the direction of the Digital Strategy (b) A further report would be provided at the next Committee Meeting explaining the inclusion of all patients within the Digital Strategy (c) A Mobile Strategy would be brought to the Committee Meeting in February 2020	**DT** **DT** **DT** **DT**
DHIC 19/08/009	**Information Governance Presentation** The Information Governance Manager introduced the presentation and confirmed that the UHB Objectives for Information Governance were based on the seven GDPR Principles. The UHB Interim Chair explained he felt that there was no substance to the objectives. The PICU Consultant and Committee Chair confirmed the same views and agreed that the objectives should be more specific and outcome based as well as being supportive of the Digital Strategy. The Information Governance Manager committed to revising the objectives The Interim Board Chair asked if there were mechanisms in place to control Information Sharing. In response, the Information Governance Manager confirmed it was not difficult to share information between users, however, guidance was needed on how the Health Board wanted information to be shared.	**JW**

	The PICU Consultant confirmed that the Health Board could share a lot more information, however, staff were afraid to do so because of GDPR rules. The Information Governance Manager confirmed that the purpose of Information Governance was to help information sharing and Cardiff & Vale were leading the way in this area. The PICU Consultant advised the Committee that a query had been made to Welsh Government regarding a potential change to legislation on information sharing to help Health Boards facilitate this. The UHB Interim Chair confirmed the Digital Strategy needed be clear and concise regarding the Health Boards intention to share information and had to overcome barriers to preventing this from happening The UHB Interim Chair commented that Information Security Scope appeared dated from an assurance perspective and advised the Information Governance Manager that this required updating. **Resolved – that:** (a) The Committee noted the presentation (b) A report outlining the revised objectives would be presented at the next Committee meeting.	**JW** **JW**
DHIC 19/08/010	**Risk Register by Exception** The DDHI confirmed the following risks as causes for concern: **1) Cyber Security** The DDHI explained a number of actions had been taken however resource was a challenge. The £50M bid to Welsh Government covered funds for further resource as a dedicated team was needed to tackle Cyber Security. The DDHI recommended that the UHB go at risk to recruit for a Cyber Security Team whilst the bid for funding was being considered. The Committee supported the recommendation as Cyber Security is an issue across all Health Boards and delaying action would prevent Cardiff & Vale from being appropriately responsive to Cyber Security Issues. **2) Software upgrade from Windows 7 to Windows 10** The DDHI confirmed that the UHB needed to upgrade over 1000 devices and funding had been requested within the £50M bid to Welsh Government for this to be facilitated.	

	The upgrade timeline had further expanded by 12 months, however, there was a concern that there would be many digital devices across the UHB which would not be functioning in 12 months' time if the funding was not approved by Welsh Government. The Deputy Executive Director of Finance asked that if money was made available, how quickly could the Digital Team use it to start the required upgrades. In response, the DDHI confirmed that the team had been in discussions with suppliers therefore they were ready to move quickly. The Committee Chair asked the DDHI to inform the Deputy Executive Director of Finance the lead time to spend money should it become available. **Resolved – that:** (a) The Committee noted the Risk Register by Exception and the more detailed discussions held on the main risks impacting upon Digital Health Intelligence.	**DT**
DHIC 19/08/011 **DHIC 19/08/012** **DHIC 19/08/013**	**Exceptions and Issues** • **GDPR Progress** The Information Governance Improvement Plan with detailed findings and action plan was taken as read by the Committee. It was noted that this document was extremely detailed and that it should be considered alongside the IG Internal Audit report on Information Governance. For future meetings a format that provides a summary of progress against prioritised outstanding actions was required so that the Committee could be assured that progress was being made. **Resolved – that:** (a) The Committee noted the findings and action plan. (b) The Committee noted the progress made. (c) Required that a summary of progress be provided to future Committees. • **IT Delivery Program** The paper provided a high level exception report on the high priority programmes within the UHB IT Delivery Plan and was taken as read by the Committee. The UHB Interim Chair made an observation that the report provided was difficult to understand, therefore, requested a more concise summary be brought to future meetings. **Resolved – that:**	**DT** **DT**

DHIC 19/08/014	(a) The Committee noted the progress in many areas of the IT Delivery Programme (b) The Committee noted the areas of exception which required further attention and consideration • **WLIMS** The WLIMS paper explained that NHS Wales procured and implemented the National Laboratory Information Management System (LIMS) some years ago and the system was intended to be the Laboratory System for Wales covering all modules in the previous Telepath System. The paper also explained that there had been significant delays in developing the required functionality to an acceptable level, such that a number of modules (including Blood Transfusion) remained on the Legacy Telepath System. The WLIMS systems has now reached the end of its contract pending re-procurement of a new National Lab System Solution as part of the LINC project. The DDHI confirmed that WLIMS was targeted to go live in September 2019. **Resolved – that:** (a) The Committee noted the progress in relation to the new National LINC project and that the project is looking to standardise procedures in Wales with C&VUHB being first to deploy as the most complex teritiary centre. (b) The Committee noted the plans put in place to mitigate risks and provide stability within the Legacy Telepath System whilst the new LINC project progresses. • **Information Governance Compliance** The Chief Executive Officer confirmed that the DDHI was the Interim Senior Information Risk Owner, until clarity on the Deputy Chief Executive Officer & Director of Transformation position at Cwm Taf Health Board was received. The Chair noted that WAO have previously indicated that they would be uncomfortable for the SIRO role to be allocated below main Board level, so she anticipated that this would only be for an interim period. The Information Governance Manager confirmed the new staffing structure: • David Thomas, Director of Digital and Health Intelligence was the interim Senior Information Risk Owner • Dr Stuart Walker, Medical Director, was the Caldicott Guardian • James Webb was the interim Data Protection Officer	

	• The information governance department was currently resourced at 5.8 WTE but was functioning below this level due to long term sickness of 1 WTE. The Information Governance Manger confirmed that during Q1 of 2019, the Information Governance Department reviewed 272 Information Governance related incidents. Of these, 1 was considered a serious incident and was subsequently reported to the Welsh Government, 6 incidents were raised with Information Commissioners Office (ICO), with 2 of the 6 been formally reported. The Information Governance Manager confirmed that there had been increased learning from continued discussions on potential breaches with the ICO. The Information Governance Manager confirmed a significant improvement within Freedom of Information Compliance. In August 2018, the department were at 31%, however, during August 2019 the department were at 86% due to a clinical drive. The Information Governance Officer confirmed that two new staff joined the department to clear the backlog of Freedom of Information requests which meant the department were at 90% of the target. The Information Governance Officer explained that Freedom of Information was a legal requirement therefore the department strive for 100% however when this is unachievable reasonable explanations are provided. The Committee Chair requested that where less than 100% was achieved explanations for the non-compliant cases be brought to the Committee for noting in future. There was also a request that benchmarking Freedom of Information compliance be undertaken against other Health Boards for future reports. The Information Governance Officer informed the Committee that the ICO were satisfied that the UHB were making progress with Subject to Access Requests. The Committee Chair asked when reports were produced in future if an age period could be included. The UHB Interim Chair expressed concern as he had not seen Subject to Access requests at satisfactory levels therefore requested an improvement plan be developed which included a trajectory outlining what the department were working towards achieving. The Committee Chair encouraged the Information Governance Manager to look at different practices when dealing with Staff Subject Access Requests to reduce the workload for the department. The Committee Chair expressed a concern that compliance monitoring via the National Integrated Intelligent Auditing System (NIIAS) was only available for National systems and was not available to C&VUHB for its local Patient Administration System. The Committee is therefore not able	**JW** **JW**

	to be assured concerning appropriate monitoring of access to patient record data. The Information Governance Manager explained that Mandatory Training Compliance was still a cause for concern, although there had been a slight increase from 71% to 73%, this was still significantly below the UHBs target. It had been recognised that some of this gap relates to staff without direct access to PC's so a presentation had been developed for Line Managers to deliver to staff face to face. The Committee welcomed this and look forward to seeing further improvement in the level of uptake. **Resolved – that:** (a) The Committee received and noted the series of updates relating to significant Information Governance issues (b) The Committee agreed that a draft Information Governance Policy be brought to the next Committee together with a schedule for all outstanding policies and procedures to be presented to the Committee for approval over its future cycles of business.	**JW**
DHIC 19/08/015	**Audits** • **Welsh Government Review of Governance** The DDHI advised the Committee that, to date, the Welsh Government Review of Governance had not been shared or made public. The Committee Chair asked how the Committee could request the Governance Review to be shared promptly. In response, the Chief Executive Officer confirmed that he would raise the concern during the Executive meeting held with Welsh Government and feedback could be provided at the next Committee meeting. The PICU Consultant confirmed that he had raised concern with Ifan Evans, Welsh Government Chief Digital Officer and emphasised importance of the Governance Review being shared. The UHB Interim Chair confirmed he would raise the concern at the Chairs meeting and feedback would be provided at the next Committee meeting. **Resolved – that:** **(a)** The Committee noted the update **(b)** A further report on the Welsh Government Review of Governance be provided at the next Committee meeting	**LR** **CJ** **DT**
DHIC 19/08/016	• **IMT Audit Assurance** The Committee Chair requested that the DDHI update the report to advise target dates for the outstanding e-IT training audit points and ensures that all actions have dates associated with their completion that are tracked and	**DT**

DHIC 19/08/017	managed under change control. These revisions should be developed and brought to the next Committee meeting. **Resolved – that:** **(a)** The Committee noted the update **(b)** A further report and action plan be brought to the next Committee Meeting • **Internal Audit – Information Governance** The Committee Chair requested that an assessment outlining work that had been carried out against the Internal Audit recommendations be brought to the next Committee Meeting. **Resolved – that:** **(a)** The Committee noted the update **(b)** A further report and assessment be brought to the next Committee Meeting	**DT** **JW** **JW**
DHIC 19/08/018	**Terms of Reference** The Director of Corporate Governance confirmed the report provided Members of the Digital & Health Intelligence Committee with the opportunity to review the Terms of Reference prior to submission to the Board for approval. The Committee Chair & Independent Member requested a change to the Quorum for the Committee to include 2 Independent Members and the Medical Director and/or 1 Executive Director. The Committee Chair & Independent Member requested the following members be added into the attendance of the Committee: • Data Protection Officer • Workforce Representative **Resolved – that:** Subject to the amendments outlined above, (a) The Committee approved the Terms of Reference for the newly established Digital & Health Intelligence Committee (b) The Committee recommended the changes to the Board for approval	**NF** **NF** **NF**
DHIC 19/08/019	**Committee Work Programme** The Director of Corporate Governance confirmed the report provided Members of the Digital & Health Intelligence Committee with the	

	opportunity to review the Committee Work Plan 2019/20 prior to presentation to the Board for approval. The Director of Corporate Governance confirmed that the key headings on the work programme would be included on the agenda. The Director of Corporate Governance confirmed the following items were to be included: 1) Controlled Documents Framework 2) Health Standards **Resolved – that:** Subject to the amendments outlined above, (a) The Committee reviewed the Work Programme 2019/20 (b) The Committee approved the Work Programme 2019/20 (c) The Committee recommended approval to the Board of Directors	**LT** **NF** **NF**
DHIC 19/08/020	**Legacy Document** The Director of Corporate Governance confirmed the report provided Members of the Digital & Health Intelligence Committee with the opportunity to review of the work its predecessor the Information Technology & Governance Committee. **Resolved – that:** (a) The Committee reviewed the Legacy Statement 2018/19 (b) The Committee noted the work undertaken by the Information Technology & Governance Committee	
DHIC 19/08/021	**Minutes of Meetings** • **Capital Management Group Meeting on 20th May 2019** **Resolved – that:** (a) The Committee noted the minutes of the Capital Management Group Meeting on 20th May 2019 • **NIMB Meeting on 11th April 2019** **Resolved – that:** (a) The Committee noted the minutes of the NIMB Meeting on 11th April 2019	
DHIC 19/08/022	**Items to bring to the attention of the Board**	

	The Committee Chair & Independent Member confirmed the following items would be brought to the attention of the Board: 1) Lightfoot – A detailed response on how Lightfoot would integrate with the UHB system 2) Digital Strategy – Intention to Implement 3) Clinical Coding – Note the intention to receive more detailed assurance 4) Terms of Reference – Changes for Approval **Resolved – that:** (a) The Committee noted the items to be taken to Board	**NF**
DHIC 19/08/023	**Review of the Meeting** There were no items discussed.	
DHIC 19/08/024	**Date & Time of next Meeting** **Tuesday 1st October 2019, 9am – 12pm, Nant Fawr 1, Ground Floor, Woodland House**	

Action Log
Following the Digital Health & Intelligence Committee
15th August 2019

Minute Ref	Subject	Agreed Action	Lead	Date	Status
Actions Completed					
Actions in Progress					
ITGSC 18/028 IGSC 17/031	GP Pilot	Three month pilot report to be submitted to the next meeting	Paul Rothwell	TBC	Evaluation on hold
19/08/008	Clinical Coding – Performance Data	The Committee Chair noted that Board receive performance data relating to clinical coding as part of the KPI's that it monitors but noted that it would be helpful for this committee to receive more detailed assurance in this area. DDHI to prepare a relevant update for the next committee.	David Thomas	3rd December 2019	On December Agenda (item 2.6)
19/08/008	£50M Digital Investment	DDHI to provide an update on the bid to Welsh Government at the next Committee Meeting	David Thomas	3rd December 2019	Verbal update to be provided at the December meeting.
19/08/008	Digital Strategy	DDHI to bring a plan to the next Committee meeting explaining how the Digital Strategy would include all patients.	David Thomas	3rd December 2019	Verbal update on December Agenda (item 2.1)

Minute Ref	Subject	Agreed Action	Lead	Date	Status
19/08/008	Mobile Strategy	It was agreed a Mobile Strategy would be brought to the Committee Meeting in February 2020	David Thomas	4th February 2020	To be brought to the February meeting.
19/08/009	Information Governance	Information Security Scope appeared dated from an assurance perspective and this required updating	James Webb	3rd December 2019	Update to be provided at the December meeting.
19/08/009	Information Governance	A report outlining the revised objectives would be presented at the next Committee meeting.	James Webb	3rd December 2019	Update to be provided at the December meeting.
19/08/010	Software Upgrade from Windows 7 to Windows 10	DDHI to inform the Deputy Executive Director of Finance the lead time to spend money should it become available.	David Thomas	TBC	Update to be given at the December meeting.
DHIC 19/08/011	GDPR Progress	Document should be considered alongside the IG Internal Audit report on Information Governance. For future meetings a format that provides a summary of progress against prioritised outstanding actions was required so that the Committee could be assured that progress was being made.	David Thomas	3rd December 2019	On December Agenda (incorporated into 2.6)
DHIC 19/08/014	Information Governance Compliance	The Committee agreed that a draft Information Governance Policy be brought to the next Committee together with a schedule for all outstanding policies and procedures to be presented to the Committee for approval over its future cycles of business.	James Webb	3rd December 2019	On December Agenda (item 4.1)

Minute Ref	Subject	Agreed Action	Lead	Date	Status
DHIC 19/08/014	Information Governance Compliance	The Committee Chair requested that where less than 100% was achieved explanations for the non-compliant cases be brought to the Committee for noting in future. There was also a request that benchmarking Freedom of Information compliance be undertaken against other Health Boards for future reports.	James Webb		This information will be provided at future meetings when required.
DHIC 19/08/014	Information Governance Compliance	The UHB Interim Chair expressed concern as he had not seen Subject to Access requests at satisfactory levels therefore requested an improvement plan be developed which included a trajectory outlining what the department were working towards achieving.	James Webb	Feb 2020	To be brought to the February meeting.
19/08/015	Welsh Government Review of Governance	A further report on the Welsh Government Review of Governance be provided at the next Committee meeting	David Thomas	3rd December 2019	On Private Agenda 03/12/2019
19/08/016	IMT Audit Assurance	DDHI update the report to advise target dates for the outstanding e-IT training audit points and ensures that all actions have dates associated with their completion that are tracked and managed under change control.	David Thomas	3rd December 2019	On December Agenda (item 2.4)
19/08/017	Internal Audit – Information Governance	An assessment outlining work that had been carried out against the Internal Audit recommendations be brought to the next Committee Meeting.	James Webb	3rd December 2019	On December Agenda (item 2.6)

Minute Ref	Subject	Agreed Action	Lead	Date	Status
Actions referred to the Board / Committees of the Board					
19/08/019	Committee Work Programme	The Committee recommended approval to the Board of Directors	Corporate Governance Officer	30th January 2020	To be included in Chairs Report and taken to Board Meeting on 30th January 2020
19/08/022	Lightfoot	Lightfoot – A detailed response on how Lightfoot would integrate with the UHB system	Corporate Governance Officer	30th January 2020	To be included in Chairs Report and taken to Board Meeting on 30th January 2020
19/08/022	Digital Strategy	Digital Strategy – Intention to Implement	Corporate Governance Officer	30th January 2020	To be included in Chairs Report and taken to Board Meeting on 30th January 2020
19/08/022	Clinical Coding	Clinical Coding – Note the intention to receive more detailed assurance	Corporate Governance Officer	30th January 2020	To be included in Chairs Report and taken to Board Meeting on 30th January 2020
19/08/022	Terms of Reference	Terms of Reference – Changes for Approval	Nicola Foreman	26th September 2019	Completed. Reported to Board on the 26th September 2019

Report Title:	**Digital & Health Intelligence Delivery Programme – Update**							
Meeting:	**Digital and Health Intelligence Committee**				**Meeting Date:**	**3rd December 2019**		
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**	**x**
Lead Executive:	**Director of Digital and Health Intelligence**							
Report Author (Title):	**Assistant Director of IT**							

SITUATION

This paper provides a high level progress report on the high priority programmes within CAV UHB's Delivery Plan.

BACKGROUND

The UHB has a constantly evolving 3 year strategic outline plan for informatics development designed to underpin delivery of our strategy, IMTP, transformation programme and the Welsh Government's Healthier Wales and Informed Health and Care policies and strategies.

Our plan includes the **3 delivery programmes,** all of which support and the C&V data repository and interoperability hub (the clinical data repository and national data repository)**:**

- Intelligent Citizen Portal, which is focussed on the implementation of the "Patient Knows Best" solution
- Integrated digital health and care record, involving data sharing and interoperability from multiple systems
- Data to knowledge programme – using insights from the "signals from noise" work being delivered by Lightfoot Solutions

Being built on **3 enabling programmes:**

- Digitally included population
- Digitally enabled workforce
- Modern Architecture & Infrastructure

ASSESSMENT

The Work Plan to support the emerging Digital Strategy (2020-2025) consists of multiple projects and programmes, both local and national which are grouped under the headings as outline above.

C&V Data Repository

This work stream focusses on accessible data, through sharing and wider clinical use of data stored in GP, community, mental health, EU, outpatient, theatre and maternity information systems. Work is continuing to deliver phase 1 of the Clinical Data Repository (CDR) with

preparation including hardware and training on FHIR (Fast Healthcare Interoperability Resources), which is the standard describing data resources and APIs for exchanging electronic health records.

Intelligent Citizen Portal

Work is continuing to develop the "Patient Knows Best" solution which will enable secure and confidential communication between patients and clinicians. A number of services are now live and using the PKB portal. The solution will enable patients to manage and view their appointments, once fully integrated with our systems.

Integrated Digital Health and Care Record

Work is progressing to enable multi-disciplinary teams to share common records, e.g. use of Vision 360 GP clinical record system to allow clinicians to see primary care data at a cluster level. GPs can now access and see community data via the PARIS system. Further enabling work is being progressed via the mobilisation programme, which aims to provide all clinical staff with access to the right information at the right time.

Data to Knowledge

In addition to working with Lightfoot to better understand insights from the data and to manage capacity and demand, we are increasing the scope and accessibility of clinical information, providing more near real-time dashboards and decision support tools, supported by modern servers and the data repository.

The key enabler programmes include the **digitally included population** where work to extend the availability of free wi-fi across the C&V estate is being progressed as well as improving access and reducing costs of translation services by greater use of digital applications. In supporting the **digitally enabled workforce,** we are embarking on a programme of PC replacement, including mobile devices where more appropriate; we recognize the importance of training and developing staff in the use of digital technologies and are developing training and support via web-based means as well as retaining a training function. The **architecture and infrastructure** requirements to support our digital strategy require additional storage and server capabilities, which are being addressed via the digital funds allocation as well as use of discretionary capital.

A more detailed update on progress against specific projects forms the remainder of this report.

Local / National Projects

- Implementation of the new EMG system into neurology due to go live 3rd December 2019
- Pharmacy system replacement programme – due to go live April 2020 – IT preparation work with the service ongoing
- National Critical Care system – procurement underway – award of contract expected October 2019 – technical review of current infrastructure within the ITU units is underway in readiness for implementation (funding available this financial year to support Network / Electrical requirements at the patient's bedside)
- E-Nursing pilot due to commence September 2019 been delayed due to development

issues – IT requirements complete and ready to support pilot
- Carecube scheduling system – support Cardiology (Cath Lab) in the implementation of a new scheduling system – due to go live March 2020.
- Adastra – support the GP Out Of Hours service with an upgrade to the infrastructure and application

Welsh Clinical Portal and GP Test Requesting

- Following implementation of WCP 3.10 during the summer, a pilot of Hospital to Hospital Referrals commenced in September with Cardiology/Cardiac Surgery. Referral numbers are steadily increasing.
- Pathology Electronic Test Requesting continues to be rolled out across the UHB. Recent go lives have been in Maternity, Dental and Pre Op Assessment Unit and Paediatric Inpatients. Planning is underway for implementation in Paediatric Outpatients, Paediatric Oncology, CAVOC (Orthopaedic inpatient & outpatients) and Emergency Unit.
- WCP Results and Notifications functionality is being implemented in additional specialties following the successful pilot in Gastroenterology.
- The GP Test Requesting Pilot at Saltmead Medical Practice is continuing with Penarth Healthcare Partnership planned to be the second practice to pilot. The project has received several expressions of interest from other practices.
- The UHB has commenced a pilot which gives GPs access to the Welsh Clinical Portal. It is recognised that extended access to other practice staff to support MDT meetings is required to ensure this initiative delivers the expected benefits.
- Pharmacy Medicine Order Sets (MOSs) functionality was deployed with WCP v3.10 on 31 July 2019. Configured new Medicine Order Sets are awaiting approval by CAV Medicines Management Group before release to live. Once released, the Implementation of MTeD in Maternity is expected towards the end of the year.
- WCP v3.11 User Acceptance Testing has commenced. This version will bring Radiology Test Requesting which will be piloted in CTM UHB first before being rolled out to other health boards.
- WCP Radiology Results – user acceptance testing has now commenced with the aim of go live by the end of the year.

PARIS

- GPs involved in cluster working have been provided access to Paris from their existing desktop PCs, uptake of this is increasing across the initial cluster (South West), leading to request for this to be expanded across Cardiff and Vale.
- UK Cris data extraction now in place, including all legal matters. This enables Mental Health to become research led in clinical practice.

Transforming Primary Care

- Social prescribing platform specified, IG assessed, and procured (Elemental). Currently being configured for use, and developed in sprints with the vendors.
- Discharge Hub – Enabled and established for south west cluster, gifting access to PARIS, WCP, GP record, and Council record (CareFirst). Making this the most richly informed MDT group in Wales.

e-Optometry Project

- The Welsh Government has instructed the procurement lead Cardiff and Vale UHB to review the options of e-Optometry (referral) as the National Electronic Referral Platform for Optometrists against the Market Place, it is recognised that this will result in a six to nine month delay in the implementation.
- The procurement report has been completed and awaiting signature by Cardiff and Vale UHB and will then be submitted to the Welsh Government for authority to proceed as will the Final Business Case.

Infrastructure

Items completed:

- Completion of Stage 2 of the restructuring and Backup Infrastructure deployment required to address evolving requirements
- Migration of a number of Service Servers from End of Life (EOL) operating systems to supported systems (eg Dental)
- EOL Storage Arrays replaced providing required expanding backup and data capture within this financial year
- Migration of internally developed applications onto a common platform of .NET v4 and Visual Studio 2017.

Good Progress / ongoing work:

- Continuing EOL Virtual Server Farm upgrade – end of year capital spend – implementation phase
- Continuing updating of Service Dept EOL Server Operating Systems – Cyber Security Essential requirements
- Continuing migration of all corporate national systems onto Windows 2012 including interface functionality;

Applications

Items completed:

- WAP v2.6.4 deployed (Federated WCP Service) enabling pilot of H2H referrals
- Neurosurgery On-Call referrals module implemented (Pilot)
- Wound Healing advice request module
- On Screen training modules released in replacement of aged EOS modules
- PMS Postcoder replacement
- An online system for staff to book places on CAV-operated resuscitation training courses.
- An online system for staff to request access to various reports available through the BIS platform.
- A&E Frequent Attenders Module enabling collation of (similar) data feeds from other health boards and public services (police, ambulance, social services, etc.) to provide reports and statistics to the Welsh Government.
- WCCG Letters feed system enabling us to push electronic copies of a range of letters created within the hospital out to CAV GP practices through WCCG.
- Virtual Fracture Clinics module – linking referrals from EU Workstation, and allowing management of referred patients within PMS and COM2.
- Patient Call system - Dental Hospital.
- Secure File Share Sync. .
- Eye-Care Measures – national program – work completed
- Child Behaviour/Psychology app recording episodes of poor behaviour (by the parents) allowing data analysis by HB Child Psychologists.
- Function Analysis Reporting enabling monitoring of some data use within portal
- Data Warehouse – Various reports updated and created (Eyecare measures, PROMS, Patient Frailty)

Good Progress / ongoing work:

- e-Advice: Diabetes Inpatient Review allowing hospital staff to request a bed-side diabetes review from diabetic specialist nursing team.
- Major Trauma System. Due to launch in UHW in 2020, including regulatory submissions to the Trauma Audit & Research Network (TARN), rehab prescriptions and M&M processes. Core functionality is mostly in place with phase 2 work underway.
- PKB – core interface functionality well underway – circa 50% on this core area of development
- Single Cancer Pathway definition and design underway
- Outpatient Follow Up work continues to address the HB's significant overstated cohort of patients in follow up cycle without future treatment needs
- Difficult Airway Alerts and monitoring Anaesthetics
- On Call Utility – monitoring issues within core corporate systems.
- Data Warehouse – Extracts – various ongoing.
- Forms 12C upgrade
- Medical Records Filing Library app. Controls placement of clinical notes and efficiency improvements in storage.

ASSURANCE is provided by:

Assurance is provided by regular internal updates and planning reviews with items for exception highlighted to the Digital Health and Intelligence Committee.

RECOMMENDATION

The Board is asked to:

- NOTE the progress in many areas of the IT Delivery Programme

Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	x
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention		Long term		Integration	x	Collaboration		Involvement	

Equality and Health Impact Assessment Completed:	Yes / No / Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

Report Title:	**Joint IMT Risk Register**							
Meeting:	**Digital and Health Intelligence Committee**					**Meeting Date:**	**3rd December 2019**	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**	**x**
Lead Executive:	**Director of Digital and Health Intelligence**							
Report Author (Title):	**Assistant Director of IT**							

SITUATION

The joint IMT Risk register is a combined register consisting of digital / Information Governance and Information / Performance.

BACKGROUND

There are currently 16 joint IMT risks identified on the report:

2 x Risks in red status with a score of 20 which include:

- Cyber Security
- Software End of Life Implications

12 x Risk in amber status with various scores which include:

- WLIMS (score 15)
- Server Infrastructure (score 16)
- Compliance with data protection legislation (score 16)
- Data Quality (score 16)
- Governance framework (IG policies and procedures) (score 16)
- Insufficient Resource – Capital & Revenue (score 15)
- NWIS Governance (score 15)
- Data availability (score 15)
- End of Life Infrastructure (access devices) (score 15)
- Clinical Records Incomplete (score 12)
- Outcome Measures (score 12)
- Effective resource utilisation (score 12)

2 x Risks have been reduced on this report to yellow status which include:

- Use of UHB Standard data processing contract (score 9)

  Procurement Department continues to send out data processing contracts to suppliers where the contract involves the processing of personal data.

- WCCIS Local team not resourced (score 8)

  ICF funding has been confirmed for 2019/20 and 2020/21 based on assessment of WCCIS impact for integrated Vale of Glamorgan teams and for paper-based therapeutics teams in the UHB.

ASSESSMENT

Full Risk Register Report is attached

ASSURANCE is provided by:

Digital & Health Intelligence Committee established to oversee progress standards for Health Services: Information management and Communications Technology

RECOMMENDATION

The Board is asked to:

- NOTE progress and updates to the Risk Register report.

Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	x
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention		Long term		Integration	x	Collaboration		Involvement	

Equality and Health Impact Assessment Completed:	Yes / No / Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

Objective	Risk Title	Principal Risks	Opened Date	Review Date	Risk Type	Exec lead for the corporate objective	Corp assessment of Impact	Corp assessment of Likelihood	Total	Risk Score (Target)	Risk Level (Target)	Mitigation Action	Further action agreed	Source of control	Lead Committee
6.8.11 A4/0023	Cyber Security	The Cyber Security threats to service continuity	12/13/2013	11/18/2019	Cyber /Service Interruptions	DD&HI	5	4	20	10	MODERATE	The UHB has in place a number of Cyber security precautions. These have include the implementation of additional VLAN's and/or firewalls/ACL's segmenting and an increased level of device patching. However further necessary work is dependent on additional capacity to supplement the current level of staffing within the department.	The requirements to address the resourcing of Cyber Security Management have been acknowledged in an approved but unfunded UHB Business Case. The requirements have been further highlighted in the National Stratia Cyber security review. Plans are currently under discussion at Welsh Government level to resource Health Boards to undertake additional Cyber security monitoring tasks. All of these requirements have been acknowledged and are included in the current re-organisation plans within the Digital and Health Intelligence Department. **Confirmation of WAG funding to support investment in Cyber resource and infrastructure have been confirmed and recruitment and procurement plans are now underway.**	Digital & Health Intelligence Committee established to oversee progress Standards for Health Services: Information management and communications technology	D&HI
6.8.9 A5/0013	Software End of Life implications	The UHB is at risk because its PCs require upgrading to Windows 10 due to support ending for Windows 7 in January 2020. There are potentially significant issues with compatibility with applications systems in use both Nationally and within the HB specifically. The UHB has circa 11,000 devices (laptops and PCs) that require operating systems upgrade; of these, 5,500 will additionally require either replacement or physical hardware upgrade.	6/1/2019	11/18/2019	Cyber /Service Interruptions	DD&HI	**4**	**5**	20	10	MODERATE	update 02/08/19: Microsoft will offer extended support on Windows 7 as part of the all Wales MS 065 contract recently negotiated and in place for all NHS organisations in Wales. This will provide support for Windows 7 PCs, beyond 2020.	The Firepower Firewalls have been configured to stop ALL Internet access, if/when a possible serious virus attack is identified and will implemented immediately. A project proposal to address Windows 10 migration plan has been submitted to Capital Management Group. **Microsoft Windows 10 security support has been extended to March2021. The UHB is utilising WAG Digital investment to fund the first phase of the implementation of the Windows 10 migiation programme**	Digital & Health Intelligence Committee established to oversee progress Standards for Health Services: Information management and communications technology	D&HI
6.8.12 A4/0024	WLIMS	The Welsh Pathology Information management system (WLIMS) implementation has taken longer than envisaged. As a result of this all Health Boards will not have migrated off their legacy pathology systems (Telepath) by end of March 2018, which is when their current telepath contracts will expire.		11/18/2019	Clinical Service Interruptions	DD&HI	5	3	15	10	MODERATE	The UHB is engaged with NWIS and other Health Boards to evaluate options available to mitigate this risk.	It has been agreed to upgrade Telepath Hardware and Software to mitigate risks. Telepath application software has been upgraded to latest version - Hardware has been installed - System has now been configured by DXC - final testing/validation now complete - **Went live 23rd Nov 2019**	Digital & Health Intelligence Committee established to oversee progress Standards for Health Services: Information management and communications technology	D&HI
6.8.6 A3/0110	Server Infrastructure	The IM&T Department is actively implementing a vFarm infrastructure that significantly reduces costs whilst dramatically increasing resilience of Server Systems. However, the cost savings are to the Health Board as a whole and Service Departments in particular and come at an increased cost to IM&T specifically. This infrastructure requires core investment to complete and revenue based support to maintain. There is a requirement to also retain a minimal number of physical servers for those systems not capable of virtualisation.	12/13/2013	11/18/2019	Service Interruptions	DD&HI	4	4	16	10	MODERATE	Whilst the processes in place provide adequate protection of server infrastructure in line with the availability of existing resources, the UHB should identify funding for the vFarm infrastructure if these improvements are to be maintained. Failure to do so will dramatically increase costs to the UHB as a whole and reduce availability and resilience of implemented systems.	The UHB recognises that it is necessary to ensure appropriate capital and revenue funding is made available to address this risk on an ongoing basis as outlined on the UHB corporate Risk Register. Over recent years significant progress has been made with capital investment. This progress will need to be maintained on an ongoing basis in capital and revenue investment. To maintain this risk at these improved levels of investment £2.1m was required in 2018/19 however only £500K discretionary capital was allocated supplemented by a further £770K Welsh Government allocation. Whilst only a further £500K discretionary capital has been allocated so far for 2019/20 the UHB is actively engaged with Welsh Government in undertaking a review of National Infrastructure requirements as part of the plans to significantly increase Digital investment in Wales. **A proportion of the Digital funds is alinged to support server infrastucture**	Digital & Health Intelligence Committee established to oversee progress Standards for Health Services: Information management and communications technology	D&HI
Obtaining information fairly and efficiently	Compliance with data protection legislation	Risk:- Non compliance with Data Protection & Confidentiality Legislation - the UHB's progress in taking forward the action plan to reduce the risk of non compliance following the ICO's assessment of our limited compliance with the DPA is not sufficient to mitigate the risk of non compliance with Data Protection Legislation. **Consequence:** Mistrust of our population and other stakeholders resulting in their unwillingness to share / divulge essential information, Significantly financial penalties - and increasing post BA case	9/28/2015	11/18/2019	Governance / Clinical	DD&HI	**4**	**4**	16	**9**	MODERAT	Clinical Board assurance and co-ordinated mitigation of risk being developed via quality and safety meetings. Ownership and community of practice anticipated to develop across IAOs/IAAs from this. GDPR awareness being used to ensure Leaders and asset owners are reminded of existing requirements and mandatory nature of the asset register. Options for enabling messaging in compliance with legislation has been considered by clinical and executives on a number of occasions, and UHB close to agreement.	Restructuring of IG department will increase amount of expert resource. Resolution of long term absence will also increase available expertise and resource to support GDPR plan, and manage the operational requirements on the corporate department. Ongoing implementation of GDPR/ICO action plan. **Information Governance Team are implementing the GDPR / ICO action plan.**	Digital & Health Intelligence Committee established to oversee progress Standards for Health Services: Information management and communications technology	D&HI
Recording information accurately and reliably	Data quality	High level risk - core business activities potentially compromised as a result of weaknesses in assurance framework in areas listed below: Absence of Standard Operating Procedures to administer patient activity, Low take up of staff training in Standard Operating Procedures to administer patient activity, Incorrect/incomplete/late recording of activity Absence of ISO 27001 certification. **Consequences:** Potential for poorer patient outcomes and experience, analysis and benchmarking flawed resulting in poor decision making, under recovery of income, inability to maximise potential of R&D	2/19/2018	11/18/2019	Governance	DD&HI	**4**	**4**	16	**8**	MODERAT	Further re-invigoration of the role out of COM2 will increase clinically validated data. Updates and training programme scheduled for mental health and our partners in order to address issues identified in recording and reporting compliance with parts 2 and 3 of the mental health measures. New dashboard release will expose greater amount of data to users, in a more user friendly way, enabling validation by relevant clinicians. Data quality group has established a work plan to improve quality and completeness of data and how it is presented.	**Data Quality Group needs to be refocused. COM2 continues to be rolled out.**	Digital & Health Intelligence Committee established to oversee progress Standards for Health Services: Information management and communications technology	D&HI
Effective governance, leadership and accountability	Governance framework (IG policies and procedures)	Risk: IG policies and procedures are not up to date/do not cover all relevant areas. Procedures are not aligned to relevant national policies. Consequence: Lack of clarity in terms of how the UHB expects its staff to work to in order for relevant accountabilities to be discharged.	2/16/2018	11/18/2019	Governance	SIRO/DD&HI	4	4	16	6	MODERAT	Update: Controlled document framework requirements delayed due to resource constraints - Integrated IG policy to be considered at DHIC for approval.	Restructuring of IG department will increase amount of expert resource. Resolution of long term absence will also increase available expertise and resource to support the review of policies. **A formal review of policies and procedures is underway.**	Digital & Health Intelligence Committee established to oversee progress Standards for Health Services: Information management and communications technology	D&HI
6.8.1 A2/0004	Insufficient Resource - Capital and Revenue	The delivery of the IM&T Strategic Work plan is based on the UHB being able to ensure that the IM&T Department is appropriately resourced to manage infrastructure and deliver projects. All bench marking information indicates that the UHB is significantly under resourced in this area. **Consequence:** Inability to support operational and strategic delivery at pace required, reliance on outsourcing at enhanced cost, non compliance with legislation (FOI / GDPR)	12/13/2013	11/18/2019	Capital / HR / Service Interruptions	DD&HI	5	3	15	10	MODERATE	The UHB continues to address priority areas in relation to its infrastructure management and strategic programme. However Service and financial plan to deliver 12.6% reduction in department's expenditure, now fully implemented	To access the £125m digital transformation fund there is a requirement to work more collaboratively with other organisations and to share tools etc. It is also essential that we support the move to a standards-based modular open architecture. It is imperative that the UHB stick to these design requirements if we are to maximise our chances of receiving funding and retaining control of our decision making authority in the digital space. **C&V digital funding allocation have been received and enables CAV to implement infrastructure investments aligned to longer term plans**	Digital & Health Intelligence Committee established to oversee progress Standards for Health Services: Information management and communications technology	D&HI
Effective governance, leadership and accountability	NWIS Governance	Governance arrangements for overseeing and challenging NWIS are weak. There is insufficient transparency, blurred lines of accountability and they lack a clear set of priorities **Consequences:** The significant resource we provide to NWIS is not optimally used to support the UHB in delivering its statutory obligations nor in supporting us to deliver our strategic objectives as identified in "Shaping Our Future Wellbeing"	2/2/2018	11/18/2019	Governance	DD&HI/ DOTH	**3**	**5**	15	**1**	Low	UHB is engaged with WG and NHS peers to take forward the recommendations of the WAO review of NWIS with a view to addressing the numerous risks identified in the report.	**CAV involvement in National programme activities and Governance review will enable joint approach to mananging the work programme.**	Digital & Health Intelligence Committee established to oversee progress Standards for Health Services: Information management and communications technology	D&HI
Sharing information appropriately and lawfully	Data availability	**Risk:** Accessibility of data: UHB does not have an ability to access and use the data it requires to carry out its full range of statutory obligations and enable delivery of our strategy and IMTP. . Specific risks - lack of access to GP data and the UHB's data residing in NWIS supplied applications (e.g. WCRS, WRRS) **Consequence** - Inability to deliver strategic UHBs, namely - Supporting people in choosing healthy behaviours, - Encouraging self management of conditions, - Enabling people to maintain or recover their health in or as close to home as possible, - Creating value by enabling the achievement of outcomes and experience that matter to people at appropriate cost, - Enable and accelerate the adoption of evidence based practice, standardising as appropriate	9/28/2015	11/18/2019	Clinical / Service / Business Interruption	DD&HI	**3**	**5**	15	**1**	Low	Approach identified to work with C&V GPs to share data across care sectors to inform improvement and to gain a better understanding of need, demand and the capacity available to meet it. National data repository programme will provide access to tools and expertise	National Architectural design group and interoperability group being set up in line with Once for Wales agreement and WG Informatics statement of intent should provide medium term solution. HB taking forward data acquisition programme in line with the development of the electronic care record. IPAD advised WRRS interface available from 1st April 2018	Digital & Health Intelligence Committee established to oversee progress Standards for Health Services: Information management and communications technology	D&HI

Objective	Risk Title	Principal Risks	Opened Date	Review Date	Risk Type	Exec lead for the corporate objective	Corp assessment of Impact	Corp assessment of Likelihood	Total	Risk Score (Target)	Risk Level (Target)	Mitigation Action	Further action agreed	Source of control	Lead Committee
6.8.2 A3/0104	End of Life Infrastructure (access devices)	Each year a number of access devices (PC's , laptops, netbooks etc.) fall in to the category of being end of life. The Health Board's clinical and business needs requires continued and expanding use access devices. This infrastructure has a maximum lifespan of typically 5 years and then requires replacement.	12/13/2013	11/18/2019	Service Interruptions	DD&HI	3	4	12	10	MODERATE	There is an impact to Business and Clinical Systems because of the age of the hardware and clinical/business application software - replacement relates to the availability of resources and departmental agreement/priorities.	The UHB recognises that it is necessary to ensure appropriate capital and revenue funding is made available to address this risk on an ongoing basis as outlined on the UHB corporate Risk Register. Over recent years significant progress has been made with capital investment. This progress will need to be maintained on an ongoing basis in capital and revenue investment. To maintain this risk at these improved levels of investment £2.1m was required in 2018/19 however only £500K discretionary capital was allocated supplemented by a further £770K Welsh Government allocation. Whilst only a further £500K discretionary capital has been allocated so far for 2019/20 the UHB is actively engaged with Welsh Government in undertaking a review of National Infrastructure requirements as part of the plans to significantly increase Digital investment in Wales.	Digital & Health Intelligence Committee established to oversee progress Standards for Health Services: Information management and communications technology	D&HI
Recording information accurately and reliably	Clinical Records Incomplete	**Risk:** Clinical records are not joined up across disciplines, care settings or geographical boundaries resulting in incomplete and out of date patient information. Summary information is not routinely shared across systems. Differing local service models which are also going through a period of significant change mean access to appropriate data is an increasing need. **Consequence** is unsupported clinical decision-making, introducing patient harm and/or disadvantage and failure to meet NHS Wales digital strategy	9/28/2015	11/18/2019	Clinical	MD	3	4	12	6	MODERAT	UHB architectural design to be reviewed to consider local data repository for bringing together in a usable way clinical information held in numerous clinical systems. UHB working through a programme to implement once for Wales requirements for data and technical interoperability standards.	**NDR / CDR programme is being developed**	Digital & Health Intelligence Committee established to oversee progress Standards for Health Services: Information management and communications technology	D&HI
Using information effectively and ethically	Outcome Measures	**Risk**: Unavailability of full, consistent care delivery information results in an inability to ascertain outcomes of care we provide, and commission, plan and improve services accordingly. **Consequence -** Low assurance on safety, quality and effectiveness of services and satisfaction with services, sub optimal decision making, inability to execute policy and strategy, reputational damage.	9/28/2015	11/18/2019	Business and Organisational Strategy	DD&HI	3	4	12	4	MODERAT	Analysis and wider engagement and communication of outcome and audit data, triangulated with efficiencies and effectiveness data as part of Medical Director led programme established. UHB and national investment in data repositories and clinical forms will support programme	Acceleration of programme - **NDR / CDR programme is being developed**	Digital & Health Intelligence Committee established to oversee progress Standards for Health Services: Information management and communications technology	D&HI
Effective governance, leadership and accountability	Effective resource utilisation	With an increasingly restricted resource, the UHB requires assurance that digital effort is expended in the most benefits laden workload. Benefits based prioritisation requires robust and matured benefits tracking and a matured reprioritisation mechanism. This requires some changes of technique within the Digital department.	10/1/2018	11/18/2019	Governance	DD&HI	3	4	12	**4**	MODERAT	Establishment of a formalised corporate prioritisation mechanism based on benefits and corporate drivers for change.	New digital directorate's operating model (being implemented in Sept/Oct 2019) will require a change in governance and priority setting across the digital arena at the UHB. A proposed digital design group will be established to set direction and priorities for the Digital and Health Intelligence functions. **Terms of Reference agreed at HSMB October 2019**	Digital & Health Intelligence Committee established to oversee progress Standards for Health Services: Information management and communications technology	D&HI
Using information effectively and ethically	Use of UHB standard data processing contract now incorporated within procurement's standard toolkit and deployed for all relevant procurements	Risk: obligations and accountabilities relating to the way data is handled are not formalised Consequence: the UHB could suffer detriment and/or have difficulties applying remedies against a third party if data is not handled appropriately	2/16/2018	11/18/2019	Governance	SIRO/DD&HI	**3**	**3**	**9**	7	MODERAT	Library of outline documents for sharing data available, with completion of these supported by corporate information governance department. Requirements to use and refer to are being emphasised within the training.	**Procurement Department continues to send out data processing contracts to suppliers where the contract involves the processing of personal data.**	Digital & Health Intelligence Committee established to oversee progress Standards for Health Services: Information management and communications technology	D&HI
6.8.13 A4/0025	WCCIS local teams not resourced	Risk: The delivery and implementation of a single instance of national Mental Health, Community and Therapies System (WCCIS) requires significant local resource to co-ordinate work streams and implement key deliverables across the UHB. Consequence: Delayed milestones, poor quality deliverables and ultimately delayed realisation of benefits. Critical deliverables are being held up, including: local business case; delivery of full functionality against the Statement of Requirements; delivery of essential product enhancements; infrastructure, system configuration, service management, ongoing support, integration with other national systems, testing, data migration.	2018	11/18/2019	Business and Organisational Strategy	DOI	4	2	8	1	MODERATE	Update 18/11/2019: Temporary posts have been funded from regional ICF monies, including 2 Business Analyst posts, regional technical , programme and project lead resources. Implementation in the UHB remains dependent on delivery of extensive functional enhancements, for which there is currently no delivery roadmap.	UHB is working with NWIS, WG and Regional IHSCP on review of WCCIS deliverables including health functionality, information standards, data migration and reviewed commercial arrangements. **ICF funding has been confirmed for 2019/20 and 2020/21 based on assessment of WCCIS impact for integrated Vale of Glamorgan teams and for paper-based therapeutics teams in the UHB.**	Digital & Health Intelligence Committee established to oversee progress Standards for Health Services: Information management and communications technology	D&HI

Report Title:	**IMT Audit Assurance**						
Meeting:	**Digital and Health Intelligence Committee**				**Meeting Date:**	**3rd December 2019**	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**	**x**
Lead Executive:	**Director of Digital and Health Intelligence**						
Report Author (Title):	**Assistant Director of IT**						

SITUATION

The IMT Audit Assurance report provides the DH&I Committee with updates on the various Digital related audits undertaken by the internal auditors.

BACKGROUND

Audits undertaken in 2018 /19 are the following:

Cyber security - Audit complete with outstanding actions

E- Advice - Audit complete with all actions complete

E- IT Training - Audit complete with all actions complete

ASSESSMENT

A brief update on progress against recommendations is shown below the full report is attached:

Audit	Progress	Notes
e- IT training	August Report: The audit has provided x 7 findings 2 of which are medium and the rest all low.	All actions are now complete November 2019
e-Advice	August Report : Finding 1 – Ongoing. (Complete September 2019) Benefits Analysis is underway. Due to complete by 31st August 2019. Finding 2 – Ongoing (Complete September 2019) We can confirm that work to document processes for testing, requesting changes and implementation is on schedule. Finding 3 – Complete. Leavers (Operating effectiveness) We can confirm that automatic closure of e-Advice accounts after 90 days inactivity is now live. Finding 4 – Complete 2 Actions have been completed with a further two – findings1 & 2 expected to be complete by September 2019	All actions are now complete November 2019
Cyber Security	No actions complete as yet due to the following Welsh Government are reviewing the £25:£25M Capital & Revenue funding offer which will include funding for Cyber security staff. It is anticipated that the outcome of this review will report in the Autumn in the meantime the UHB continues to address highest Cyber security risk on a prioritised basis within existing resources.	In anticipation of receiving WG funding, resources are being recruited to in November 2019.
Virtualisation	3 actions outstanding: The UHB has recently agreed and started the recruitment process to fill one of the existing vacancies within the Server Team with a view to increasing the pool of resources. Currently at the very early stages of preparing documentation. It will not be possible to upskill existing staff due to the demand on their time in undertaking other tasks. Once the vacancy (above) is filled this may enable opportunities for upskilling. Further actions to be complete by March 2019 - Continue to monitor progress	Actions being addressed by the departmental restructure process which is ongoing and recruitment process will begin November 2019
Maternity	1 action still open - Development now agreed with supplier with no cost to the service. Awaiting confirmation of timescales	Continue to monitor progress – Jan 19 Service chasing supplier for date

ASSURANCE is provided by: Regular reviews of recommendations within the Digital & Health Intelligence senior management meetings.

RECOMMENDATION

The Board is asked to:

- NOTE progress and updates to the IMT Audit Assurance report.

Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	x
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention		Long term		Integration	x	Collaboration		Involvement	

Equality and Health Impact Assessment Completed:	Yes / No / Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

Cardiff and Vale University Health Board Audit Assurance Review Plan

Internal Audit Plan 2018/19

Planned output	Audit Ref	Corporate Risk Register	Outline Scope	Indicative Audit days	Executive Lead	Outline timing
IM&T						
Cyber Security			Audit Complete and attached		Director Digital & Health Intelligence	
E- Advice			Audit Complete and attached		Director Digital & Health Intelligence	**All Actions Complete**
E – IT Training			Audit Complete and attached		Director Digital & Health Intelligence	**All Actions Complete**

Internal Audit Plan 2017/18
April 2017 NHS Wales Shared Services Partnership Audit and Assurance Services

Planned output	Audit Ref	Corporate Risk Register	Outline Scope	Indicative Audit days	Executive Lead	Outline timing
IM&T						
Virtulisation			Review the security and resilience of the updated virtualised environment.	15 days	Director of Therapies	Q3

Contents

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	2 Actions have been completed with a further two – findings1 & 2 expected to be complete by September 2019	
Cyber Security	No actions complete as yet due to the following Welsh Government are reviewing the £25:£25M Capital & Revenue funding offer which will include funding for Cyber security staff. It is anticipated that the outcome of this review will report in the Autumn in the meantime the UHB continues to address highest Cyber security risk on a prioritised basis within existing resources.	In anticipation of receiving WG funding, resources are being recruited to in November 2019.
Virtualisation	3 actions outstanding: The UHB has recently agreed and started the recruitment process to fill one of the existing vacancies within the Server Team with a view to increasing the pool of resources. Currently at the very early stages of preparing documentation. It will not be possible to upskill existing staff due to the demand on their time in undertaking other tasks. Once the vacancy (above) is filled this may enable opportunities for upskilling. Further actions to be complete by March 2019 - Continue to monitor progress	Actions being addressed by the departmental restructure process which is ongoing and recruitment process will begin November 2019
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e-IT Training Audit Report April 2019

Risk & Recommendation	Priority	Management Response	Responsible Officer	Previously agreed actions	Current Status
Finding 1: Temporarily reduced training content (Operating effectiveness) Due to a lack in the availability of training staff at the end of 2018 and the beginning of 2019 a decision was made to temporarily reduce the course content for the Paris system to "Central Index and Referral" only. It was appreciated at the time that "this would diminish quality/comprehension, and place more onus on the service support delivered to new staff/users by managers/peers post classroom training". The actual negative impact on services is not being evaluated, thus training quality may suffer to such an extent that it could result in the inadequate usage of the systems by poorly trained staff. **Risk** Users do not develop the knowledge to use the systems appropriately. **Recommendation**	Medium	The shorten classroom training delivery is augmented with on-line content, and has been assessed by the clinical board user leads as suitable to the training needs of staff. **Risk avoided**	Mark Cahalane	Service lead users (Co-Ordinators) to assess course content and assess suitability.	**Complete**

Risk & Recommendation	Priority	Management Response	Responsible Officer	Previously agreed actions	Current Status
As assessment of the impact of these measures should be carried out and procedures developed for actions in similar circumstances in the future.					
Finding 2: Learning package update (Operating effectiveness) The Paris training system was not updated to the latest version which resulted in the relevant learning package being out of sync with the current version of the Paris system. Attendants are therefore learning an older version of the system and not the one that is currently implemented. Thus the training being delivered is not appropriate and without proper controls and agreed procedures this could affect the quality of training resulting in the inadequate use of the system. **Risk** Users do not develop the knowledge to use the systems appropriately **Recommendation** Relevant policies and procedures should be put in place to set out the circumstances under which this kind of drift can be allowed (if at all), any	Medium	There is some misunderstanding here As each version release of PARIS is also updated onto the PARIS training system. System patches (within versions) are assessed for training content and the training system upgraded to that patch if training content is impacted. A second training/support environment (the REP environment) exists to assure a training support environment that is an exact replica of LIVE (indeed a copy of yesterday's LIVE including data) to aide specific or bespoke issue training. **Risk Misunderstood**	Mark Cahalane		**Complete**

Risk & Recommendation	Priority	Management Response	Responsible Officer	Previously agreed actions	Current Status
mitigation measures, how many versions the training system can be allowed to be behind and any other provisions to ensure adequate quality levels of training are preserved.					
Finding 3: Pre-assessment for learning difficulties (Design) It was noted from review of customer feedback given by a member of staff at the end of a training session that comments had been made in respect of the difficulties in completing the training as follows: "my dyslexia causes me issues" and "… my dyslexia impacts on my learning". There is no pre-assessment in place to determine if any training attendants have learning difficulties. The means that attendants with learning difficulties are disadvantaged in the class room and therefore the training is not effective and they may not be able to use the systems properly. **Risk** Users do not develop the knowledge to use the systems appropriately	Low	Agree a process for ensuring any LD is captured. Develop the Training Booking system to include a mandatory Learning Difficulties field within the user profile screen. The LD will automatically display against the user when booking them in for training sessions. Initially the LD field will default to NONE however the IT Trainers are to check/update the LD field when requests for training received.	Pam Andrews/Amin Rahman/IT Trainers	Training Booking system has been developed to include a mandatory Learning Difficulties field within the user profile screen. The LD will automatically display against the user when booking them in for training sessions. Initially the LD field will default to NONE however the IT Trainers are to check/update the LD field when requests for training received.	**Complete**

Risk & Recommendation	Priority	Management Response	Responsible Officer	Previously agreed actions	Current Status
Recommendation To introduce a relevant pre-assessment process and procedures to ensure that staff with learning difficulties are able to learn the systems to the required level					
Finding 4: Document control (Operating effectiveness) The training material contains document control information including version, sign off and reason for update. It was noted that version information was inconsistent and some fields were left blank (sign off and user acceptance fields). This may result in the wrong version of training material being used in training sessions. **Risk** Users do not develop the knowledge to use the systems appropriately. **Recommendation** Document control information to be standardised and completed in full on training documents	Low	Training documents are currently version controlled but not standardised. Standardising them would be a very low priority within the current resource.	Pam Andrews/Matt Pryor		**Complete**
Finding 5: Sign off (Operating effectiveness) Learning packages are reviewed before they are commissioned and a	Low	A review and sign off procedure for the Welsh Clinical Portal involving the service coordinators who represent the training customers (attendants) will be considered	Jo Brooks/Bill McClernon/Peter Noneley	Ongoing – will be agreed at next user group meeting	**Complete**

Risk & Recommendation	Priority	Management Response	Responsible Officer	Previously agreed actions	Current Status
consultative process is in place which includes trainers and managers. The PMS and Paris systems also includes a review and sign off procedure involving the service coordinators who represent the training customers (attendants). However, a sign off of training packages by service customers is not carried out for Welsh Clinical Portal training, instead user feedback is used to identify issues. Issues that can be identified and corrected before the training is delivered are therefore only addressed after staff have been trained. **Risk** Users do not develop the knowledge to use the system appropriately. **Recommendation** A sign off process should be introduced involving training customers for the Welsh Clinical Portal		and discussed with the WCP trainer on return to work from Work Life Balance absence. This could take the form of a WCP 'super user' group who review and comment on new versions of the training package before they are made available for general use.			
Finding 6: Learning impact assessment (Operating effectiveness)	Low	An impact assessment process is in draft but has been suspended due to the Work Life Balance absence of the WCP trainer. This and the regular review of feedback	Jo Brooks/Bill McClernon/Peter Noneley		**Complete – e-learning software has been modified**

Risk & Recommendation	Priority	Management Response	Responsible Officer	Previously agreed actions	Current Status
Training attendants' feedback is collected at the end of the session. There is no impact assessment process in place to evaluate the training attendants' opinions once they have had a chance to use their acquired knowledge in the work environment. In addition the mailbox containing feedback emails from attendants in relation to onscreen WCP and PMS training has not been reviewed from July 2018. Constructive comments provided by attendants are not reviewed and training quality is not improved due to a lack of feedback from those who have had the chance to test their knowledge in the work environment **Risk** Users do not develop the knowledge to use the systems appropriately **Recommendation** An impact assessment process should be introduced in order to gather and evaluate the feedback from training attendants after they have had the opportunity to use the relevant		emails will recommence once the trainer has returned to post.			**to accommodate this feature**

Risk & Recommendation	Priority	Management Response	Responsible Officer	Previously agreed actions	Current Status
systems. The feedback emails should be reviewed on a regular basis.					
Finding 7: Post learning support (Operating effectiveness) Post learning support information is restricted to helpdesk contact information and attendants are not informed as to who the IT champions and service co-ordinators are that they could contact with any queries once they are actually using the systems. Attendants are therefore not aware of the full range of help and support that is available. Some staff queries may go unanswered. In addition there is lack of a standard programme of refresher sessions, with service co-ordinators noting that these would be of use. **Risk** Users do not develop the knowledge to use the systems appropriately. **Recommendation** The training material should be updated to include a range of options for post learning support other than just helpdesk contact information.	Low	Training materials include contact information for the "IT User Support" team which is managed by the IT Trainers and Implementation Officer. Both e-mail and telephone contact details are included. Users are able to contact for advice, refresh and support to meet their requirements. If e-learning material is available the link to the learning is also included. Refresh sessions have previously been included into a rolling schedule however take up from end users (and support from managers to ensure attendance) was so poor that it was deemed a waste of the limited resource within the training team. Refresh sessions can be (and are) delivered on request by the service customers.	Pam Andrews/IT Trainers		**Complete**

Risk & Recommendation	Priority	Management Response	Responsible Officer	Previously agreed actions	Current Status
The need for refresher sessions should be reviewed in conjunction with service customers					

e-Advice Project Audit Report April 2019

Risk & Recommendation	Priority	Management Response	Responsible Officer	Previously agreed actions	Current Status
Finding 1 – Defined Benefits (Operating effectiveness) **Finding** An evaluation report summary and evaluation criteria produced by GE Healthcare before their contract ended was produced, however this was at an early stage and there has been no full assessment of the benefits of the project. The original stated benefits were given as: • Improved dialogue between primary and secondary care • Reduction in OP referrals by specialty • Reduction in New OP appointments by specialty • Improved patient experience • Improved education for Primary Care The e-Advice system is currently managed and supported primarily by two members of IM&T staff on a "best endeavours" basis, without any additional formal/ dedicated resource. Given the expanding use of the system, the UHB does not fully know whether the benefits deriving from the	Medium	With the resource available an exercise will be carried out to review and quantify the original key benefit identified in the project outline document 'a minimum of 10% avoidance of attendance in Outpatients is likely to be achieved by GPs implementing an e-advice service'. A wider benefits review will be carried out if additional resource is made available. Our service users recognise the benefits that e-Advice brings.	Jo Brooks/Victoria Davies-Frayne	A report on the benefits realisation of the key benefits has been produced and signed off.	**Complete**

Risk & Recommendation	Priority	Management Response	Responsible Officer	Previously agreed actions	Current Status
system warrant the resource, or an increased resource. **Risk** Impact to services due to insufficient resources. **Recommendation** Management should undertake an exercise to review and quantify benefits from the ongoing use of the e-Advice system to ensure benefits are maximised and the system is sufficiently supported and resourced.					
Finding 2 – Testing Processes (Operating effectiveness) **Finding** There is a lack of control of changes and testing. Due to the limited resources in place, changes to the system and testing of required changes is performed on a "best endeavours" basis. This means there is not always significant amount of documented evidence retained in relation to each change. Although a log of changes is maintained and priorities are assigned, this is done according to staff's assessment of the impact/ severity of the change, rather than following any documented criteria.	Medium	There are processes in place to manage testing, approvals, roll back and assigning a severity to changes which allow for a quick response. It is recognised that these processes have lacked some formality due to the resource available. However work has already started on formal documentation to support ease of handover to other members of the department if this became necessary.	Jo Brooks/Victoria Davies-Frayne	Work to formally document processes has been completed and is due to be signed off by the team in August 2019.	**Complete**

Risk & Recommendation	Priority	Management Response	Responsible Officer	Previously agreed actions	Current Status
Changes are typically identified through discussion with users and/or internal email request, followed by an exercise of determining requirements. Once initial development is complete, an updated version of e-Advice is released to the test environment. The requestor/s are then invited to test the change and respond with any issues. From this point a go-live date is agreed. However these stages are not always evidenced **Risk** Uncontrolled changes impacting the availability of the system. **Recommendation** Management should document the approach to testing and implementing changes. This should include documentation of requirements around change categorisation, the extent of testing required, the approval process, the approach to rolling back changes, and criteria to be used when assigning a severity to changes.					
Finding 3 – Leavers (Operating effectiveness) **Finding** e-Advice administration staff are currently dependent on local	Medium	A report to identify account inactivity of 90 days will auto-run daily following which inactive accounts will be closed. Accounts can be reactivated on request.	Head of Department	The report will be available to auto-run daily from 1st July 2019.	**Action Complete**

Risk & Recommendation	Priority	Management Response	Responsible Officer	Previously agreed actions	Current Status
managers/ HR notifying them when a user/ staff member leaves in order that their e-Advice account is disabled, meaning it is possible for leaver accounts to remain active when this doesn't happen. This risk is mitigated to some extent by the fact that an active directory/ network account is also required to access the system, and a process is in place to ensure active directory accounts are disabled after being inactive for 90 days. **Risk** Leaver accounts may remain active/ open to possible misuse. **Recommendation** A regular, at least annual, exercise should be undertaken to confirm the validity of user accounts and ensure any leavers accounts are identified and disabled.					
Finding 4 – Superusers (Operating effectiveness) **Finding** User support for the system is currently primarily handled by two members of IM&T staff. There are no department based super users in place to deal with	Low	The team are looking at ways to relieve the administration workload on them. A service announcement will be sent out to all the super users reminding them of the actions that they can carry out e.g. authorising of accounts, closing accounts. New users are no able to self-register. Super users will be	Head of Department	A service announcement will be sent out by the end of June 2019. Updated announcements will be published as required.	**Action Complete**

Risk & Recommendation	Priority	Management Response	Responsible Officer	Previously agreed actions	Current Status
queries and act as a first point of contact. As the use of the system expands this level of resource within IM&T may not be able to cope. **Risk** Increased workload due to support queries/ impact to systems and services. **Recommendation** Management should consider the use of local e-Advice super users.		encouraged to take an increased role in user acceptance testing.		Other proposed actions will be ongoing.	

Cyber Security Audit Report May 2019

Risk & Recommendation	Priority	Management Response	Responsible Officer	Previously agreed actions	Current Status
Finding 1 – Resource and Actions (Operating effectiveness) **Finding** The Stratia report identified the need for investment in cyber security staff in order to improve the UHBs position. However this has not been provided and the majority of the actions defined within the Stratia report have not been completed with the main reason for the lack of action being a lack of resource within IM&T. This has been exacerbated by key staff having left, which has led to the organisation struggling to meet the day to day demands with little scope for improvements. This leads to an increased risk of vulnerabilities existing and being exploited within the organisation. **Risk** Poor or non-existent stewardship in relation to cyber-security. **Recommendation** A review of the resources available within IM&T and the requirements of	High	A review of the current IT and Information departments has been completed and a restructure proposal created. This includes additional cyber security resources to manage and deliver the NESSUS and SIEM requirements, utilising the additional funding being made available by Welsh Government.	David Thomas Deadline Sept 2019		Welsh Government are reviewing the £25:£25M Capital & Revenue funding offer which will include funding for Cyber security staff. It is anticipated that the outcome of this review will report in the Autumn in the meantime the UHB continues to address highest Cyber security risk on a prioritised basis within existing resources.

Risk & Recommendation	Priority	Management Response	Responsible Officer	Previously agreed actions	Current Status
the organisation should be undertaken to ensure that the department can appropriately meet the demands. Additional investment should be considered in order to provide a cyber security function.					
Finding 2 – Management Process (design) **Finding** Due to the lack of a cyber security lead, cyber security is dealt with in a reactive and ad hoc manner without any structure as there is no formal / operational cyber security group and currently no reporting process for cyber security or KPI reporting on this. This means that the UHB is not fully sighted on its cyber security position. **Risk** Poor or non-existent stewardship in relation to cyber-security. **Recommendation** An active monitoring process which feeds into KPI reporting should be developed and maintained within IM&T.	High	The restructure of the directorate includes additional resource to manage cyber security issues. A key role for this function will be the development of a monitoring system that supports the KPI reporting against cyber security.	David Thomas Deadline Sept 2019		In anticipation of receiving WG funding, resources are being recruited to in November 2019. In the meantime, monitoring process has been developed with the technical IT team.
Finding 3 – Lead Role (Operating effectiveness) **Finding** There is no current operational lead for cyber security and no structured	High	The restructure of the IT and information functions being proposed will result in the establishment of cyber security roles which will monitor and respond to cyber incidents and will develop policy,	David Thomas Deadline Sept 2019		In anticipation of receiving WG funding, resources are being recruited

Risk & Recommendation	Priority	Management Response	Responsible Officer	Previously agreed actions	Current Status
programme to improve the UHBs position with respect to cyber security. Without this role being extant and operational the UHB will not be able to fully reduce its cyber security risks. **Risk** Poor or non-existent stewardship in relation to cyber-security. **Recommendation** Resources should be provided to allow for a cyber security role to be properly defined and operating appropriately.		processes and procedures to reduce the likelihood of a cyber security incident.			to in November 2019. This includes a Head of Cyber Security position
Finding 4 – Active Monitoring (Operating effectiveness) **Finding** Although the Health Board has security tools in place, due to a lack of resource it has not maximised the benefits of these with Nessus (a vulnerability scanner) not being used. In addition, the organisation does not have the ability to efficiently deal with a cyber incident as it has not yet enacted the national Security Incident and Event Management (SIEM) product, and there is no incident response plan in place. As such the organisation is not fully able to quantify and fix its vulnerabilities, and would find it	**High**	The creation of new cyber security roles in the restructured directorate will mean that a proactive stance on monitoring of cyber security is created as part of a wider Cyber response plan, which will also incorporate use of the NESSUS and SIEM solutions.	David Thomas Sept 2019		In anticipation of receiving WG funding, resources are being recruited to in November 2019. Alternative arrangements are being explored whereby the function be commissioned via a managed service contract.

Risk & Recommendation	Priority	Management Response	Responsible Officer	Previously agreed actions	Current Status
difficult to identify and deal with a malicious actor gaining access to the network. **Risk** Risk of loss of IT services as a result of attack from entities external to the organisation, exploiting common vulnerabilities. **Recommendation** Active monitoring should be established. A Cyber response plan should be developed.					
Finding 5 – Old software (Operating effectiveness) **Finding** The organisation continues to use a number of devices running old software (operating system, servers, databases), and is also using old hardware such as switches. Although these are known to IM&T, there is no formal, resourced plan to remove all of these. Until these are updated / removed the organisation will be at increased risk of a cyber attack, or a that a cyber attack becomes more widespread within the UHB as older devices contain security vulnerabilities and no longer have manufacturer support.	Medium	A formal plan is in the early stages of production and will address removal of aged and insecure software as well as devices. This will be implemented by the cyber security team proposed in the new directorate structure.	David Thomas Deadline Sept 2019		In anticipation of receiving WG funding, resources are being recruited to in November 2019. An outline plan to manage old structure has been developed but not yet implemented

Risk & Recommendation	Priority	Management Response	Responsible Officer	Previously agreed actions	Current Status
Risk Risk of loss of IT services as a result of attack from entities external to the organisation, exploiting common vulnerabilities. **Recommendation** A formal, resourced plan for the removal of old software and devices should be established.					
Finding 6 – Patching (Operating effectiveness) **Finding** There are weaknesses within the patching regimen for the organisation: • for desktops, although patching is automatic, there are some where this process is not working and so the pc is not getting the patch; • for servers, patching is manual, with the timing of patching varying dependant on the nature of the server. Some can be patched and restarted, however some that are running clinical systems cannot be taken down, and are therefore patched opportunistically. However	Medium	Patching of PCs is being investigated as time allows to identify the scale of the risk. A patch management procedure will be developed to address matching of all devices. This procedure will describe how patches and updates will be managed, with reference to the national standards and alerts managed through NWIS.	David Thomas Deadline Sept 2019		A deployment programme is underway and patching/ updates are included as part of this programme

Risk & Recommendation	Priority	Management Response	Responsible Officer	Previously agreed actions	Current Status
there is no formal patch plan / process that set this out; • for firmware / network hardware, this is also on an ad hoc basis without a formalised structure. Without a formal procedure that defines the patching mechanism for all items within the UHB, there is a risk that vital updates will be missed and the UHB will be exposed to unnecessary risk. **Risk** Risk of loss of IT services as a result of attack from entities external to the organisation, exploiting common vulnerabilities. **Recommendation** A formal patch management procedure should be developed that sets out the mechanisms for patching / updating all items within the Health Board.					
Finding 7 – Staff awareness (Operating effectiveness) **Finding** Although there is an Information Security Policy, together with other related policies, there is no structured mechanism for providing regular	Medium	The profile of cyber security will be raised via the creation of regular proactive bulletins, available to all staff via the intranet, which will remind staff of good practice.	David Thomas Deadline Sept 2019		In Progress - Communications in relation to Cyber will be ongoing and also form part of the Window 10 /

Risk & Recommendation	Priority	Management Response	Responsible Officer	Previously agreed actions	Current Status
updates / reminders to staff on good practice related to cyber security. Studies have shown that in general, employee actions / mistakes have led to approximately 50% of breaches. As such, this leads to an increased risk to the Health Board. **Risk** Poor or non-existent stewardship in relation to cyber-security. **Recommendation** Regular cyber security "bulletins" should be published via the intranet, with reminders of good practice.					office 365 deployments
Finding 8 – Security Policy (Operating effectiveness) **Finding** The IT Security Policy is out of date as it dates from 2015 with the next review date given as 31 march 2018. The policy still refers to the Data Protection Act 1998 and not the GDPR. **Risk** Poor or non-existent stewardship in relation to cyber-security. **Recommendation** The IT Security Policy should be reviewed and updated.	Medium	The current IT security policy is scheduled to be reviewed to reflect changes in legislation, IT architecture and national policy.	David Thomas Deadline Sept 2019		Currently in progress – will be complete in line with Window 10 deployment best practice

Virtualisation Audit Report December 2017

Risk & Recommendation	Priority	Management Response	Responsible Officer	Previously agreed actions	Current Status
R1 – Resilience **Finding** There are weaknesses regarding the resilience of the server team and the virtual environment. The team responsible for managing the virtual environment is very small, with knowledge concentrated in a limited number of staff. Although the wider IT team can provide support on an on-going basis the UHB is at risk should any significant event occur when the key staff members are absent. **Recommendation** *The UHB should consider widening the pool of staff with the skills to manage the virtual environment by:* *- recruitment; and* *- up skilling existing staff and providing protected time to develop the skills.*	**High**	The IT Department will review potential opportunities for recruitment and training and provide an update on potential for progress. ***October 2018 – update*** *The UHB has recently agreed and started the recruitment process to fill the existing vacancy within the Server Team with a view to increasing the pool of resources. Currently at the very early stages of preparing documentation.* *It will not be possible to upskill existing staff due to the demand on their time in undertaking other tasks. Once the vacancy (above) is filled this may enable opportunities for upskilling.*	Phil Clee / N Lewis 6 months	Due to be complete Sept 2018 New completion date March 2019 *(See management response update)*	Actions being addressed by the departmental restructure process which is ongoing and recruitment process will begin November 2019
R2 –Patching **Finding**	**Medium**	Agreed ***October 2018 – update***	Phil Clee / N Lewis 6months	Due to be complete Sept 2018	Actions being addressed by the departmental

Risk & Recommendation	Priority	Management Response	Responsible Officer	Previously agreed actions	Current Status
Although the ESXi hosts are currently patched and up to date, there is no formal SOP for patching these, and patching is done on an ad-hoc / infrequent basis. This is partly due to the small size of the team and the lack of a test environment which would allow for verification that the updates are safe / stable. This introduces the risk of a significant weakness being unpatched in the future **Recommendation** *A formal SOP should be developed setting out the basis for patching / updating ESXi hosts and the mechanism for doing this.* *Consideration should be given to providing a test environment.*		*The demand on existing resources prevents this approach being changed. Once the recruitment of new Server Team staff is completed the opportunity to formalise this approach will be reviewed.*		New completion date March 2019 *(See management response update)*	restructure process which is ongoing and recruitment process will begin November 2019
R3 – VM Creation **Finding** VMs are created from pre created template, however there is no SOP for this process. Given that there are only 2 people who create VMs this leaves the UHB at risk in the event of loss of staff, as any replacements couldn't easily pick up the role.	**Medium**	Agreed ***October 2018 – Update*** *The demand on existing resources prevents this approach being changed. Once the recruitment of new Server Team staff is completed the opportunity to formalise this approach will be reviewed.*	Phil Clee / N Lewis 6 months	Due to be complete Sept 2018 New completion date March 2019 *(See management response update)*	Actions being addressed by the departmental restructure process which is ongoing and recruitment process will

Risk & Recommendation	Priority	Management Response	Responsible Officer	Previously agreed actions	Current Status
Recommendation *A SOP for VM creation should be developed, setting out the process and the location of the templates.*					begin November 2019

Maternity Audit Report June 2015

Risk & Recommendation	Priority	Management Response	Responsible Officer	Previously agreed actions	Current Status
R2. Password reset A standard set of rules and questions should be put in place and completed before a password reset is granted to ensure appropriateness	MEDIUM	This function needs to go through Euroking for a system modification. We have no control over any upgrade dates. This will need to go through a major development with them so will take time and require approval from Euroking.	System Administrator Head of Operational Delivery	Still awaiting development from EuroKing Discussion underway with other HBs to support the development and split the costs for E3 development due to financial position. Previous Update: Meeting with Euroking in February 2018 to discuss progress but restricted due to Euroking system modification **Jan 2019** Due to be delivered next	**Partially Complete:** **July 2019** Awaiting confirmation of date from supplier for upgrade to the system – continue to monitor this action. Development now agreed with supplier with no cost to the service. Monitor progress of development & implementation.

Risk & Recommendation	Priority	Management Response	Responsible Officer	Previously agreed actions	Current Status
				financial year 2019. Jan 2019 Service awaiting confirmation from EuroKing to find out which upgrade it will be developed in.	

Report Title:	**GDPR Progress Report**								
Meeting:	**Digital and Health Intelligence Committee**						**Meeting Date:**	**3rd December 2019**	
Status:	**For Discussion**		**For Assurance**		**Y**	**For Approval**		**For Information**	
Lead Executive:	**Director of Digital and Health Intelligence**								
Report Author (Title):	**Information Governance Manager**								

See attached Appendix 1.

To streamline assurance arrangements, a combined ICO/GDPR action plan/Caldicott Guardian Report (CPiP) has previously been presented to DHIC. An action from the previous meeting has requested a summary of progress against the prioritised outstanding actions.

RECOMMENDATION

The Committee is asked to:

NOTE progress on the GDPR Progress report

Shaping our Future Wellbeing Strategic Objectives
This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	x
4. Offer services that deliver the population health our citizens are entitled to expect	x	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered
Please tick as relevant, click here for more information

Prevention		Long term		Integration		Collaboration		Involvement	

Equality and Health Impact Assessment Completed:	Yes / No / Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

Ref:	Recommendation	Action	Current Status/Completion Date
R1	Create or update relevant policies and procedures as soon as practicable ensuring accompanying or supporting documents are clearly referenced.	**Information Governance Policy** The UHB has adapted four national policies and consolidated these into a single overarching policy to enable a pragmatic approach to working. NHS Wales need to work through implications of Office 365 implementation regarding retention of emails. **Subject Access Request Procedure** The previous procedure has been updated and is now in line with GDPR. In line with recent ICO guidance, there is a requirement to reassess local working practices. **Freedom of Information Procedure** The previous procedure has now been updated.	**IG Policy:** Submitted to DHIC for consideration prior to formal ratification. 01.02.2020 (subject to ratification procedure) **Subject Access Request Procedure:** 01.02.2020 (subject to ratification procedure) **Freedom of Information Procedure:** 01.02.2020 (subject to ratification procedure)
R2	A reminder should be sent to all staff to ensure that all IG breaches are entered onto Datix immediately.	Requirements for IG reporting are clearly outlined in the UHB's draft IG policy. Requirements are clearly outlined in mandatory e-learning training. Requirements are being re-iterated through the quarterly	**Outlined in IG Policy:** 01.02.2020 (subject to ratification procedure) **Outlined in e-learning training:** Complete **Re-iterated through quarterly quality and safety committee meetings:** Ongoing

		quality and safety committee meetings.	
R3	All areas should be asked to complete an IAR or feed into an IAR. Further guidance should be issued over what information to collect and how to record it using the standard template.	The IG team has targeted the two areas highlighted in the internal audit. As a result, Dermatology now has an IAR and Internal Medicine has been issued guidance over what to include and how to record it on the standard template. Clinical Boards reminded of their responsibility to maintain all IARs on a 'live' basis.	Ongoing
R4	The UHB should seek to ensure all staff complete the IG training module.	The IG team has developed an Information Governance training presentation, which has been trialled in Cardiology and is available to other areas. This is intended for classroom-based delivery and is aimed at increasing compliance among clinical staff.	Ongoing
R5	The processes / guidance for staff dealing with transfers of information to non-EEA states is not complete. Staffs do not always understand the need for gaining explicit consent for this and thus may not do so.	Whilst explicit consent is not necessarily required, UHB staff should be aware that certain conditions must be met in order for transfers to be made outside of the EEA. This is explicitly covered in the UHB's draft IG Policy and supported by the UHB's Data Protection Impact Assessment.	Ongoing

Report Title:	**Clinical Coding – Performance Data**								
Meeting:	**Digital Health Intelligence Committee**						**Meeting Date:**	**3rd December 2019**	
Status:	**For Discussion**		**For Assurance**	**x**	**For Approval**		**For Information**		
Lead Executive:	**Director of Digital Health Intelligence**								
Report Author (Title):	**Information Governance Manager**								

SITUATION

This report considers the performance of the Clinical Coding Department. Clinical Coding performance is measured against Welsh Government targets in terms of its completeness and accuracy.

BACKGROUND

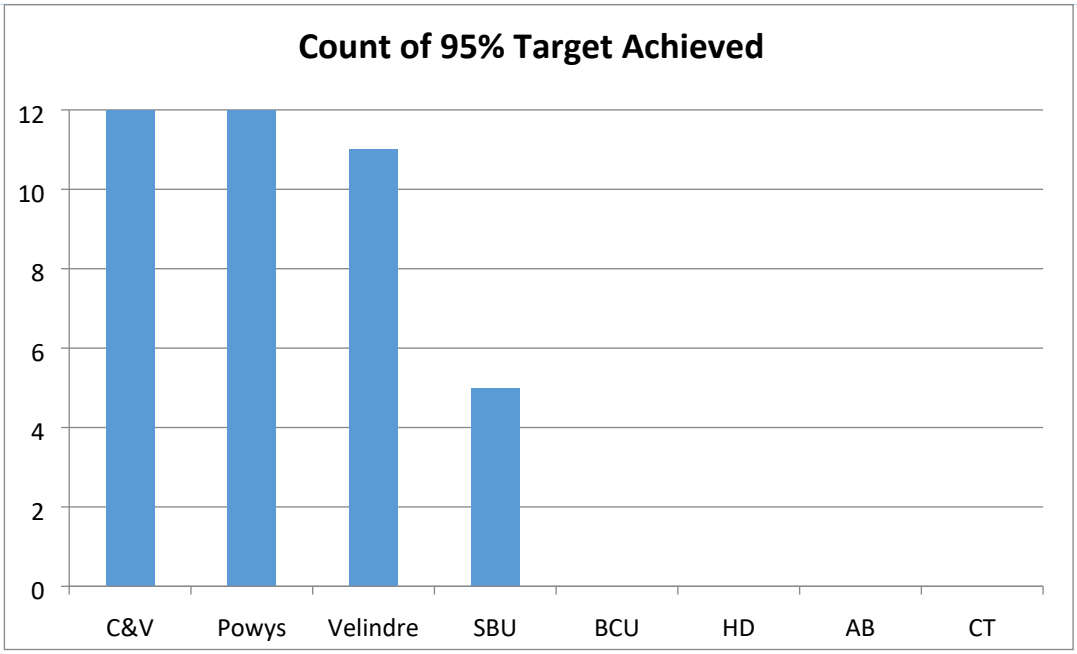
All secondary care organisations are mandated to translate medical terms used in the inpatient setting that describe a patient's complaint, problem, diagnosis, treatment into a sequence of alphanumerical codes standardised by national guidelines . This permits easy storage, retrieval and analysis of the data for the purpose of, for example, patient level costing, clinical research and audit, clinical benchmarking, case mix management, statistics.

All Clinical Coding Departments are mandated by Welsh Government to submit a minimum of 95% completeness within 30 days of discharge. Coding Departments are audited each year by NWIS and accuracy is based on a requirement for a year on year improvement. The UHB is required to code approximately 160,000 finished consultant episodes (FCEs) per annum.

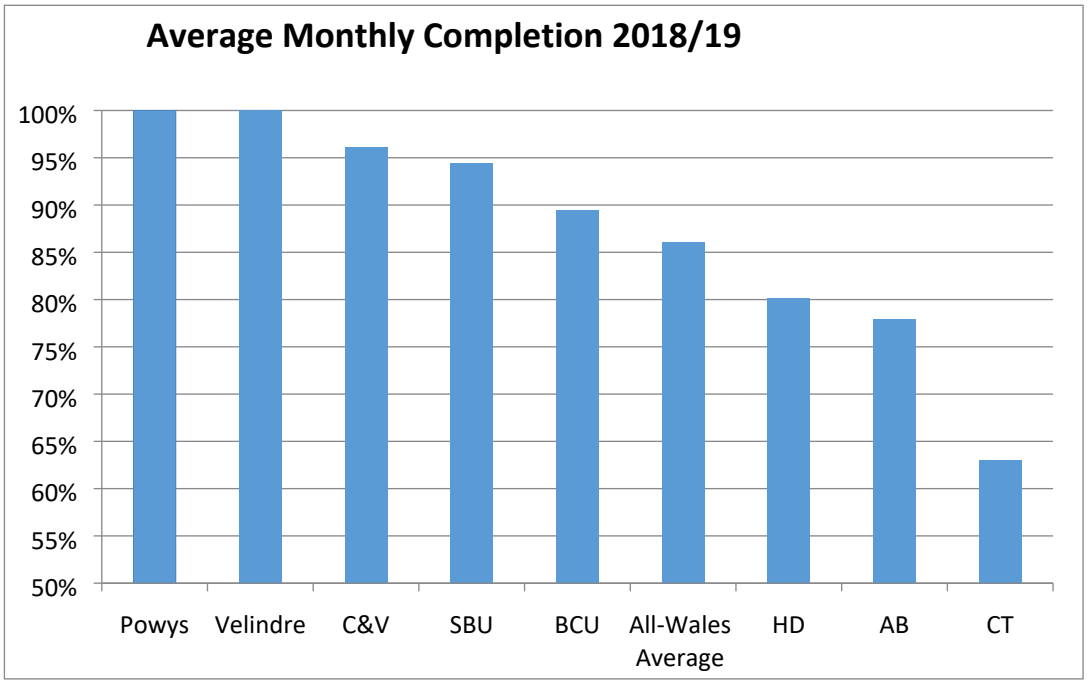
ASSESSMENT

1. Coding Completeness

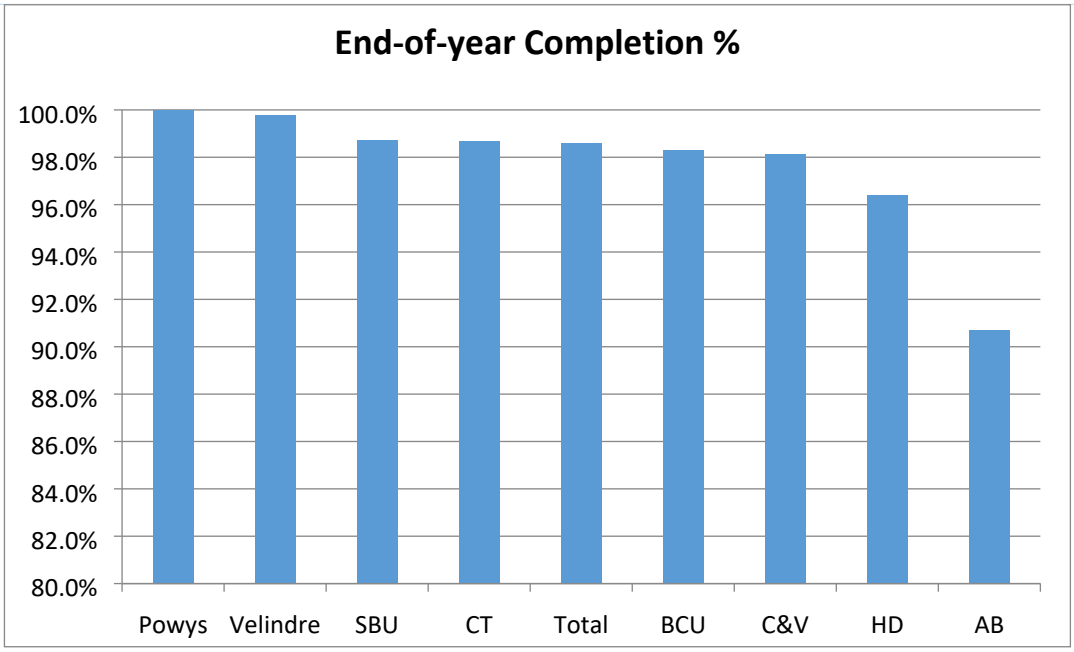
The below graph represents the number of months in which each NHS Wales organisation has achieved the required 95% coding completeness for the 2018/19 financial year.



The below graph represents the average monthly completion percentage for each NHS Wales organisation for the 2018/19 financial year.



The below graph represents the final completion % at the time of the end-of year submission.



Cardiff and Vale and Powys are the only UHBs to successfully reach the 95% target for each month in 2018/19 and to average above 95% completeness within one month. The UHB is able to achieve this by obtaining patient records the day directly after discharge and maintaining focus on the current month. Despite this, three other UHBs are able to achieve marginally higher overall completion figures by the time of the final 2018/19 APC data submission.

The UHB's Coding department considers itself to have the ability to achieve both higher monthly and annual completion percentages. The limiting factor is the availability of patient records, both immediately following discharge and throughout the course of the financial year.

2. Coding Completeness of Deceased Records

Due to the impact on the Risk Adjusted Mortality Index (RAMI), the department prioritises the coding of deceased notes. The uncoded numbers of deceased records for the previous financial years are as follows:

Financial Year	Uncoded
2015/16	128
2016/17	49
2017/18	21
2018/19	19

3. Accuracy

Clinical coding departments are required to achieve the following percentages for accuracy:

- Primary Diagnosis ≥ 90%

- Secondary Diagnosis ≥80%
- Primary Procedure ≥90%
- Secondary Procedure ≥80%

The following table presents the results from this year's Clinical Coding Audit Report, conducted by NWIS.

Code Type	Target	Percentage Correct
Primary Diagnosis	90%	93.33%
Secondary Diagnosis	80%	92.45%
Primary Procedure	90%	99.56%
Secondary Procedure	80%	97.33%

Clinical Coding departments are also measured against the Welsh Government Clinical Coding Accuracy Measure, a single percentage representing overall accuracy.

Clinical Coding Accuracy Measure	
2018	90.26%
2019	94.24%

ASSURANCE is provided by:

- The UHB's ongoing level of compliance with Welsh Assembly accuracy and completion targets.

RECOMMENDATION

The Board is asked to:

- **NOTE** the performance of the UHB's Clinical Coding Department.

Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	

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4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	x
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered
Please tick as relevant, click here for more information

Prevention		Long term	x	Integration		Collaboration		Involvement	

Equality and Health Impact Assessment Completed:	Not Applicable If "yes" please provide copy of the assessment. This will be linked to the report when published.

Report Title:	**Digital Delivery Programme – Exception & Issues Report**						
Meeting:	**Digital and Health Intelligence Committee**				**Meeting Date:**	**3rd December 2019**	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**	**x**
Lead Executive:	**Director of Digital and Health Intelligence**						
Report Author (Title):	**Assistant Director of IT**						

SITUATION

This paper provides a high level exception report on the high priority programmes within CAV UHB's IT Delivery Plan.

BACKGROUND

The UHB has a constantly evolving 3 year strategic outline plan for informatics development designed to underpin delivery of our emerging digital strategy, IMTP, transformation programme and the Welsh Government's Healthier Wales and Informed Health and Care policies and strategies.

Our plan includes the **3 overarching delivery programmes:**

- Intelligent Citizen Portal - this focusses on the implementation of the "Patient Knows Best" system to provide an integrated portal solution
- Integrated digital health and care record – enabling the sharing of patient data from multiple systems across health and social care
- Data to knowledge programme- gaining insights via "signals from Noise" working with our partner, Lightfoot Solutions

ASSESSMENT

High level issues to report to the DHIC:

Intelligent Citizen Portal – delays in implementing PKB in a fully integrated way – this is due to specific requirements in how to integrate between CAV's patient administration system (PMS) and PKB – the necessary components being demographics and clinical documents.

Data to knowledge programme – although good progress has been made with providing data to Lightfoot (now an automated feed for in-patient and out-patient data), there are challenges in being able to provide data feeds 7 days a week (current provision is Monday to Friday).

Exception items raised for noting:

- **Major Incident** – Blaenavon National Data Centre outage on Saturday 29th June due to air conditioning failure, which resulted in the entire outage of the Data Centre. It took several hours to fail over to Newport Data Centre. The outage impacted the majority of national systems including the All Wales Laboratory Information Management System (WLIMS), Welsh Clinical Portal, Hospital Pharmacy System, with interruption to many services taking several days to resolve. A number of reviews have taken place in relation to this incident (including an independent one). The summary comprehensive report was approved by the National Informatics Planning and delivery group on 28th Oct 2019. It outlined the many recommendations in relation to mitigation of such risks in the future including the potential to upgrade the Data Centre hosting provision from a tier 2+ Data Centre standard to a Tier 3 facility. The recommendations are being overseen by the National Service Management Board (NSMB). The option of upgrading to a Tier 3 Data Centre Facility is being reviewed as part of the current National IT Infrastructure review.

- **WCCIS** continues to fall functionally short of what was agreed and procured. The supplier has been issued with two non-conformance notices due to failure to deliver functionality as set out in the Statement of Requirements (SoR) at procurement stage in 2014. A roadmap for delivery of this functionality is yet to be provided. On 28/10/2019 CareWorks, the developer of the WCCIS system, was bought by Advanced Computer Software Group

- **Windows 10 upgrade project:** Windows 7 becomes End of Life on 14/1/2020. It is necessary that the Health Board either replace or upgrade all of its Devices that are not currently Windows 10 to avoid Cyber Security risks. As part of the agreement for the new Office 365 enterprise Contract, agreement has been reached to provide an extension to Windows 7 security support until 31/3/21. The Health Board has been successful in gaining WG Digital Capital and Revenue Funding to help deliver this project. Procurement and recruitment plans are underway to deliver this programme. This will mitigate this Cyber security risk and provide a springboard for Digital infrastructure transformation and mobilisation.
- **WG Digital Funding Programme 2019/20:** The UHB has been successful in gaining a WG Digital Funding allocation for 2019/20 of circa £3M of Capital and Revenue to help commence the delivery of an exciting programme of Digital Infrastructure transformation in the following areas:
    - Windows 10 implementation Programme
    - Launch of Office 365 programme
    - Investment in Cyber security Infrastructure and Team
    - Expansion of pervasive WiFi
    - Mobilisation Programme

ASSURANCE is provided by:

Major Incident –In relation to the outage of the NWIS Data Centre and its impacts, the reviews have now been completed and approved by IPAD. Recommendations are being overseen by NSMB. In addition the option to upgrade the National Data centre is being looked at as part of the current National IT Infrastructure Review.

WCCIS assurance is provided through ongoing local and regional involvement in national

programme groups, including the new Service Management Board.

Windows 10 Upgrade: Options have been developed for Windows 10 upgrades, mitigated by the extension of windows 7 support until 31/3/2021. In addition a programme has commenced facilitated by WG Digital funding to support this objective.

WG Digital Funding Programme 2019/20. Plans are in place with Finance, Procurement and Recruitment to take forward the components outlined in the circa £3M WG Digital funding programme for 21019/20.

RECOMMENDATION

The Board is asked to:

- NOTE the areas of exception which require further attention and consideration.

Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
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Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention		Long term		Integration	x	Collaboration		Involvement	

Equality and Health Impact Assessment Completed:	Yes / No / Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

Report Title:	**Review of 'Information Governance Policy'**						
Meeting:	**Digital Health Intelligence Committee**				**Meeting Date:**	**03/12/2019**	
Status:	**For Discussion**		**For Assurance**		**For Approval**	**X**	**For Information**
Lead Executive:	**Director of Digital Health Intelligence**						
Report Author (Title):	**Information Governance Manager**						

SITUATION:

The UHB requires a central Information Governance policy to underpin its Information Governance framework. This policy must outline the overarching IG principles and draw together all appropriate IG procedures needed to comply with current data protection legislation, including the GDPR and the Data Protection Act 2018. This will act as a point of reference for all UHB employees and link with all other relevant UHB policies and procedures.

BACKGROUND:

Four all-Wales policies have been issued to all NHS Wales organisations. These are:

- Information Governance Policy
- IT Security Policy
- Email Use Policy
- Internet Use Policy

The UHB currently has individual corresponding policies which need to be updated to be brought in line with current legislative requirements.

ASSESSMENT:

The UHB's IG team has consolidated these four national policies into a single overarching IG policy for ease of reference.

It is also believed that incorporating these elements under the IG umbrella will help to increase understanding of the broad remit of IG and, consequently, raise the profile of IG within the UHB. The IG team has also adapted the content of these policies to enable UHB staff to apply a proportionate and pragmatic approach to working.

RECOMMENDATION:

The Board is asked to:

- **APPROVE** the updated 'Information Governance Policy'.

Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
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4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	**X**
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention		Long term		Integration		Collaboration	**X**	Involvement	

Equality and Health Impact Assessment Completed:	Yes / No / Not Applicable If "yes" please provide copy of the assessment. This will be linked to the report when published.

Cardiff and Vale UHB
Information Governance Policy
DRAFT

Author: Information Governance Department
NOT YET Approved by: Information Governance Executive Team
NOT YET Approved by: Digital Health Intelligence Committee
Version: DRAFT 0.3
Date: 15/11/2019
Review date: 2 years following ratification

Contents

1. Introduction

Cardiff and Vale UHB considers information to be a vital asset, and a key enabler, on which the UHB is dependent as we move forward in delivering our Shaping Our Future Wellbeing strategy and becoming a data driven organisation.

It is therefore of paramount importance to ensure that information is efficiently managed, and that appropriate policies, procedures, management accountability and structures provide a robust governance framework for information management.

2. Purpose

It is the policy of the UHB to ensure that:

- We protect the legal rights of individuals, patients and staff in respect of confidentiality and privacy.
- We safeguard our information and systems.
- We make appropriate use of ICT services, such as email and the internet.
- Our staff have access to the relevant and appropriate information they require at the point that it is required.
- The value of the information that the UHB manages is increasingly realised
- All services transition towards the appropriate adoption of the UHB's technical and data standards and achieve these by 2023.
- Opportunities to achieve improvements in clinical and cost-effective care provided by digital technologies are realised.
- We improve the ability of our population, patients, and staff to make timely, evidence-based decisions.
- Our staff are valued, trusted and enabled.
- Our staff are supported to better manage and balance work and out-of-work commitments.
- We comply and act in the intended spirit of the Welsh Government's policy and notably the 'Once for Wales' design principles.

3. Scope

This policy applies to the workforce of Cardiff and Vale UHB including staff, students, trainees, secondees, volunteers, contracted third parties and any other persons undertaking duties on behalf of the UHB, across all areas of our business, including: the provision, planning and commissioning of direct care, teaching and training; and scientific work including research.

It applies to all forms of information controlled and processed by Cardiff and Vale UHB including video, digital and paper; and covers all business functions and the information, information systems, networks, physical environment and relevant people who support those business functions.

The policy covers the following areas:

- Roles and Responsibilities
- Use and protection of Data

- Data and technical standards
- Privacy notices
- Information security
- Internet Use
- Email Use

4. Roles and responsibilities

This policy is intended to be enabling and expects that the professionalism of all staff to familiarise themselves with the policy content and ensure the policy requirements are implemented and followed at all times. In adopting a high trust approach, it is an absolute requirement that all staff members undertake the appropriate level of information governance training at least every two years. It is also essential that breaches of this policy and related legislation are reported by the individual via Datix or agreed local reporting mechanisms and to the Data Protection Officer at the earliest opportunity.

UHB.DPO@Wales.NHS.UK

The UHB's accountability and governance structure for Information Governance requires specific roles to be fulfilled. These are set out below:

The Chief Executive is responsible for ensuring the highest level of organisational commitment to the policy and the availability of resources to support its implementation and any associated legal requirements. The Chief Executive is responsible for ensuring that there is a designated individual within the UHB who assumes the responsibilities of three statutory positions.

The Data Protection Officer is responsible for to ensuring that the UHB processes the personal data of its staff, patients and population in compliance with the data protection legislation.

The Senior Information Risk Officer (SIRO) is responsible for ensuring that information security and information governance risks are managed. Specific responsibilities include:

- Leading and fostering a culture that values, protects and uses information for the success of the organisation and benefit of its customers.
- Owning the organisation's overall information risk policy and risk assessment processes and ensuring they are implemented consistently by Information Asset Owners.
- Advising the Chief Executive or relevant accounting officer on the information risk aspects of his/her statement on internal controls.
- Owning the organisation's information incident management framework.

The Caldicott Guardian is responsible for safeguarding the processing of patient information.

The Head of each Clinical Directorate, Clinical Board & Corporate Department is responsible for appointing Information Asset Owners and Administrators to act as accountable officers and named points of contact for IG matters.

Information Asset Owners are responsible for the implementation of this policy in respect of the data held acquired, stored within their assets and transferred from their assets (e.g. IT systems, databases, video stores, clinical record libraries). Specifically, Information Asset Owners should have undertaken a self assessment of their directorate's compliance with data protection regulation, using the ICO's tools (link: https://ico.org.uk/for-organisations/data-protection-self-assessment/) once every 24 months and have logged completion with the IG department. Information Asset Administrators will support the Information Asset Owners in fulfilling these obligations.

Managers are responsible for the implementation of this policy within their department/directorate. In addition, they must ensure that their users and staff are aware of this policy, understand their responsibilities in complying with the policy requirements and are up to date with mandatory information governance training.

5. Data Protection and Compliance

Data protection legislation is about the rights and freedoms of living individuals and in particular their right to privacy in respect of their personal data. It stipulates that those who record and use any personal data must be open, clear and transparent about why personal data is being collected, and how the data is going to be used, stored and shared.

While the emphasis on this policy is on the protection of personal data, the UHB owns and processes business and other sensitive data. The security of 'sensitive' data is also governed by this policy.

5.1.1 Definition of Personal Data

For the purpose of this policy, the use of the term "personal data" encompasses any information relating to an identifiable person who can be directly or indirectly identified, in particular by reference to an identifier.

This definition provides for a wide range of personal identifiers to constitute personal data, including name, identification number, location data or online identifier, reflecting changes in technology and the way organisations collect information about people.

Personal data that has been pseudonymised – e.g. key-coded – will fall within the scope of the GDPR depending on how difficult it is to attribute the pseudonym to a particular individual.

5.1.2 Special Categories of Personal Data

Special categories of personal data are defined by data protection legislation as including any data concerning an individual's racial or ethnic origin, political opinions, religious or philosophical beliefs, trade union membership, health, sex life, sexual orientation, genetic and biometric data where processed to uniquely identify an individual.

5.2 Using data

5.2.1 Fair and Lawful Processing

The UHB will process personal, special category and sensitive data fairly and lawfully, in line with data protection legislation and in accordance with the UHB's patient and staff privacy notices. Processing broadly means collecting, using, disclosing, sharing, retaining or disposing of personal data or information.

In order for the processing of data to be fair, the SIRO, on behalf of the UHB will maintain and publish in a highly open, transparent and accessible way, privacy notices for patients and staff which clearly set out the information held by the UHB and how it is used are available below.

Patient Privacy Notice

Employee Privacy Notice

All sizeable patient facing areas should provide patients with clear information signposting them to the web page at which the UHB's privacy notice for patients can be viewed. It is the responsibility of the manager of the clinical area to have this in place.

Where an activity can be carried out without the need for personal or sensitive data to be disclosed, anonymised data should be used. Where personal data is required, then the minimum amount of identifiable information required should be used and, wherever appropriate, the data should be pseudonymised.

Personal or sensitive information should not be processed where the UHB does not have a lawful basis for processing such information under the data protection legislation which is not reliant on the consent of individuals (e.g. necessary for the health or social care purposes). Exceptions to this must be agreed with the SIRO and Caldicott Guardian.

Where there are any queries, staff must consult the Information Governance Office before processing or sharing personal or sensitive data.

5.2.2 Information Asset Management

5.2.1.1 Information Asset Registers

To protect individual's rights laid out in the Data Protection Act 2018 and the GDPR (2018), it is important that the UHB has knowledge of, and can swiftly access, all of the personal and sensitive data that it holds, regardless of the medium in which it is held. To achieve this, each Clinical Directorate, Clinical Board and Corporate Department must identify and record the lawful basis for the information it processes in an information asset register. It is the responsibility of the Information Asset Owners to ensure that the information asset registers are accurate and up to date and the responsibility of individual members of staff to store data they hold in a way it can be accessed swiftly.

As a minimum, information asset registers should document all "departmental" shared drives managed by an individual within the Directorate, all servers owned by the directorate and all systems used and contracted for by the Directorate (including messaging systems), incorporating:

- the type of information held

- where it came from,
- who it is shared with
- how this information is used
- the legal basis for holding this data – If in doubt consult the UHB's web page or ask the IG department
- When it should be destroyed (if not in the medical record or essential for business use – e.g. a contract, then the longest retention period including email should be 6 months unless specifically referenced in the UHB's retention schedule, available via Information Governance webpage.
- Who this data is shared with – e.g. Royal Colleges, WG, other NHS organisations, Local Authorities
- Where data is shared, the legal basis for sharing the data (as above, public duty should be used where the basis is patient care)
- Confirmation that no data is stored or transferred outside the European Economic Area, including for Artificial Intelligence processing within the cloud.

5.2.1.2 Registering Security, Hosting and Back up arrangements

To ensure that the UHB maintains service resilience in line with the EU directive on the security of Networks and Information Systems, all existing and new systems provided or used by the UHB should have a Security, Hosting and Back Up agreement with the UHB's informatics department, with the required details included on the information asset register. It is the responsibility of the Information Asset Owners to ensure that these details are accurate and up to date.

5.2.1.3 Managing paper care records

Members of staff who have received and are using the paper care record are responsible for ensuring that the location of the record is known and tracked on the appropriate electronic system.

The paper care record must not be split. Where only a single volume of a file containing several volumes is required, this may be moved for a very minimal time (never longer than the current working shift) and holders of both segments of the record must be aware. This must be reflected via the tracking mechanism on the appropriate electronic system.

5.2.1.4 Storing and moving data

Section 6.1 refers to expected standards and requirements for the control and storage of data.

5.2.3 Individual's Rights & Consent

Individuals have certain rights with regard to the processing of their personal data. Information Asset Owners must ensure that appropriate arrangements are in place to manage these rights.

In particular, where the directorate is reliant on "Consent" as the legal basis for holding patient identifiable data, you must ensure that the way you have attained the consent follows the ICO's guidance:

- A request to gain consent to use information about the patient should be made prominent and be clearly separated from other requests for consent – such as those in regards to treatment.

- Consent has required a positive opt-in such as un-ticked opt-in boxes or similar active opt-in methods.
- Consent should be specific and granular. You should allow individuals to consent separately to different purposes and types of processing wherever appropriate.
- Be clear that this consent is for NHS Wales & Cardiff and Vale UHB and name any specific third party organisations that will rely on this consent.

5.2.4 Accuracy of Personal Data

Arrangements must be in place to ensure that any personal data held by the UHB is accurate and up to date, or contains a time stamp.

5.2.5 Establishing new data processing activities

New data processing activities include, but are not limited to: the introduction of new data capture systems, the collection of additional data items, the undertaking of Artificial Intelligence which does not involve the intervention of a human and extending the sharing of data.

5.2.5.1 Data Protection Impact Assessment (DPIA)

All new projects or major new flows of information must consider information governance practices from the outset to ensure that personal data is protected at all times. Any processing that is likely to result in a high risk must be assessed by a DPIA, especially any transfer outside of the European Economic Area. This also provides assurance that the UHB is working to the necessary standards and are complying with data protection legislation. In order to identify information risks, a DPIA must be completed. If there is any doubt as to what and whether a DPIA is required, the information governance department should be requested to assist.

The results of the DPIA must both be filed and discussed with the Information Governance Department (who may consult the ICO) and signed off by the UHB's Data Protection Officer and Senior Information Risk Owner. Any controls identified as being required must be acted upon and put in place.

5.2.5.2 Third Parties and Contractual Arrangements

Where the organisation uses any third party who processes personal data on its behalf, any processing must be subject to a legally binding written contract which meets the requirements of data protection legislation.

UHB documents & specifications (such as the UHB's Data Processing Contract, Security Arrangements, Contracts, Procurement technical specification, codes of conduct, access and auditing specifications) must be used in formalising the arrangements for the processing and sharing of the personal data the UHB controls or will be controllers of (that which it processes for its own purposes). This is to ensure that personal data is processed in a consistent manner and the roles of responsibilities of the parties are clearly understood.

No part of a UHB agreement can be varied without the prior written approval of the relevant Director, particularly the minimum indemnity limit of £5 million per annum.

5.2.6 Incident Management and Breach Reporting

Staff must be aware of their department's arrangements that are in place to identify, report (via Datix), manage and resolve any data breaches within specified legal timescales (presently 72 hours). Lessons learnt will be shared to continually improve procedures and services, and consideration given to updating risk registers accordingly. Incidents must be reported immediately following local reporting arrangements.

5.2.7 Information Governance Compliance

All information asset owners and departments must have monitoring arrangements in place to ensure that personal and sensitive data is being used appropriately and lawfully.

5.3 Records Management

Cardiff and Vale University Health Board (the UHB) understands the definition of records to be:

"Information created, received and maintained as evidence and information by an organisation or person, in pursuance of legal obligations, or in the transaction of business". *Reference BS ISO 15489.1*

"An NHS record is anything which contains information (in any media) which has been created or gathered as a result of any aspect of the work of NHS employees including consultants, agency or casual staff." *Reference. Department of Health Records Management: NHS Code of Practice Part 1*

All records held by the UHB fall within the scope of this policy as these are either personal (relating to patients, public and employees) or corporate (for example financial records, letters, reports) and regardless of whether they are held in electronic, virtual or physical format. It applies to all areas and services within the remit of the UHB.

The UHB is committed to the handling and processing of all health records in accordance with the legal requirements, codes of practice and guidance issued by relevant authorities including, but not restricted to, the Welsh Government and the Information Commissioner's Office.

To achieve this, the UHB and its employees will follow the Lord Chancellor's Code of Practice on the management of records issued under section 46 of the Freedom of Information Act 2000.

All staff should understand and be aware of the importance attached to the way in which records are managed and the relationship of records management to assist in achieving the overall business strategy of the organisation.

Records will be managed in accordance with the UHB's Records Management Retention and Destruction Protocol and Schedule.

5.4 Access to Information

The UHB is in some circumstances required by law to disclose information. Examples include information requested under:

- Freedom of Information Act 2000
- Environmental Information Regulation 2004
- General Data Protection Regulation

For further detail, please see the below links or contact the Information Governance department.

[Link to UHB's FOI & EIR Procedure]
[Link to UHB's Subject Access Request Procedure]

All staff have a responsibility to provide information for where requested to do so by the Information Governance team.

Processes must be in place for disclosure under these circumstances. Where required, advice should be sought from the UHB's information governance department.

5.5 Confidentiality

5.5.1 Confidentiality: Code of Practice for Health and Social Care in Wales

The UHB has adopted the Confidentiality: Code of Practice for Health and Social Care in Wales. All staff have an obligation of confidentiality regardless of their role and are required to respect the personal data and privacy of others.

Staff must not access information about any individuals who they are not providing care, treatment or administration services to in a professional capacity. Rights to access information are provided for staff to undertake their professional role and are for work related purposes only. It is only acceptable for staff to access their own record where self-service access has been granted.

Appropriate information will be shared securely with other NHS and partner organisations in the interests of patient, donor care and service management. (See section 5.6 on Information Sharing for further details).

5.6 Sharing Personal Data

5.6.1 Wales Accord for the Sharing of Personal Information (WASPI)

The WASPI Framework provides good practice to assist organisations to share personal data effectively and lawfully. WASPI is utilised by organisations directly concerned with the health, education, safety, crime prevention and social wellbeing of people in Wales. << http://www.waspi.org/nhs >>

The UHB will use the WASPI Framework for any situation that requires the regular sharing of information outside of NHS Wales wherever appropriate. Advice must be sought from the information governance department in such circumstances.

5.6.2 One-off Disclosures of Personal Data

Formal Information Sharing Protocols (ISPs) or other agreements must be used when sharing information between external organisations, partner organisations, and external providers acting in the capacity of a data controller. ISPs provide a framework for the secure and confidential obtaining, holding, recording, storing and sharing of information. Advice must be sought from the information governance department in such circumstances.

Personal data may need to be shared externally on a one-off basis, where an ISP or equivalent sharing document does not exist. Advice must be sought from the information governance department in such circumstances.

5.7 Welsh Control Standard for Electronic Health and Care Records

5.7.1 The Control Standard

The Wales Control Standard for Electronic Health and Care Records describes the principles and common standards that apply to shared electronic health and care records in Wales, and provides the mechanism through which organisations commit to them. NHS Wales organisations have committed to abide by the Control Standard. The Control Standard will be underpinned by local level policies and procedures to ensure electronic records are accessed and used appropriately.

5.8 Data Quality

Key components of data quality include; accuracy, completeness, validity, timeliness, free from duplication or fragmentation, defined and consistent. Data from all areas should be recorded and processed at all levels in the Health Board using relevant skills and knowledge.
The Health Board has set 8 key objectives in order to achieve the policy aims. They are:

1. Data is accurate and up to date:
   - Correct and accurately reflects what actually happened
   - Precise and includes all data processed in the organisation

2. Data is complete: Data should be captured in full and where applicable a valid and traced NHS number must be included to support operational use.

3. Data is valid
   - Data should be held in a format which conforms to recognised national standards
   - Must be mapped by codes to national values where these are in existence
   - Held in computer systems that are programmed to only accept valid entries wherever possible

4. Data is timely
   - Data should be collected at the earliest opportunity, preferably at the time and place of the activity taking place
   - Data is available when required for its intended use

5. Data is free from duplication and fragmentation: Patients must not have duplicated or confused patient records e.g. should not have two or more separate records held on Patient Management

Systems.

6. Data is defined and consistent: The data being collected should be understood by the staff collecting and interpreting it.

7. Coverage: Data from all areas of activity - clinical or corporate should be recorded in the appropriate place and format.

8. Data quality management: At every level across the Health Board those managing data quality must have the appropriate skills and knowledge.

5.9 Data and Technical Standards

The UHB will adopt and comply with the standards set out in Welsh Health Circulars, Data Set Change Notices and the Welsh Data Dictionary.

The UHB will adopt the WTSB technical standards as they are produced for all new systems and upgrades, and information asset owners should be establishing development programmes for systems to be fully compliant by 2023.

Asset owners will ensure that the data and images are made available to the UHB's clinical data repository, via a method agreed with the corporate informatics department.

6. Information Security

6.1 User Access Controls

Access to information will be controlled on the basis of business requirements.

System Managers will ensure that appropriate security controls and data validation processes, including audit trails, will be designed into application systems that store any information, especially personal data.

The workforce has a responsibility to access only the information which they need to know in order to carry out their duties. Examples of inappropriate access include but are not restricted to:

- Accessing your own health record;
- Accessing any record of colleagues, family, friends, neighbours etc., even if you have their consent, except where this forms part of your legitimate duties;
- Accessing the record of any individual without a legitimate business requirement.

6.1.1 Physical Access Controls

Maintaining confidentiality in clinical areas can be challenging and the need to preserve confidentiality must be carefully balanced with the appropriate care, treatment and safety of the patient.

Individuals, departments and Information Asset Owners are responsible for determining the relevant security measures required based on local risk assessment.

All reasonable steps should be taken to ensure high standards of security in areas where data is kept. As a minimum, offices, vehicles and computers should be locked when the user is absent. Access cards, PIN codes, key codes, etc. must be kept secure and regularly changed as required.

All central file servers and central network equipment will be located in secure areas with access restricted to designated staff as required by their job function.

6.1.2 Passwords

The workforce are responsible for the security of their own passwords which must be developed in line with NHS guidance ensuring they are regularly changed. Passwords must not be disclosed to anyone. Recognising that, at the current time, the UHB still has a limited number of generic accounts, users will be held fully responsible and accountable for any infringement and breaches of data protection legislation where they have shared their log in details.

In the absence of evidence to the contrary, any inappropriate access to a system will be deemed as the action of the user. If a user believes that any of their passwords have been compromised, they must change them immediately.

6.1.3 Remote Working

NHS Wales recognises that there is a need for a flexible approach to where, when and how our workforce undertake their duties or roles. Handling confidential information outside of your normal working environment brings risks that must be managed.

Examples of remote working include, but are not restricted to:

- Working from home
- Working whilst travelling on public/shared transport
- Working from public venues (e.g. coffee shops, hotels etc.)
- Working at other organisations (e.g. NHS, local authority or academic establishments etc.)
- Working abroad

As a control measure to mitigate risks involved in remote working, no member of the workforce will work remotely unless they have been authorised to do so. Remote working must not be authorised for anyone who is not up to date with mandatory training in information governance.

6.1.4 Staff Leavers and Movers

Managers will be responsible for ensuring that local leaving procedures are followed when any member of the workforce leaves or changes roles to ensure that user accounts are revoked / amended as required and any equipment and/or files are returned. Confidential, patient or staff information must not be transferred to a new role unless authorised by the relevant heads of service. A leaver's checklist should be completed in all cases.

6.1.5 Third Party Access to Systems

Any third party access to systems must have prior authorisation from both the IT and IG departments.

6.2 Storage of Information

All information stored on or within the UHB is the property of the UHB, unless there are contractual agreements that state otherwise. For legal purposes the UHB should be informed of, and agree to, all arrangements where we are hosting an information asset but are not the asset owner. An example of this is information stored in an email, which has been sent by a member of staff, but not in their capacity as an employee of Cardiff and Vale UHB (e.g. on trade union, University or Royal College business)

All software, information and programmes developed for the UHB by the workforce during the course of their employment will remain the property of the UHB.

Wherever possible, personal information should be stored on a UHB secure server. If it is to be stored outside a secure server (e.g. laptop c drive, flash stick): - the computer / device should be password protected and the data encrypted. The storage of personal data in the "Cloud" presently requires approval by the Welsh Information Governance Board

All systems should be backed up as part of an agreed backup regime. Where business critical information is held on local hard drives, portable devices or removable media, the IT department must be informed and agreements on how to back up the data reached.

6.3 Portable Devices and Removable Media

Whilst it is recognised that both portable devices and removable media are widely used throughout NHS Wales, unless they are used appropriately they pose a security risk to the organisation.

Portable devices include, but are not limited to, laptops, tablets, Dictaphones®, mobile phones and cameras.

All portable devices must either be encrypted, or access the network via NHS Wales approved applications (e.g. Mobile Device Management Software).

Users must ensure that all portable devices are physically connected (plugged in) to the UHB's network every 4 weeks and that all upgrades and cyber patches are updated at this time. Upgrades via wifi are not acceptable at the present time due to affordability and available bandwidth.

Users must not attach any personal (i.e. privately owned) portable devices to any NHS organisational network without prior authorisation.

Removable media includes, but is not limited to, USB 'sticks' (memory sticks), memory cards, external hard drives, CDs / DVDs and tapes. Appropriate controls must be in place to ensure any personal information copied to removable media is encrypted.

All removable media such as CDs must be encrypted if used to transport confidential information and should only be used if no other secure method of transfer is available. Users must not send details of how to unencrypt with the removable media.

6.4 Secure Disposal

For the purposes of this policy, confidential waste is any paper, electronic or other waste of any other format which contains personal data or business sensitive information.

6.4.1 Paper

All confidential paper waste must be stored securely and disposed of in a timely manner in the designated confidential waste bins or bags; or shredded on site as appropriate. This must be carried out in line with local retention and destruction arrangements.

6.4.2 Electronic

Any IT equipment or other electronic waste must be disposed of securely in accordance with local disposal arrangements. For further information, please contact your IT Department.

6.4.3 Other Items

Any other items containing confidential information which cannot be classed as paper or electronic records e.g. film x-rays, orthodontic casts, carbon fax/printer rolls etc, must be destroyed under special conditions. For further information, please contact your information governance team.

6.5 Transporting and relocation of information

6.5.1 Transporting Information

When information is to be transported from one location to another location, local procedures must be formulated and followed to ensure the security of that information.

6.5.2 Relocating information

When information is to be relocated to another location, local procedures must be formulated and followed to ensure no information is left at the original location.

7. Use of the internet

7.1 Position Statement

Internet access is provided to staff to assist them in the performance of their duties. The provision of these facilities represents a major commitment on the part of the UHB in terms of investment and resources.

All members of staff should become competent in using internet services to the level required for their role in order to be more efficient and effective in their day-to-day activities.

The UHB will support its workforce in understanding how to safely use internet services and it is important that users understand the legal, professional and ethical obligations that apply to its use. If used correctly, the internet can increase efficiency and safety within patient care.

7.2 Conditions & Restrictions on Internet Use

To avoid inadvertent breaches of this policy, inappropriate content will be blocked by default where possible. Inappropriate material must not be accessed. Exceptions may be authorised for certain staff where access to particular web pages are a requirement of the role. Subject matter considered inappropriate is detailed in the appendix.

Some sites may be blocked by default due to their general impact on network resources and access to these for work purposes can be requested by contacting the Local IT Service Desk.

Regardless of where accessed, users must not participate in any online activity or create or transmit or store material that is likely to bring the organisation into disrepute or incur liability on the part of NHS Wales.

Business Sensitive Information or Personal Data (which includes photographs and video recordings) of any patient, member of the public, or member of staff taken must not be uploaded to any form of non-NHS-approved online storage, media sharing sites, social media, blogs, chat rooms or similar, without both the authorisation of a head of service and the consent of the individual who is the Data Subject of that recording. The NHS Wales Social Media Policy provides information on the appropriate use of social media.

It is each user's responsibility to ensure that their internet facilities are used appropriately.

7.3 Personal Use of the Internet

The UHB allows staff reasonable personal use of internet services providing this is within the bounds of the law and decency and compliance with policy.

Personal use should be incidental and reasonable and should be included in your personal time. In addition to this, users must not stream or download large volumes of data (e.g. streaming audio or video, multimedia content, software packages) as these may have a negative impact on network resources.

Staff members are encouraged to use the CAV free Wi-Fi facilities by default on personally-owned devices.

Staff who use NHS equipment outside NHS Wales premises (for example – in a home environment) are permitted to connect to the internet. Use of the internet under these circumstances must be through a secure VPN connection provided by the UHB. Use of the equipment for such purposes is still subject to the same conditions as laid out in this policy.

All personal use of the internet is carried out at the user's own risk. The UHB does not accept responsibility or liability for any loss caused by or liability arising from personal use of the internet.

Internet access facilities must not be used to run or support any kind of paid or unpaid personal business venture outside work, whether or not it is conducted in a user's own time or otherwise.

8. Email

8.1 Inappropriate emails

Inappropriate content and material must not be sent by email. Inappropriate content including prohibited language in emails may be blocked. Subject matter considered inappropriate is detailed in the appendix.

Regardless of where accessed, users must not use the UHB's email system to participate in any activity, to create, transmit or store material that is likely to bring the UHB into disrepute or incur liability on the part of the UHB.

Some users may need to receive and send potentially offensive material as part of their role (for example - child protection). Arrangements must be authorised to facilitate this requirement.

8.2 Personal Data and Business Sensitive Information: Filtering and Misdirection

The NHS Wales network is considered to be secure for the transfer of any information including personal data and business sensitive information within NHS Wales and organisations with Transport Layer Security (TLS) enabled. This includes all email addresses within the NHS email directory that end in "wales.nhs.uk", which are hosted on the NHS Wales email service and the email services of TLS enabled organisations as listed on HOWIS. The list can be accessed here:

http://howis.wales.nhs.uk/sites3/page.cfm?orgid=852&pid=74727

Whilst it is safe and secure to transfer personal data between these addresses without encryption or passwords, the user must have a lawful basis for doing so. Please note that universities are not included in this list.

Transfer of personal data or business sensitive information between any email address not ending in "wales.nhs.uk", or TLS enabled is not currently considered secure. Where this type of information needs to be sent, appropriate security measures must be implemented. For example, the information should be sent via the Secure File Sharing Portal or via email with an appropriate level of encryption.

Users must be vigilant in ensuring that all emails are sent to the correct recipient and must check that the correct email address is used, for example by checking the NHS Wales email address book. Even where the recipient email address is considered secure, as a mitigating factor to avoid any inadvertent misdirection, encryption of any email attachment containing sensitive data should be considered. Misdirected emails should be reported via local incident reporting processes.

8.3 Personal Use of Email

The UHB allows staff reasonable personal use of their email account providing this is within the bounds of the law and decency and compliance with policy.

Personal use should be incidental and reasonable and should be included in your personal time. It is a requirement that you mark personal emails as personal in the subject heading. In doing so, staff should recognise that these emails will be monitored and may be subject to Information Access requests made to the UHB. Staff members are therefore strongly encouraged to use their personal email accessed via CAV free Wi-Fi facilities by default on personally-owned devices.

Staff who use NHS equipment outside NHS Wales premises (for example – in a home environment) are permitted to send personal emails. Use of the email under these circumstances must be through a secure VPN connection provided by the UHB. Use of the equipment for such purposes is still subject to the same conditions as laid out in this policy.

All personal use of email is carried out at the user's own risk. The UHB does not accept responsibility or liability for any loss caused by or liability arising from personal use of email.

The UHB's email must not be used to run or support any kind of paid or unpaid personal business venture outside work, whether or not it is conducted in a user's own time or otherwise.

Users must not subscribe to or provide any NHS email address to any third party organisation for personal use.

8.4 Records Management and Access to Information requests in respect of Email

Staff are encouraged not to use the email system as a storage facility. By design, all emails should either be deleted or saved securely to the appropriate record (e.g. to a clinical / business record or network drive).

Information held on computers, including those held in email accounts may be subject to requests for information under relevant legislation and regulation. As such any staff member who stores data in email folders should comply with section 5.2.1.1 Information Asset Registers.

To minimise risk of non compliance with data protection, from the 1st October 2019 (6 months post 1st April 2019) any email received after the 1st April 2019 which is over 6 months old and is not stored in a size limited archive named 'Archive' on your personal folders within Outlook will be automatically and irretrievably deleted by the UHB.

All staff should be mindful that it may be necessary to conduct a search for information and this may take place with or without the author's knowledge or consent.

9. Training and Awareness

Information governance is everyone's responsibility. Training is mandatory for UHB staff and must be completed at commencement of employment and at least every two years subsequently. Non-NHS employees must have appropriate information governance training in line with the requirements of their role.

Staff who need support in understanding the legal, professional and ethical obligations that apply to them should contact their local Information Governance Department.

The UHB's workforce should become competent in using email services to the level required of their role in order to be efficient and effective in their day-to-day activities.

In order to ensure that this work is successfully supported and completed, there must be robust IGT programmes in place. To this effect, managers will:

- Complete training needs analyses for all staff as part of mandatory training in line with the Information Governance Training Programme Framework
- Manage staff training attendance -for new staff and refresher training
- Maintain ESR and local training records
- Identify and implement refresher training where incidents and poor performance has been identified

The arrangements for regular monitoring compliance are as follows:

- Overall compliance – to the DHIC via the SIRO
- Local compliance – to the clinical board performance reviews by clinical board directors
- Corporate arrangements – to the DHIC via the SIRO
- Compliance by formal assessment:
  - Health and Care Standards 3.4 and 3.5
  - Caldicott annual assessment - Internal Audits sponsored by the DHIC
  - Annual and specific audits by the Welsh Audit Office
  - Any other audits or assessments directed by the Welsh Government

10. Monitoring and compliance

The UHB trusts and respects the privacy of its employees and does not want to interfere in their personal lives. However, it reserves the right to monitor work processes to ensure the effectiveness of the service as a legitimate business interest. This will mean that any personal activities that the employee practices in work may come under scrutiny.

The UHB uses software to automatically and continually record the amount of time spent by staff accessing the internet and the type of websites visited by staff. Attempts to access any prohibited websites which are blocked is also recorded.

The UHB uses software to scan emails for inappropriate content and filters are in place to detect this. Where an email is blocked, emails may be checked for compliance when a user requests an email to be released. All email use will be logged to display date, time, username, email content; and the address to which the message is being sent.

Staff should be reassured that the UHB will take a considered approach to monitoring. However, it reserves the right to adopt different monitoring patterns as required. Monitoring is normally conducted where it is suspected that there is a breach of either policy or legislation. Furthermore, on deciding whether such analysis is appropriate in any given circumstances, full consideration is given to the rights of the employee.

Managers are expected to speak to staff of their concerns should any minor issues arise. If breaches are detected, an investigation may take place. Where this or another policy is found to have been breached, disciplinary procedures will be followed.

Concerns about possible fraud and or corruption should be reported to the counter fraud department.

In order for the UHB to achieve good information governance practice staff must be encouraged to recognise the importance of good governance and report any breaches to enable lessons to be learned. They must be provided with the necessary tools, support, knowledge and training to help them deliver their services in compliance with legislation. Ultimately, a skilled workforce will have the confidence to challenge bad information governance practice and understand how to use information legally in the right place at the right time. This should minimise the risk of incidents occurring or recurring.

11. Review

This policy will be reviewed every two years or more frequently where the contents are affected by major internal or external changes such as:

- Changes in legislation;
- Practice change or change in system/technology; or
- Changing methodology.

12. Equality Impact Assessment

This policy has been subject to an equality assessment.

Following assessment, this policy was not felt to be discriminatory or detrimental in any way with regard to the protected characteristics, the Welsh Language or carers.

13. Documents to read alongside this Procedure

- Records Management Procedure
- Records Management Retention and Destruction Protocol and Schedule
- Information Governance Policy and Framework
- Data Protection Act Policy and Procedures
- Freedom of Information Act Procedure
- Risk Management Policy
- Information Risk Management Procedure
- Guide to Incident Reporting Incident Management Investigation and Reporting. [Serious incidents]
- Electronic and Paper Clinical Results Review and Retention Protocol

- Records Management Code of Practice for Health and Social Care 2016
- Data Quality Operational Management and Responsibilities
- Records Management Policy
- Records Management Retention and Destruction Protocol
- Validation at Source System (VASS) checks mandated by Welsh Government.
- Data Standard Change Notifications (DSCNs) issued by the National Wales Informatics Service
- Other relevant documents mandated by Welsh Government

Appendix: Inappropriate use

For the avoidance of doubt, the UHB will generally consider any of the following inappropriate use:

- Knowingly using another person's NHS Wales email account and its functions, or allowing their email account to be used by another person without the relevant permission. Note: If an email is required to be sent on another person's behalf then this must be performed using delegated permissions functionality and must be approved for use beforehand;
- Allowing access to NHS Wales email services by anyone not authorised to access the services, such as by a friend or family member;
- Communicating or disclosing confidential or sensitive information unless appropriate security measures and authorisation are in place;
- Communicating or saving any information or images which are unlawful, or could be regarded as defamatory, offensive, abusive, obscene, hateful, pornographic, violent, terrorist, indecent, being discriminatory in relation to the protected characteristics, or using the email system to inflict bullying or harassment on any person.
- Knowingly breaching copyright or Intellectual Property Rights (IPR)
- 'Hacking' into others' accounts or unauthorised areas;
- Obtaining or distributing unlicensed or illegal software by email;
- Deliberately attempting to circumvent security systems protecting the integrity of the NHS Wales network;
- Any purpose that denies service to other users (for example, deliberate or reckless overloading of access links or switching equipment);
- Deliberately disabling or overloading any ICT system or network, or attempting to disable or circumvent any system intended to protect the privacy or security of employees, patients or others;
- Intentionally introducing malicious software such as Viruses, Worms, and Trojans into the NHS Wales network;
- Expressing personal views that may bring the UHB into disrepute;
- Distributing unsolicited commercial or advertising materials;
- Communicating unsolicited personal views on political, social, or religious matters with the intention of imposing that view on any other person. This does not preclude Trade Union officials from communicating with staff on Trade Union related matters;
- Installing additional email related software, or changing the configuration of existing software without appropriate permission;
- Sending unlicensed or illegal software or data including executable software, such as shareware, public domain and commercial software without correct authorisation;
- Forwarding chain email or spam (unsolicited mail) within the organisation or to other organisations;
- Subscribing to a third party email notification using a NHS Wales email account for reasons not connected to work, membership of a professional body or trade union;
- Sending personal photos or videos;
- Registering an NHS Wales e-mail address with any third party company for personal use (e.g. department store accounts; online grocery shopping accounts);
- Access to internet based e-mail providers including services such as Hotmail, Freeserve, Tiscali etc is prohibited for reasons of security with the exception of:
    - Access to email services provided by a recognised professional body or a trade union recognised by the employer;
    - Any UK university hosted e-mail account (accounts ending in .ac.uk);
    - Any email account hosted by a body which the employee contributes to in conjunction with their NHS role, such as a local authority or tertiary organisation.

Annex 1: Policy Development - Version Control

Revision History

Date	Version	Author	Revision Summary
1/8/18	-	Andrew Fletcher, NWIS	NWIS policy documents for Information Governance, Information Security, Internet Use and Email Use
15/8/18	V0.1	Andrew Nelson	Amendments to draw documents together and include UHB 12 commandments, local variation and requirements for adoption of technical and data standards
17/8/18	V0.2	PJR, JW & AVN	Inclusion of DQ, data standards and medical records. Clarification of information ownership in respect of data stored on UHB network
15/11/2019	V0.3	JW & DJ	Incorporation of all-Wales Email Policy.

Reviewers

This document requires the following reviews:

Date	Version	Name	Position

Approvers

This document requires the following approvals:

Date	Version	Name	Position

Annex 2: Equality Impact Assessment

Equality Impact Assessment (EQIA) Form		
Ref no: POL/IGMAG/IG/v1		
Name of the policy, service, scheme or project:	Service Area	
C&V Information Governance Policy	Information Governance	
Preparation		
Aims and Brief Description	The policy is a new All Wales Information Governance Policy. The policy will replace all local policies in this area.	
Which Director is responsible for this policy/service/scheme etc	Adaptation of existing policies and the NWIS policy	
Who is involved in undertaking the EQIA		
Have you consulted with stakeholders in the development of this policy?	*Yes. A sub group has developed this policy with a membership consisting of information governance leads and an OSSMB representative. IM&T leads and the Wales Partnership Forum have been consulted.* *The NHS Wales Information Governance Management and Advisory Group have approved the text of this Policy. The policy will be approved by the Wales Information Governance Board.*	
Does the policy assist services or staff in meeting their most basic needs such as; Improved Health, fair recruitment etc	*Yes. The policy will provide consistency throughout NHS Wales in having a single policy. This will ensure that staff who work across boundaries have a consistent standard to work to, hence strengthening the governance framework. A key driver during the process was the need to recognise that organisations needed to trust their staff.*	
Who and how many (if known) may be affected by the policy?	*All NHS Wales staff within the Health Boards and NHS Trusts.*	
What guidance have you used in the development of this service, policy etc?	*The policy is based on good practice and legal obligations as set out by the Information Commissioners Office and in the legislation. The policy has also been constructed from existing agreed principles and the corporate knowledge of its stakeholders.*	

Equality Duties

The Policy/service/project or scheme aims to meet the specific duties set out in equality legislation.	Protected Characteristics										
	Race	Sex/Gender	Disability	Sexual orientation	Religion and Belief	Age	Gender reassignment	Pregnancy and Maternity	Marriage & civil Partnerships	Welsh Language	Carers
To eliminate discrimination and harassment	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Promote equality of opportunity	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Promote good relations and positive attitudes	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Encourage participation in public life	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
In relation to disability only, should the policy / service / project or scheme take account of difference, even if involves treating some individuals more favourably?							✓				

Key	
✓	Yes
x	No
-	Neutral

Human Rights Based Approach – Issues of Dignity & Respect

The Human Rights Act contains 15 rights, all of which NHS organisations have a duty. The 7 rights that are relevant to healthcare are listed below.

Consider is the policy/service/project or scheme relevant to:	Yes	No	N/A
Article 2: The Right to Life	X		
Article 3: the right not to be tortured or treated in a inhumane or degrading way	X		
Article 5: The right to liberty	X		
Article 6: the right to a fair trial	X		
Article 8: the right to respect for private and family life	X		
Article 9: Freedom of thought, conscience and religion	X		
Article 14: prohibition of discrimination	X		

Measuring the Impact

What operational impact does this **policy, service, scheme or project**, have with regard to the Protected Characteristics. Please cross reference with equality duties

	Impact – operational & financial
Race	This is a high level framework approach which aims to achieve the values under the policy, it is the protection of everybody's information and gives clear guidelines. The policy details how the organization protects someone's data and security without prohibiting access to services and providing adequate access to data to meet individual needs and the appropriate sharing of data.
Sex/gender	
Disability	
Sexual orientation	
Religion belief and non belief	
Age	
Gender reassignment	
Pregnancy and maternity	
Marriage and civil partnership	

Other areas	
Welsh language	
Carers	

Outcome report

Equality Impact Assessment: Recommendations Please list below any recommendations for action that you plan to take as a result of this impact assessment						
Recommendation		**Action Required**	**Lead Officer**	**Time-scale**	**Resource implications**	**Comments**
1	Communication of the changes	Make sure staff aware of the changes	AF	ASAP	Time	

Recommendation	Likelihood	Impact	Risk Grading
1	2	2	4
2	2	2	4

Risk Assessment based on above recommendations

Reputation and compromise position			**Outcome**
It is providing security and reassurance to stakeholders that the information we hold is used appropriately and any breach may lead to fines and reputational damage.			To ensure that information is used and protected appropriately and a framework in place to ensure that happens.
Training and dissemination of policy			
More training and dissemination in Health Boards on this policy.			
Is the policy etc lawful?	**Yes** ☒	**No** ☐	**Review date**
Does the EQIA group support the policy be adopted?	**Yes** ☒	**No** ☐	**3 years**
Signed on behalf of C&V Equal Impact Assessment Group	S Brooks	Lead Officer	
Date:	8 May 2018	Date: 8 May 2018	

	1	2	3	4	5
	Negligible	**Minor**	**Moderate**	**Major**	**Catastrophic**

Statutory duty	No or minimal impact or breach of guidance / statutory duty Potential for public concern Informal complaint Risk of claim remote	Breech of statutory legislation Formal complaint Local media coverage – short term reduction in public confidence Failure to meet internal standards Claims less than £10,000 Elements of public expectations not being met	Single breech in statutory duty Challenging external recommendations Local media interest Claims between £10,000 and £100,000 Formal complaint expected Impacts on small number of the population	Multiple breeches in statutory duty Legal action certain between £100,000 and £1million Multiple complaints expected National media interest	Multiple breeches in statutory duty Legal action certain amounting to over £1million National media interest Zero compliance with legislation Impacts on large percentage of the population Gross failure to meet national standards

Risk Grading Descriptors

LIKELIHOOD DESCRIPTION	
5 Almost Certain	Likely to occur, on many occasions
4 Likely	Will probably occur, but is not a persistent issue
3 Possible	May occur occasionally
2 Unlikely	Not expected it to happen, but may do
1 Rare	Can't believe that this will ever happen

Report Title:	**Review of 'Dealing with Subject Access Requests under the Data Protection Act Procedure'**							
Meeting:	**Digital Health Intelligence Committee**					**Meeting Date:**	**03/12/2019**	
Status:	**For Discussion**		**For Assurance**		**For Approval**	**X**	**For Information**	
Lead Executive:	**Director of Digital Health Intelligence**							
Report Author (Title):	**Information Governance Manager**							

SITUATION:

The UHB needs to ensure that its staff are aware of their responsibilities to assist the UHB in implementing its procedure for processing Subject Access Requests under the GDPR. The UHB's current procedure was produced for compliance with the Data Protection Act 1998.

BACKGROUND:

Data protection legislation grants a number of rights to data subjects. These have been strengthened by the advent of the GDPR. One such right is the Right to Access, which allows data subjects to receive a copy from organisations of all information held relating to them. The UHB receives approximately 3000 Subject Access Requests per annum, mainly from patients but also from UHB employees.

ASSESSMENT:

The Information Governance team in partnership with Medical Records have reviewed and amended the UHB's 'Dealing with Subject Access Requests under the Data Protection Act Procedure'.

GDPR has brought about significant change in this area:

- Reduced time for compliance (now 1 month)
- Inability to charge for requests
- Requests can now be made by any means (including verbal)

Conforming to a strict procedure such as this is necessary to ensure compliance with the GDPR and avoiding the significant financial regulatory penalties made possible under Article 83 of the Regulation.

RECOMMENDATION:

The Board is asked to:

- **APPROVE** the updated 'Dealing with Subject Access Requests under the Data Protection Act Procedure'.

Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	**X**
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention		Long term		Integration		Collaboration	**X**	Involvement	

Equality and Health Impact Assessment Completed:	Yes / No / Not Applicable If "yes" please provide copy of the assessment. This will be linked to the report when published.

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Caerdydd a'r Fro | Cardiff and Vale University Health Board	**Reference Number: UHB 291 Version Number: 1 Date of Next Review: 18 Dec 2018 Previous Trust/LHB Reference Number:N/A**

Dealing with Subject Access Requests under Data Protection Legislation Procedure

Introduction and Aim

The General Data Protection Regulation and the Data Protection Act 2018 (together, the **Data Protection Legislation**) are the main pieces of legislation governing the protection of personal data in the UK.

Articles 12 to 22 of the GDPR give individuals various rights in respect of their personal information, including under Article 15 of the GDPR, the right for any living individual (or their nominated representative e.g. a solicitor) to request access to the personal information that an organisation is holding about them. This is known as the right to "subject access request". Organisations have a legal obligation to comply with these requests and provide personal information to the requestors subject to certain specified exemptions.

GDPR also gives individuals the following rights that might be relevant to this procedure:

- The right to be informed
- The right to rectification
- The right to erasure
- The right to restrict processing
- The right to data portability
- The right to object
- Rights in relation to automated decision making and profiling

If personal data is being processed, individuals have as the right to be given a description of the data, the purposes of the processing and if the information is to be shared, who it will be shared with. The individual is also entitled to apply for access to personal data of which they are the subject. Access encompasses the rights to obtain a copy of the record in permanent form, have information provided in an intelligible format (and explained where necessary, eg medical abbreviations) and where the individual agrees, the access right may be met by providing a facility for the individual to view the record without obtaining a copy.

If a request is for a medical report/record to be created, or for interpretation within a medical report/record, this will fall under the Access to Medical Reports Act 1988 (AMRA). As these both require new data to be created, they are outside the scope of the Data Protection Legislation.

This procedure outlines the standard process to be followed by Cardiff and Vale University Health Board (the UHB) to ensure that we adhere to the legislation and we have a consistent approach for dealing with requests for personal information. This procedure supports the UHB's overarching Information Governance Framework.

The procedure will ensure that the UHB fully complies with the legislative requirements of the Data Protection Legislation thereby mitigating any potential risks resulting out of non compliance, such as substantial fines or enforcement action from the Information Commissioner. This procedure will also demonstrate that the UHB operates in an open and transparent manner thereby enhancing the

reputation of the organisation.

Objectives

In accordance with the Data Protection Legislation, this procedure will ensure that:

- All staff will be able to recognise requests and will know what needs to be done with them such as where they need to be sent for action
- Staff responsible for processing requests follow agreed and approved processes ensuring full compliance with the Data Protection Legislation
- All subject access requests are processed within the legislative timeframe
- Appropriate and relevant information will be released in accordance with the requirements of the Data Protection Legislation
- Advice and assistance will be provided where appropriate and necessary
- Complaints about any aspect of the UHB's compliance with the Data Protection Legislation are dealt with promptly and impartially

 Interests of third parties who may be affected by any disclosure of information are respected.

Scope

Elements of this procedure apply to all of our staff in all locations including those with honorary contracts.

Equality Impact Assessment	An Equality Impact Assessment has not been completed as this procedure has been written to support the Information Governance Policy. The Equality Impact Assessment completed for the Policy found there to be some impact in relation to communication and an Action Plan has been developed to address the issues.
Documents to read alongside this Procedure	Information Governance Policy General Data Protection Regulation Data Protection Act 2018 Data Protection Act Policy Freedom of Information Act 2000 Freedom of Information Act Policy Freedom of Information Act Procedures Disclosure of Personal Data to the Police Guidelines
Approved by	Information Technology and Governance Sub Committee
Accountable Executive or Clinical Board Director	Medical Director – Caldicott Guardian Senior Information Risk Officer (SIRO)
Author(s)	Senior Manager Performance and Compliance

Disclaimer

If the review date of this document has passed please ensure that the version you a using is the most up to date either by contacting the document author or the Governance Directorate.

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Summary of reviews/amendments

Version Number	Date of Review Approved	Date Published	Summary of Amendments
1	18/12/2015	06/04/2016	New Document
2			Updated document

Contents Page

10	16. Standard Application Form 17. Record of Verbal Request	

1. Compliance with the Data Protection Legislation

Under the Data Protection Legislation requests must be complied with within one month of the UHB receiving it, or in any case within one month of receipt of any further information required to identify the correct individual and, where applicable, the required fee is paid. This period may be extended for a further two months where necessary, taking into account the complexity and number of requests.

The UHB has identified where subject access requests are more likely to be made and will ensure that awareness training is provided to all staff in those areas. Staff in areas where requests are ultimately handled must be provided with comprehensive training. The training should cover:

- required format of a subject access request;
- correct identification of the requesting individual;
- location of personal information;
- timescales for compliance;
- provision of information in an intelligible format;
- action to be taken if the information includes third party data or if it has been determined that access will seriously harm an individual

The UHB will ensure that its subject access procedures are reviewed regularly, and will implement additional procedures to assess and improve performance in meeting the statutory timeframes (or any more restricted timeframes required by the subject access request procedures).

2. Roles and Responsibilities

2.1 Medical Director

The Medical Director as Caldicott Guardian has responsibility to ensure compliance with the Data Protection Act in respect of Medical Records

2.2 Board Secretary

The Director of Informatics as Senior Information Risk Officer (SIRO) has responsibility to ensure compliance with the Data Protection Legislation in respect of all other corporate records including those containing personal information. Whilst the UHB will use its reasonable offers to make as much personal information in respect of Subject Access Requests, lack of intraoperability between some IT systems may mean that such requests cannot be fully complied with.

References to designated managers extend to appropriate alternates in terms of discharging relevant roles and responsibilities.

Routine processing of subject access requests will fall primarily within the following areas:

Information Governance Department – Non medical records Legal services Medical Records Department – Centrally held Medical Records

- **Non centrally held medical records.** These include the following areas and each will have devolved Standard Operating Procedures (SOP) for dealing with these requests these will be detailed within this procedure. These devolved areas include:

- Dental Hospital – Dental records
- Occupational Health Department – Occupational Health Records
- Community Teams – Community Records
- Mental Health Records - Employee Wellbeing Service
- Physiotherapy Records
- Podiatry Records
- Dietetic Records
- Occupational Therapy Records
- Primary Care Records
- Media Resources Records

2.3 Information Governance Department

Information Governance Department will provide advice and support for all UHB staff in relation to the Data Protection Legislation and will be responsible for releasing or overseeing the release processes for all records other than medical records which will be issued by the Medical Records Department.

Within the Information Governance Department there will be an Information Governance Co-ordinator with responsibility for receiving and logging requests within a central data base. The co-ordinator will issue

acknowledgement letters and will oversee the process of obtaining and collating information throughout the UHB.

2.4 Medical Records (Central)

The team within central medical records will be responsible for processing requests for access to medical records held centrally. The Department will provide a quarterly report on activity to the information governance team for onward reporting to the Information Technology and Governance Sub Committee to provide assurance that the UHB is meeting its legal obligation in respect of subject access under the Data Protection Legislation. Appendix 1 provides full details of the process to be followed in central medical records department. There are separate procedures for process to be followed in the devolved areas and these are attached in the appendices below.

2.5 All Staff

All staff are responsible for ensuring that all requests seeking access to personal information are directed to the appropriate area as defined above as soon as the request is received. If advice or guidance is required this will be provided by the Information Governance Department.

Staff who are required to provide information which is held within their area in response to a subject access request must ensure that every effort is undertaken to identify, locate, retrieve and provide the information as soon as practicably possible in order that the UHB can fully comply with the subject access time limit requirements. It is an offence to delete information that is held which has been requested under the Data Protection Legislation. Should there be any doubt about what can and cannot be provided, then guidance and advice must be sought from the information governance department.

3. Making a request to access personal information (subject access request)

- Applicants who make contact either in person or by telephone should be encouraged to put their request in writing. However, this is not a requirement of the legislation and therefore the UHB must accept requests made verbally. Wherever possible verbal requests should be documented on the relevant pro forma (Contents item 10 refers).
- Standard subject access request form should be issued to the requestor advising the form should be returned to the Information Governance Department or Medical Records Legal Services.
- Requests received by letter, fax or e-mail must be directed immediately to the Information Governance Department or Medical Records Legal Services.
- Applicants will be required to provide appropriate proof of identification before the request can be processed. The identification acceptable

would be driving licence, passport or copy of a recent utility bill, no more than three months old.

- Requests from nominated representatives (e.g. solicitor) acting on behalf of an individual must have signed written consent from the individual and this will be retained with the SAR from and proof of identification.
- The UHB is legally obliged to comply with all subject access requests within one month of receipt of request. The one month to commence only after receiving the verified proof of identification and, where applicable, the necessary fee. The UHB may extend the one month period for a further two months where necessary, taking into account the complexity and number of requests.

4. Charging for subject access requests

- No fees apply to the processing of subject access requests of any kind unless a request is manifestly unfounded or excessive. No charges will be made to cover photocopying or postage fees unless the applicant offers to pay these costs and the UHB accepts this offer. If the applicant subsequently withdraws this offer these costs cannot be charged. . .
- Where the UHB is able to charge a fee, this must be requested promptly on receipt of the subject access request. The one month deadline will not commence until the fee and proof of identification is received from the applicant and the ID is approved as suitable for processing of the request under the Data Protection Legislation.
- If the fee and/or proof of identification has not been received with the initial application but all the necessary information required to process the application has been provided then a standard letter (SL2) should be issued to the applicant to request the outstanding item.

5. Procedures for processing requests

- Requests may be received anywhere within the UHB. Although the UHB encourages individuals to put their requests in writing, this is not a requirement of the legislation and so requests may be made verbally.
- All requests must be transferred immediately to the appropriate department either Medical Records, Information Governance Department (IG) or devolved medical records settings as per item 2.2 Requests for General Practice records should be directed to the relevant practice .
- Requests to be logged in databases and either reference number or hospital number allocated
- Request to be acknowledged (SL1)
- If sufficient information provided by applicant to continue processing request this to be forwarded to the appropriate individuals/departments for information to be extracted
- Information to be returned for consideration for release
- Response to be issued including information appropriate for disclose

More detailed area specific procedures are provided in the appendices below

6. Requests from the Police

If requests are received from the police then information can be provided if consent has been given by the relevant individual, any consent must be documented.

The police may seek personal data under an exemption in the Data Protection Act 2018 that permits the UHB to make a disclosure without the subjects consent. The exemption at paragraph 2 of Schedule 2 of the Data Protection Act 2018 may apply when disclosure of personal data to the police is necessary for the purposes of:

a. the prevention and detection of crime, or b. the apprehension or prosecution of offenders

Information can be provided without consent if it is believed that gaining consent would prejudice an investigation (e.g. evidence destroyed).

Police forces have standard forms for requesting personal data, in accordance with guidance issued by the Association of Chief Police Officers (ACPO). The form should certify that the information is required for an investigation concerning national security, the prevention or detection of crime, or the apprehension or prosecution of offenders, and that the investigation would be prejudiced by a failure to disclose the information. The form must be signed by the senior officer in charge of the investigation

Disclosures of personal information to the police should only be made by departmental managers, equivalent or more senior members of UHB staff. All disclosures must be recorded; including the reasons how and why the decision to disclose was reached.

It is important to ensure the identity of anyone requesting information is checked and that only the minimum amount of information is provided to satisfy the request. Always seek advice when making any decision regarding disclosure and ensure that a record is retained within the patients' health record or the employee personnel file detailing the reasoning for decisions to release information.

In addition the UHB can receive Courts Orders for information to be provided and these must be complied with unless it is decided to challenge the Order at Court. Further information is contained within the following document "Disclosure of Personal Data to the Police Guidelines"

7. Reporting Arrangements

Compliance against the one month response limit will be recorded and reported to the Information Technology and Governance Sub Committee (ITGSC), within the integrated Information Governance Report, at every meeting. The reports

will identify any areas of weakness for compliance within the UHB and plans to address continued poor performance will be developed and monitored via the ITGSC. If necessary any identified high risk areas will be included within the IG risk register as will the requirement to comply with the one month limit and potential risks of fines or enforcement action from the Information Commissioner.

8. Complaints and feedback

If applicants are dissatisfied with the way the UHB has dealt with their subject access request they can appeal against any decisions by writing either to the Director of Informatics/SIRO, in relation to medical records access, or the SIRO for non health records. The file will then be reviewed by the Senior Manager responsible for Information Governance and the findings and outcomes of the review will be discussed with the Director of Informatics/SIRO and the decision of the review will be communicated to the applicant by the Senior Manager responsible for Information Governance on behalf of the Director of Informatics/SIRO. The response must include contact information for Information Commissioners Office (ICO) and explain the right of the applicant to request the ICO to review the matter as the independent regulator with responsibility for data protection issues.

APPENDIX 1

STANDARD OPERATING PROCEDURES FOR DEALING WITH NON MEDICAL RECORDS

1. Receipt of Request

- Requests can be received anywhere within the UHB and do not need to be made in writing. All requests must be sent immediately to the Information Governance Department (IG).
- On receipt of request the IG Co-ordinator will log the request on the database allocating a unique identifying reference number.
- Create a new electronic file within the Information Governance s:/drive using the unique reference number and this file will be used to save all correspondence relating to the request and its processing this will include copies of information issued/redacted.
- If the request contains sufficient information to process the IG co-ordinator will issue a standard acknowledgement letter stating the request will be processed within one month.
- If identification has not been included this will be requested by the IG co-ordinator using standard letter
- If insufficient information provided to process the request a standard letter will be issued along with an accompanying subject access request form

- If request is from a representative of an individual a letter of consent must be obtained.

2. Processing of Request

- On receipt of all documentation and proof of identification the co-ordinator will ensure the documents are valid.
- Following confirmation of identity and receipt of fee (if any applicable) the start date and due date will be entered on the database.
- Any fee receivedwill be banked and receipt obtained
- The standard acknowledgement letter will be issued to include the cashiers receipt for the payment of any fee received.
- The co-ordinator will then issue a request to the relevant departments identified by the requestor as holding the information they wish to access. If an individual has requested all information held on them within the organisation a search of all relevant databases and filing systems (including archived systems) should be initiated
- The co-ordinator will monitor timely responses from the departments providing the information for responding

Types of personal information that may be held by the UHB include the following ○ Personnel /Human resources files if the applicant is /was a member of staff or applied for a post within the UHB (or any predecessor organisations in existence before 2009 organisational changes)

- ○ Complaints files
- ○ Client files or reports such as delayed transfers of care or applications for funding
- ○ Payments made or received by the applicant
- ○ Information held by other organisations on behalf of the UHB
- ○ E-mails held within filing systems or outlook boxes
- ○ General files

3. Reviewing information

Once information returned to the Information Governance Department will undertake the following process:

- All information collated will be reviewed by a member of the Information Governance Team
- If any third party individual, not including a health professional, is named or has provided information about the applicant the following must be considered by the IG team prior to releasing information:- ○ Can the request be complied with without revealing information which relates to and identifies any third party individuals? If so the third party information must either be removed prior to releasing or

alternatively the consent of the third party individuals must be obtained

- Careful consideration must be given prior to disclosure to ensure that the applicant would not suffer harm or distress on receipt of the information. This will be the subject of discussion with the relevant departmental manager

4. Releasing / Refusing Information

Generally, the UHB will provide information to the requestor except where an exemption preventing or restricting access applies. Access may be denied or restricted where:

- The record contains information which relates to or identifies a third party that is not a care professional and has not consented to the disclosure. If possible the individual should be provided with access to that part of the record which does not contain the third party information.
- Access to all or part of the record will prejudice the carrying out of social work by reason of the fact that serious harm to the physical or mental well-being of the individual or any other person is likely. If possible the individual should be provided with access to that part of the record that does not pose the risk of serious harm.
- Access to all or part of the record will seriously harm the physical or mental well-being of the individual or any other person. If possible the individual should be provided with access to that part of the record that does not pose the risk of serious harm.
- Any other exemption under the Data Protection Legislation applies.

Wherever practical, responses will be sent via secure electronic methods of transmission. Where a patient records a "hard copy" response, these are to be sent via recorded delivery marked private and confidential. As soon as any reply has been issued the database will be updated to reflect the date and compliance with the one month limit.

APPENDIX 2

REQUESTS TO ACCESS HEALTH RECORDS CENTRALLY HELD (HEALTH RECORDS DEPARTMENT)

Relevant legislation

Access to Health Records Act 1990

- Applies to deceased patients only. Relatives can only have access to information from November 1st 1991.

General Data Protection Regulation and Data Protection Act 2018

- Applies to all other patients wishing to access their records. Access to Health Records can be supplied from birth.

Applications

1.
2. The applicant will be asked to complete an application form in order to assist with verification to ensure the correct case records are actioned.
3. All applications will be logged on a central database, stating department, clinician and date sent on the master control sheet.
4. All 'patient' applications must be billed and paid for before work on medical records is commenced. If proof of identification is not provided this will be requested before request will be processed.
5. An application will be deemed valid from the date of receipt of completed application form from solicitor or invoice payment by patient.
6. If request is for records not held centrally the request will be logged on the main database and forwarded to the relevant area to process and respond. The date the response is issued must be advised to the legal team to update the central database for monitoring against one month limit.

Processing and Responding

1. The relevant medical record will be obtained and passed to the appropriate health care professional for advice. He/she should consult with other health professionals who have had a significant input to the patient's care.
2. The health care professional should see the record itself or an extract. If the applicant is to see an extract, that extract must be provided by the health care professional.
3. If supervision of access to the record is necessary, an appointment will be made for the applicant to meet the health records manager.

4. The health records are viewed by the applicant/s in the presence of the health records manager. The applicant is entitled to be supplied with photocopies of records and these will be provided as necessary.
5. On conclusion of the inspection, the control sheet will be appropriately noted and filed with the application form.
6. Records are sent to the solicitor of applicant via courier. Update database with details.

Fees

- No charge will be made for photocopying and postage unless the applicant offers to pay this and this offer is not subsequently withdrawn .

Information and Advice to Patients

- Information advising patients of their rights under the Data Protection Legislation will be displayed in the hospital, and information booklets will also provide guidance.
- If patients have difficulty making an application, staff from the Legal Department in Health Records will provide assistance.

Procedures for Dealing with Requests from Benefit Agency Benefits Claims

1. Receive claim form from Benefits Agency e.g. CICB, DSS and date stamp.
2. Enter information onto control sheet and ensure that progress is noted appropriately.
3. Enter details into either DSS or insurance book or control sheet.
4. If a medical record report is required, pass the appropriate forms to the clinician responsible.
5. Double wrap any health records to the Benefits Agency and send recorded delivery.
6. If confirmation of attendance or admission dates are required, check details on PMS, enter details on relevant form, sign, date and hospital stamp. Post to Benefits Agency.

Procedures for Dealing with Insurance Claims Insurance Claims

1. Receive claims forms from insurance companies e.g. BUPA, PPP, WHA etc. Date stamp.
2. Confirm if attendance or admission dates are required, check details on Patient Management System, enter correct dates on form, sign, date and add hospital stamp.
3. If medical report is required, pass the health record and appropriate forms to the clinician responsible.
4. Post completed form to patient or insurance company as required.
5. Enter details in book.

Litigation

1. Inform UHB Head of Corporate Governance of any possible forthcoming litigation cases.

APPENDIX 3

REQUESTS TO ACCESS DENTAL RECORDS

Relevant legislation

Access to Health Records Act 1990

- Applies to deceased patients only. Relatives can only have access to information from November 1st 1991.

General Data Protection Regulation and Data Protection Act 2018

- Applies to all other patients wishing to access their records. Access to Health Records can be supplied from birth.

Applications

1. The applicant will be asked to complete the standard application (see Contents item 10) and return to Information Governance Department
2. When form returned IG will log on the central database (reflecting that it is a request for Dental Records)
3. IG Dept will check the request contains sufficient information to process including appropriate identification and/or required fee.
4. If identification and/or any applicable fee have not been included this will be requested by the IG co-ordinator using standard letter
5. If request is from a representative of an individual a letter of consent must be obtained.
6. As soon as all information including fee and identification is provided all documentation will be sent immediately to Dental for processing.
7. When request received in Dental any applicable fee will be banked and a receipt obtained.
8. A standard acknowledgement letter will be issued with the receipt for payment attached stating the request will be processed within 40 calendar days.

If requests are received directly by the Dental Hospital they must inform the Information Governance Department to ensure that the request is logged appropriately.

Processing and Responding

1 The relevant record will be retrieved and copied, If images or photographs are requested these will be copied to CD
2 Once all the requested information is collated and copied this will be considered to ensure it does not contain personal information relating to another individual other than the requestor.
3 Once satisfied all information is suitable and appropriate for issue the complete file will be sent to the consultant who had the last contact with the person making the request.
4 This consultant will review the complete file and authorise its release to the requestor.
5 Any delays in returning the file will be actively chased to ensure that breaches of the one month time limit are minimized.
6 As soon as the consultant confirms authorization the response should be sent via recorded delivery marked private and confidential. Or alternatively the requestor can collect if they wish to do so.
7 As soon as the reply has been issued Information Governance Department MUST be notified in order that the database can be updated to reflect the date and compliance with the one month limit.

Requests from Dentists / GP's

When requests received directly from GP's or dentists then a standard application form must be sent directly to the patient concerned. No requests will be processed until the signed application form is returned from the patient with all the required documentation and the processes identified above will then be followed.

Requests from Solicitors/Legal representatives forwarded from Medical Records Legal Department

Confirmation must be sought and obtained that dental records are specifically required before these requests will be actioned to ensure that there is no unnecessary work undertaken to retrieve and provide dental records which are not wanted.

Once confirmation provided records will be provided directly to Medical Records legal department for issue.

APPENDIX 4

REQUESTS TO ACCESS OCCUPATIONAL HEALTH RECORDS

Applications

1. Applications must be sent to Occupational Health Department (OHD)

2. The applicant will be asked to complete a standard application form
3. OHD Medical Secretaries will notify Information Governance (IG) of the application either by e-mail or telephone and the application will be logged in the main IG database.
4. If request is from a representative then a letter of consent must be provided or obtained.
5. OHD Medical secretaries will issue a standard acknowledgement letter stating the request will be processed within one month.
6. If identification and/or fee have not been included this will be requested.
7. All applications must be billed and paid for before work is commenced.
8. An application will be deemed valid from the date of receipt of completed application form or invoice payment by patient.

Processing and Responding

1. The fee will be banked and receipt obtained.
2. The relevant record will be retrieved and referred to the appropriate healthcare professional for any advice. He/she should consult with other healthcare professionals who have had input to the individuals care.
3. The HC professional should see the record itself or an extract. If the applicant is to see an extract, that extract must be provided by the health care professional.
4. The records must be viewed by the applicant/s in the presence of an agreed OHD professional. The applicant is entitled to be supplied with photocopies of records and these will be provided as necessary.
5. If supervision of access to the record is necessary, an appointment will be made for the applicant.
6. On conclusion of the inspection, OHD medical secretaries will notify IG Dept either by e-mail or telephone for the database to be updated accordingly.
7. Records that are copied for issue will be sent via courier and IG Dept must be notified of the date for the database to be updated accordingly.

Fees

1. No charge will be made for photocopying and postage unless the applicant offers to pay this and this offer is not subsequently withdrawn.

APPENDIX 5

STANDARD OPERATING PROCEDURES FOR DEALING WITH REQUESTS TO ACCESS RECORDS HELD BY COMMUNITY TEAMS

Relevant legislation
Access to Health Records Act 1990

- Applies to deceased patients only. Relatives can only have access to information from November 1st 1991.

General Data Protection Regulation and Data Protection Act 2018

- Applies to all other patients wishing to access their records. Access to Health Records can be supplied from birth.

APPENDIX 6

REQUESTS TO ACCESS MENTAL HEALTH AND ROOKWOOD HOSPITAL RECORDS

Relevant legislation

Access to Health Records Act 1990

- Applies to deceased patients only. Relatives can only have access to information from November 1st 1991.

General Data Protection Regulation and Data Protection Act 2018

- Applies to all other patients wishing to access their records. Access to Health Records can be supplied from birth.

Applications

1. The applicant will be asked to complete an application form in order to assist with verification to ensure the correct case records are actioned.
2. Once completed application form received this should be acknowledged either in writing or verbally.
3. Proof of identification must be sought and provided before work to retrieve records commences.
4. All applications will be logged on a central database, stating department, clinician and date sent on the database.

Charging

2. 1 No charge will be made for photocopying and postage unless the applicant offers to pay this and this offer is not subsequently withdrawn.

Processing and Responding

1. The relevant medical records will be obtained, including obtaining information from the Paris system, OT records, physiotherapy records and copies of all information will be made.
2. The completed file will be passed to the consultant (healthcare professional) who had the last contact with the patient for them to review the file. He/she should consult with other health professionals who have had a significant input to the patient's care.
3. The health care professional should see the record itself or an extract.
4. If the applicant has only requested to view an extract, that extract must be provided by the health care professional and once approval to disclose is provided by the healthcare professional arrangements can be

made for the records to be viewed by the applicant/s in the presence of the health records manager.

5. The applicant is entitled to be supplied with photocopies of records and these will be provided as necessary.
6. If supervision of access to the record is necessary, an appointment will be made for the applicant to meet the health records manager.
7. On conclusion of the inspection, the database will be appropriately noted.
8. If applicant has requested copies the once the file has been signed off by the healthcare professional the applicant will be contacted to establish the preferred method of sending or they will be given an option for collection.
9. If file is posted this will be via courier.

APPENDIX 7

STANDARD OPERATING PROCEDURES FOR DEALING WITH REQUESTS TO ACCESS PHYSIOTHERAPY RECORDS

Relevant legislation

Access to Health Records Act 1990

- Applies to deceased patients only. Relatives can only have access to information from November 1st 1991.

General Data Protection Regulation and Data Protection Act 2018

- Applies to all other patients wishing to access their records. Access to Health Records can be supplied from birth.

APPENDIX 8

STANDARD OPERATING PROCEDURES FOR DEALING WITH REQUESTS TO ACCESS PODIATRY RECORDS

Relevant legislation

Access to Health Records Act 1990

Applies to deceased patients only. Relatives can only have access to information from November 1st 1991. Access to a deceased person's medical notes should not be given if when the patient was alive, they indicated that they did not wish their notes to be disclosed to a particular person. Under the Data Protection Act 2018, access to a patient's medical records can only be disclosed providing the request satisfies one of the following conditions:

- The requestor has a legitimate care or research relationship with the patient(s).
- The disclosure is necessary for a justifiable business purpose.
- There is a legal obligation to disclose.
- The requestor has patient/subject consent to the disclosure

General Data Protection Regulation and Data Protection Act 2018

 Applies to all other patients wishing to access their records. Access to Health Records can be supplied from birth.

Applications

Any application for the copy of podiatry medical records should be made to the Head of Service, and must contain enough information to identify the person for whom the request is being sought. The request should always contain the written consent of the patient or their legal representative, and satisfy one of the conditions detailed above.

Podiatry Records are held in the following areas:

- Patient's PARIS Case Notes
- Patient's manual file (if applicable) Case Notes
- Assessments and Reports Letters to and from patient
- Results of medical investigations
- Letters to and from other Health Professionals

1. The applicant will be asked to complete an application form in order to assist with verification to ensure the correct case records are actioned.
2. Once completed application form received this should be acknowledged either in writing or verbally.

3. Proof of identification must be sought and provided before work to retrieve records commences.
4. All applications will be notified to the IG Dept for logging on the database

Charges

No charge is payable

1 No charge will be made for photocopying and postage unless the applicant offers to pay this and this offer is not subsequently withdrawn.

Processing and Responding

1. Any requests for copies of a patient's medical records received for any past or previous patient must be referred to the Head of Service or relevant Health Professional Lead in charge of the patient's care **before** notes are photocopied and/or printed out.
2. A copy of the request should be placed in the patient's manual file with the title "*Letter Requesting Copy of Medical Records*" .
3. The Head of Service or relevant Lead Professional in charge of the patient's care should check the patient's Podiatry records and either approve or refuse for copies of the patient's Podiatry records to be sent.
4. If the request for providing a copy of the patient's medical records is approved, the Head of Service or relevant Health Professional Lead in charge of the patient's care will inform the relevant Podiatry Service(s).
5. If the request for providing a copy of the patient's medical records is refused, Head of Service or relevant Health Professional in charge of the person's care will inform the relevant Podiatry Service(s) that the patient's medical records should not be disclosed and the reason why. The request should then be returned to the relevant referring person stating that under the Data Protection Act 2018, access to a patient's medical records cannot be disclosed and the reason for this must be provided.
6. Copies of the medical records should be posted by recorded delivery for confidentiality reasons in line with the UHB's "*Protocol for sending patient identifiable data or data useable for identity theft*". If someone is unavailable to take delivery of the medical records, they will need to be collected from the Post Office indicated on the card posted through the requestor's letterbox
7. Once the response has been issued IG Dept must be notified for the database to be updated t reflect the compliance against the one month limit

Further detailed information is available in the following document
“Guidance on the Management of the Request for Copies of Patient's Podiatry

Records”

APPENDIX 9

STANDARD OPERATING PROCEDURES FOR DEALING WITH REQUESTS TO ACCESS DIETETIC RECORDS

Relevant legislation

Access to Health Records Act 1990

- Applies to deceased patients only. Relatives can only have access to information from November 1st 1991.

General Data Protection Regulation and Data Protection Act 2018

- Applies to all other patients wishing to access their records. Access to Health Records can be supplied from birth.

Dealt with by Legal Services Medical Records
Request received verbally - send standard form to requestor
Completed form to be returned to Medical Records and request logged Request to be sent to Head of Dietetics.

APPENDIX 10

STANDARD OPERATING PROCEDURES FOR DEALING WITH REQUESTS TO ACCESS RADIOLOGY IMAGES

Relevant legislation

Access to Health Records Act 1990

- Applies to deceased patients only. Relatives can only have access to information from November 1st 1991.

General Data Protection Regulation and Data Protection Act 2018

- Applies to all other patients wishing to access their records. Access to Health Records can be supplied from birth.

APPENDIX 11

STANDARD OPERATING PROCEDURES FOR DEALING WITH REQUESTS TO ACCESS EMPLOYEE WELLBEING SERVICE RECORDS

Relevant legislation

Access to Health Records Act 1990

- Applies to deceased patients only. Relatives can only have access to information from November 1st 1991.

General Data Protection Regulation and Data Protection Act 2018

- Applies to all other patients wishing to access their records. Access to Health Records can be supplied from birth.

APPENDIX 12

PRIMARY CARE MEDICAL RECORDS

Relevant legislation

Access to Health Records Act 1990

- Applies to deceased patients only. Relatives can only have access to information from November 1st 1991.

General Data Protection Regulation and Data Protection Act 2018

Applies to all other patients wishing to access their records. Access to Health Records can be supplied from birth.

APPENDIX 13

EMERGENCY UNIT

Relevant legislation

Access to Health Records Act 1990

- Applies to deceased patients only. Relatives can only have access to information from November 1st 1991.

General Data Protection Regulation and Data Protection Act 2018

Applies to all other patients wishing to access their records. Access to Health Records can be supplied from birth.

APPENDIX 14

IVF

Relevant legislation

Access to Health Records Act 1990

- Applies to deceased patients only. Relatives can only have access to information from November 1st 1991.

General Data Protection Regulation and Data Protection Act 2018

- Applies to all other patients wishing to access their records. Access to Health Records can be supplied from birth.

APPENDIX 15

Media Resources

Relevant legislation

Access to Health Records Act 1990

- Applies to deceased patients only. Relatives can only have access to information from November 1st 1991.

General Data Protection Regulation and Data Protection Act 2018

- Applies to all other patients wishing to access their records. Access to Health Records can be supplied from birth.

APPENDIX 16

Standard Application Form

CARDIFF AND VALE UNIVERSITY HEALTH BOARD
BWRDD IECHYD PRIFYSGOL CAERDYDD A'R FRO
APPLICATION FOR ACCESS TO PERSONAL DATA
DATA PROTECTION ACT 1998

PLEASE COMPLETE IN BLOCK CAPITALS
DETAILS OF THE RECORD TO BE ACCESSED

Hospital/Clinic: _____

Patient: **Surname**: _____**Forename**: _____

Address: _____

_____

Date of Birth: _____ **Hospital Ref. No**._____
(If known)
Contact Telephone No: _____

Email Address: _____

If the name and/or address was different from the above during the period(s) to which the application relates please give details below:-

Previous Name: _____

Previous Address: _____

_____

PATIENT HOSPITAL CONTACTS:
Please provide as much information as possible. Give full details of all the episodes you are interested in and if you only wish to receive data relating to a specific aspect of one or other of these episodes please specify in the comments section.

CLINIC WARD ATTENDED	DATES	CONSULTANT	COMMENT

DETAILS OF APPLICANT (if different)

Surname: _____ **Forename:** _____

Address:

_____

_____

_

DECLARATION

I declare that the information given by me is correct to the best of my knowledge and that I am entitled to apply for access to the health record referred to above under the terms of the General Data Protection Regulation (GDPR).

1.	I am the patient	**YES**	**NO**
2.	I have been asked to act by the patient and have attached the patient's written authorisation.		
3.	I am acting in locoparentis and the patient is under 16 and :		
	Is incapable of understanding the request		
	Has consented to my making the request		
4.	I am the deceased patient's personal representative and have attached proof. (We will accept either a copy of the deceased		

	patients will, where you are named; or proof that you are their appointed representative. Without this proof, we are unable to carry out your request.)0		

PLEASE NOTE we also require photographic identification (copy of driving license/passport) and a copy of a utility bill with your current address. This is so we are able to confirm your identity and ensure we disclose records to the correct address. Without this ID, we will be unable to process your request so it is important to supply this ID immediately to avoid delay.

Signed: _____ Date:

_____

APPENDIX 17

CASEWORKER	Date Requested	Date Received
Dental		
Casualty		
X-Ray		
Physio		
UHW		
CRI/ ST DAVIDS		
Rookwood		
Llandough		
Whitchurch		
Barry		
# Old/New		
Ish Notes		
Colposcopy		
Neurophysiology		
Community & Health		
CRI Hand Notes		
UHL Hand Notes		
Media Resources		
Orthoptics		
CIT Folder		
Portal		
Audiology		
Derm Notes		

PATIENT NUMBER:

Patient Name:

Date Received:	Date Required:

Requested By:

Address to be Disclosed to:

NOTES NEEDED

ALL	**PART** FROM: TO:

Date Acknowledgement letter sent:

CONSENT

Consultant Sent To:

Date Sent To Consultant:

Sent Electronic Sign off **YES** **NO**

Electronic Sign Off Received from Consultant Date:

Actual Date Sent out:

CARMARTHEN ARCHIVE

	DISTRICT		**ORTHO**		**SCANNING**		**MICROFILM**		**MATERNITY**	
	Req	Rec	Req	Rec	Req	Rec	Req	Rec	Rec	Rec
Rookwood										
Barry/Picon										
Llandough										
UHW										

Remarks:

Report Title:	**Review of 'Freedom of Information Act 2000 and Environmental Information Regulations Act 2004 Procedure'**							
Meeting:	**Digital Health Intelligence Committee**					**Meeting Date:**	**03/12/2019**	
Status:	**For Discussion**		**For Assurance**		**For Approval**	**X**	**For Information**	
Lead Executive:	**Director of Digital Health Intelligence**							
Report Author (Title):	**Information Governance Manager**							

SITUATION:

The UHB needs to ensure that its staff are aware of their responsibilities to assist the UHB in implementing its procedure for processing requests under the Freedom of Information Act 2000 (the Act) and the Environmental Information Regulations 2004. The UHB's current procedure is due for review and needs to reflect updated practices.

BACKGROUND:

The Act grants a right of access to information held by, or on behalf of public authorities. This requires the sourcing of information across the UHB and information held by third parties on the UHB's behalf. The UHB received approximately 600 FOI requests in 2018. The UHB's working practices have evolved over the last 12 months to satisfy increased demand.

ASSESSMENT:

The Information Governance department has reviewed the UHB's 'Freedom of Information Act 2000 and Environmental Information Regulations Act 2004 Procedure'.

This review has led to the following changes:

- Roles and responsibilities updated to reflect current personnel
- Service input is obtained at an earlier stage to prevent delay in the approval process.
- Links to current legislation, Codes of Practice and UHB policies have also been updated.

The ICO actively monitors those organisations that consistently fall short of the minimum expected compliance level of 90%. The ICO has signified their intention to increase FOI compliance via regulatory enforcement action. This requires the UHB to conform with the 'Freedom of Information Act 2000 and Environmental Information Regulations Act 2004 Procedure'.

RECOMMENDATION:

The Board is asked to:

- **APPROVE** the updated 'Freedom of Information Act 2000 and Environmental Information Regulations Act 2004 Procedure'.

Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	**X**
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention		Long term		Integration		Collaboration	**X**	Involvement	

Equality and Health Impact Assessment Completed:	Yes / No / Not Applicable If "yes" please provide copy of the assessment. This will be linked to the report when published.

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Caerdydd a'r Fro | Cardiff and Vale University Health Board	**Reference Number:** ***TBA*** *unless document for review* **Version Number: 1** *unless document for review* **Date of Next Review:** *To be included when document approved* **Previous Trust/LHB Reference Number:** *Any reference number this document has been previously known as*

FREEDOM OF INFORMATION ACT 2000 AND ENVIRONMENTAL INFORMATION REGULATIONS 2004 PROCEDURE

Introduction and Aim

The Freedom of Information Act 2000, (FoI) and Environmental Information Regulations 2004 (EIR) are part of the Government's commitment to greater openness in the public sector. They give rights to the public to scrutinise the decisions of public authorities more closely and also provide a legal right for individuals to request information held by public authorities**.**

This procedure supports the Freedom of information Act Policy which falls within the scope of the UHB's overarching Information Governance Framework.

The procedure will ensure that the UHB fully complies with the legislative requirements of the FoI thereby mitigating any potential risks resulting out of non compliance enforcement notices from the Information Commissioner. This procedure will also demonstrate that the UHB operates in an open and transparent manner thereby enhancing the reputation of the organisation.

Objectives

In accordance with FoI this procedure will ensure that:

- All staff will be able to recognise requests and will know where they need to be sent for processing
- Staff responsible for managing and processing requests follow agreed and approved processes ensuring full compliance with FoI
- Requests are processed within the legislative timeframe
- Appropriate and relevant information will be released in accordance with FoI requirements
- Advice and assistance will be provided where appropriate and necessary
- Complaints about any aspect of the UHB's compliance with FoI are dealt with promptly and impartially
- Interests of third parties who may be affected by any disclosure of information are respected.

Scope

This procedure applies to all of our staff in all locations including those with honorary contracts

Equality Impact Assessment	An Equality Impact Assessment (EqIA) has been completed for the associated policy and this found there to be a positive impact. Key actions have been identified and these have been incorporated within the Procedure developed in support of the policy.
Documents to read alongside this Procedure	• Freedom of Information Act 2000 • Data Protection Act 2018 • Environmental Information Regulations 2004 • Re-Use of Public Sector Information Regulations 2005 • WHC (2000)71 – For the Record: Managing Records in NHS Trusts and Health Authorities • Freedom of Information Code of Practice Issued under section 45 of the Act (July 2018), the CoP sets out good practice in handling requests for information. It will be necessary to comply with the CoP to fulfil the duty set out in Section 16 of the Act. • Lord Chancellor's Code of Practice on the Management of Records under section 46 of the Freedom of Information Act 2000 (July 2009) Part I sets out good practice in records management and applies to all FOI authorities and other bodies subject to the Public Records Act 1958 or the Public Records Act (Northern Ireland) 1923. • Data Protection Act Policy (to be removed) • Information Governance Policy • UHB Scheme of Delegation • Records Management Policy • Records Retention and Destruction Procedures
Approved by	Digital Health Intelligence Committee
Accountable Executive or Clinical Board Director	Medical Director
Author(s)	Information Governance Manager

Disclaimer

If the review date of this document has passed please ensure that the version you ar using is the most up to date either by contacting the document author or the Governance Directorate.

Summary of reviews/amendments			
Version Number	**Date of Review Approved**	**Date Published**	**Summary of Amendments**
	Date of Committee or Group Approval	*TBA*	*State if either a new document, revised document (please list main amendments). List title and reference number of any documents that may be superseded*

Contents Page

1. Background

The Freedom of Information Act 2000 (FoI) and Environmental Information Regulations 2004 (EIR) are part of the Government's commitment to greater openness in the public sector. They give rights to the public to scrutinise the decisions of public authorities more closely and also provide a legal right for individuals to request information held by public authorities**.**

Subject to specified exemptions and certain conditions contained in the FoI, Section 1 of the Act gives a general right of access to recorded information held. Any person making a request in writing in accordance with the requirements of the Act has the right to:

a) Be informed in writing whether we hold the information of the description as specified in the request (this is referred to as the "duty to confirm or deny"); and
b) Have it communicated to them, if it is held

There is no requirement for applicants to specify that a request for information is being made in accordance with the provisions of the FoI or EIR. However, the provisions of this legislation will apply to all requests that are submitted to Cardiff and Vale University Health Board (the UHB) seeking information.

The aim of this procedure is to ensure that the provisions of the FoI, EIR and the associated Re-use of Public Sector Information (PSI) Directive are adhered to.

The UHB supports the principle that openness should be the norm in public life and it will help and inform the public in relation to individuals' statutory rights to know about the organisation by ensuring that we routinely publish appropriate information. The administrative processes outlined in this procedure will not obstruct any existing current processes of providing help and information to the public whether that is provided orally, or via information available within our Publication Scheme.

The UHB accepts that individuals also have certain rights to privacy and confidentiality. The FoI clearly explains and defines the interface between the Freedom of Information Act 2000 and the General Data Protection Regulation (GDPR) and Data Protection Act 2018 (the DPA). This Procedure does not overturn the common law duty of confidence or statutory provisions (including the Human Rights Act 1998 and the Data Protection Act 2018) that prevent disclosure of personal identifiable information. The right to release personal identifiable information is covered by the subject access provisions of the GDPR and DPA and is dealt with in relevant UHB policies.

This procedure should not be read in isolation and consideration should be given to the Secretary of State's Code of Practice under Sections 45 and 46 on the practice to be followed in "Handling Requests for Information" and "Management of Records" respectively. The UHB

further recognises that although these Codes are not legally binding, failure to comply with them may lead to a failure to comply with the Act

2. LEGAL OBLIGATIONS

The UHB will:

- **Adopt and Maintain a Publication Scheme as required**

The UHB will routinely publish information held in a Publication Scheme as required. The scheme will fully detail all the information it will make routinely available to the public and indicate what information will be available on request. The UHB will ensure that the scheme is populated, maintained and regularly updated. The maintenance of an up-to-date and easy to understand Publication Scheme is an essential part of the UHB's commitment to openness. The more information published routinely the fewer formal requests will be received. Furthermore, when information can be made available under the Publication Scheme, then the administrative process necessary under the Freedom of Information Act rights of access are avoided, as published information qualifies for an exemption. The Publication Scheme will be available via the UHB web site.

- **Provide a General Right of Access to Recorded Information**

The Act states that all requests submitted to the University Health Board must be in a written format (this includes e-mail) and must detail:

- The name of the individual requesting the information
- An address for correspondence (postal or electronic)
- A description or details of the information requested

- **Provide Advice and Assistance to Requestors**

When a verbal request for information under FoI is made, the requestor must be asked to put their request in writing. If the requestor is unable to do this for any reason which includes some form of disability, they should be referred to the Information Governance Team who will provide advice and assistance in accordance with the requirements of the Act to ensure that all reasonable adjustments are made.

The only exception to this requirement relates to requests for information which will be eligible to be issued under EIR, such requests do not have the same requirement to be submitted in writing. Requests for information that would be covered within the confines of EIR can be made in writing, by e-mail, verbally over the telephone or by other means of communication for example such as by sign language.

When a request for environmental information is received by the UHB it will be handled in accordance with the requirements of the EIR and not the FoI. There is no requirement to specify or provide a reason or purpose for requesting information. However, the UHB maintains a right to request further details and information about the information that is required in order to narrow down what might otherwise be a vague or broad request.

Requestors are entitled to request information, and receive a response, in the language of their choice and the UHB is committed to ensuring it corresponds in the preferred language wherever possible.

FoI is fully retrospective and will apply to all information held by Cardiff and Vale UHB at the time the request is made and also to information pertaining to all the previous organisations that fall under its authority following re-organisations. The importance of effective systems of records management within the UHB cannot be emphasised or stressed strongly enough and all staff must ensure that information is maintained and destroyed in line with the Records Management Policy, Retention and Destruction Protocol and also guidance as contained in WHC (2000) 71 "For the Record: Managing Records in NHS Trusts and Health Authorities".

The provision of advice and assistance to members of the public about every aspect of the health services which the UHB provides is part of the day to day business process of the UHB. A key element of the procedure is that the release of information does not become cumbersome, time consuming or resource intensive. It is therefore expected that written requests for information which are part of our day to day business will continue to be handled in the normal way. The UHB will offer advice and assistance to any person wishing to make a request for information. We are committed to completing information requests within the statutory time scale of 20 working days and sooner wherever possible. In certain circumstances this time scale may be extended. Repeated or vexatious requests for information will be refused. The UHB will maintain its commitment to openness, scrutiny and the public interest while claiming exemptions where appropriate. Whilst the Act contains provision for the UHB to make charges when responding to requests, in the spirit of openness the UHB intends to provide as much information as possible free of charge. However, if a request is particularly complex or voluminous, or has a commercial implication, the UHB may request a fee in accordance with the fees regulations as set out by the Secretary of State.

- The UHB will have in place an appropriate procedure for balancing the public interest when considering an exemption which requires such a test.
- Any request in writing for recorded information will be considered a Freedom of Information request. There is no need for requests to indicate they are made under the Act
- The UHB may refuse requests where the cost of supply of the information would exceed the appropriate limit in accordance with the FoI and Data Protection (Appropriate Limit and Fees) Regulations 2004. This limit is currently £ 450.
- Where clarification is required or fees applicable, before providing the information, requesters will be informed in writing. The requester will be given two months to provide the clarification or fee and this will be communicated to the requester. If clarification or fees are not provided within this time the request will be closed and filed.
- Where we do not hold the information being requested but another organisation does, we will advise the requester to contact that other

organisation. Wherever possible we will provide up to date contact details for that organisation.

- Where the information being requested is held by us but was created by a third party, we will make every reasonable effort to contact that third party and consult with them regarding the disclosure.

A Standard Operating Procedure (SOP) outlining the processing of requests is attached as attachment I and attachment 2 provides a flowchart for the process.

3. REVIEW OF REQUESTS

Where a requester appeals against a decision and requests a review of the response to their request, a review will be undertaken by an individual, nominated by the Medical Director, who was not involved in making the original decision. The individual must be at least a senior manager or above. The request for a review will be acknowledged within five working days of receipt and the UHB will aim to provide a full response within 20 working days beginning the day following receipt, in accordance with guidance from the Information Commissioner's Office. Following this further review if there is no satisfactory conclusion and the requester remains dissatisfied, the matter can then be referred to the Office of the Information Commissioner who will act as an arbitrator in reviewing individual cases.

The UHB will accept a request for review in relation to an information request no more than six months after the date the response was originally sent. In the case of the EIR, a request for a further review must be made within 40 working days of receiving the initial response (i.e. on becoming aware of their dissatisfaction with it).

4. COMPLAINTS PROCESS

Although complaints about the UHB's alleged failure under FoI and EiR are exempt from the NHS Wales Concerns Complaints and Redress Arrangements, complaints will be formally investigated by the UHB. The complaint will be acknowledged with the outcome of the investigation being formally documented and the complainant being notified of the outcome within 20 working days from the date of receipt of the complaint.

Complaints about the handling of a request for information will be addressed to Head of Information Governance and Assurance or the SIRO. The request for a review will be acknowledged within five working days of receipt and the UHB will aim to provide a full response within 20 working days beginning the day following receipt, in accordance with guidance from the Information Commissioner's Office.

5. CONDITIONS AND EXEMPTIONS

FoI contains 25 exemptions to the right of access. The exemptions listed in part 2 of the Act set the boundaries to the rights of access: if information is exempt then individuals do not have a right of access to it under the Act. The exemptions ensure a proper balance is achieved between the right to know, the right to personal privacy and the delivery of effective governance.

In determining whether an exemption may apply, the UHB will ensure that it will provide any and all other information which is eligible for disclosure. The UHB procedures provide for the redaction of any material which cannot be disclosed when it appears within the content of an otherwise disclosable document.

It is a requirement of the FoI that requests are time limited for responses to be issued. The Act stipulates that all requests must be completed and responded to within 20 working days from the date of receiving the request within the organisation. Where the UHB applies a conditional postponement, or exercises an exemption to withhold the information, the applicant must again be notified of this and informed within the required 20 working days deadline. It is good practise to inform applicants of any decision as soon as this detail is know, as opposed to waiting for the 20 day deadline, and where ever possible this good practice will be implemented.

FoI details two categories of exemption, absolute and non-absolute. An absolute exemption means that the UHB does not need to confirm or deny that it holds the requested information. A non-absolute exemption means that the UHB has to consider the public interest test prior to making a decision. The UHB is committed to using these exemptions responsibly.

If the UHB decides to refuse a request for information under any of the exemptions, the applicant will be informed of the reasons for this decision as soon as possible as best practice dictates and at the very latest within the 20 working days deadline. As set out in section 17(7) of the Freedom of Information Act 2000, all applicants will also be informed of the standard UHB set procedures for making a complaint about the discharge of its duties under the FoI and of the right to complain to the Information Commissioner.

6. PUBLIC SECTOR CONTRACTS

The UHB procurement processes will be compliant with any applicable EC procurement regulations and also with the FoI. This Procedure should be read in conjunction with the UHB Procurement Policy. Partnership agencies and commercial suppliers of goods and services should be made aware of the obligations under the FoI and under the Section 45 Code. In deciding whether any information may be exempt from disclosure because it may:

- Involve a breach of confidentiality imposed by a third party, or
- Breach a trade secret, or
- Prejudice the commercial interests of any party,

the UHB will take into account current guidance issued by the office of the Information Commissioner or the Department of Constitutional Affairs.

7. CONSULTATION WITH THIRD PARTIES

It is recognised that in some cases the decision to disclose information to an applicant may affect the legal rights of a third party, for example where information is subject to the common law duty of confidence or where it

constitutes "personal data" within the meaning of the Data Protection Act 2018. Unless an exemption provided for in the FoI applies in relation to any particular information, the UHB will be obliged to disclose that information in response to a request.

8. ACCEPTING INFORMATION IN CONFIDENCE FROM THIRD PARTIES

Cardiff and Vale University Health Board

- will only accept information from third parties in confidence if it is necessary to obtain that information in connection with the exercise of any of the authority's functions and it would not be otherwise provided.
- will not agree to hold information received from third parties "in confidence" which is not confidential in nature. Acceptance of any confidentiality provisions must be for good reasons, and capable of being justified to the Information Commissioner.

Internal University Health Board documents/correspondence cannot be classed as 'in confidence' for the purposes of FoI. Prior to the release of any documents or correspondence they will be reviewed and, where necessary, redaction will be undertaken in line with FoI principles.

9. CHARGES AND FEES

Generally, the UHB will not charge for information that it has chosen to publish within the Publication Scheme as contained within the web site. However, charges may be levied for hard copies, multiple copies or copying onto media such as CD-ROM. The Publication Scheme will provide further information and guidance on charges.

The UHB will follow the statutory Fees Regulations for general rights of access made under the FoIA. In all cases where there is a choice made to charge for information published through the Publication Scheme or levy a fee arising from an information request under general rights of access, a fees notice will be issued to the applicant as required by section 9 of the FoIA. Applicants will be required to pay any fees within a period of three months beginning with the day on which the fees notice is given to them.

10. LEGAL ADVICE

Occasions will arise when there is a need for legal advice to be sought, and this process will be co-ordinated through the Board Secretary.

11. RESPONSIBILITIES

Chief Executive

The Chief Executive (CE) must ensure that the University Health Board complies with its statutory obligations under the FoIA, EIR and PSI. The CE is ultimately responsible for all processes and procedures put in place to continue to support the provisions of these pieces of legislation.

Medical Director – (Caldicott Guardian)
The Medical Director has responsibility for Information Governance within the UHB and will be the champion for FOI and EIR. The Medical Director will undertake board level responsibility for the FoI and EIR and Personal Sector Information. The Medical Director will ensure that there are effective arrangements in place within the UHB to ensure compliance with the provisions of the legislation and will ensure regular reports are produced, and an Annual Report, to provide assurance to the Board that compliance is met.

Senior Information Risk Owner (SIRO)
The SIRO will ensure that any complaints received in relation to the handling of FoI requests are fully investigated and requesters notified of the outcome of the investigation.

Head of Information Governance and Assurance
Will oversee the management of the Information Governance Team in respect of all related legislation.

Information Governance Manager
Information Governance Manager will be the lead for the UHB. This manager will be accountable for the administration of this procedure and will ensure that all the processes required to co-ordinate the work needed to adhere to the legislation are completed. The manager will ensure that all FoI, EIR and PSI matters are co-ordinated centrally and will have operational responsibility for implementing these procedures and for monitoring and reviewing its effectiveness.

Section 16 of the Act imposes a duty to provide advice and assistance to applicants and would-be applicants. The UHB will do this taking into account other statutory duties, e.g. the Disability Discrimination Act 1995. The Information Governance Manager will co-ordinate the effective discharge of this duty.

Executive Functions
Executive Directors will ensure that requests received which are relevant for their areas will be delegated for processing by their most appropriate relevant deputy, assistant or other responsible individual as decided by them.
Executive Directors will authorise issue of completed responses in accordance with the Scheme of Delegation or in accordance with their individual internal delegation arrangements.

Clinical Boards Heads of Operations and Delivery (HoDs), Clinical Board Directors (CBDs) and Directorate Managers (DMs)
All HoDs, and CBDs and DMs will ensure that the requirements of this procedure are met within their own Clinical Board (CB) area. The DMs will arrange for information to be collated and provided to the Corporate Governance Senior Information and Communication Manager within 10 working days. If responses are not provided, requests will be escalated to the HoDs and CBDs. Draft responses will be submitted for approval to HoDs and CBDs for their authorisation and approval for issue in accordance with the

UHB Scheme of Delegation. Reports on compliance with the 20 day time limit will be provided to CBs for information and action.

Staff

All staff have a responsibility to ensure they process information in accordance with the FoIA, PSI and EIR and the policies, standards, procedures and guidance agreed by Cardiff and Vale UHB. All UHB staff must be made aware of the implications of this procedure and their obligations to adhere to it.

Attachment 1

Standard Operating Procedure
Freedom of information Act Processing

Stage 1 – Receipt of request

1.1 Requests received via e-mail or post

1.2 If request received via non central source it must be forwarded immediately to the Information Governance Team

1.3 Requests received in headquarters must be scanned and e-mailed to the generic FOI e-mail address

1.4 Requests will be logged by the IG team

1.5 i) If a request is sufficiently clear and does not require further clarification for processing, the request will be acknowledged.
ii) If clarification is required, the request will be acknowledged and the additional information will be asked for advising that the request will not be processed fully until the required clarification is received.

1.6 All requests from MP's, AM's, elected members and Trade Unions will be logged and acknowledged as normal.

1.7 All requests from the media will be advised to the communications team

Stage 2 – Accessing Information

2.1 The FoI lead in Information Governance Team will send details of the request to the relevant Clinical Board lead asking for a response to be provided within 2 weeks. Details of who will be leading will be recorded within the database.

2.2 The department responsible must provide information within the two weeks deadline or advise the FoI lead of any delays or issues immediately.

2.3 If any concerns regarding the release of any of the requested information should arise, these must be discussed with the FoI lead in the Information Governance team.

Stage 3 – Providing information

3.1 Once approved response returned to the FoI lead the following actions will be completed in readiness for issue:
a) response (word) document will be protected from editing and saved in the relevant file. The word document will be converted into PDF format (protected) for issue and saved in the disclosure log file.

3.2 If no fees or charges are payable or outstanding, or if no exemptions or exceptions are applicable, the FoI lead will provide the response to the requestor promptly within 20 working days.

3.3 Information will be provided to the requestor in a permanent form as acceptable to the applicant or through the provision of a reasonable opportunity to inspect a record containing the information or the

provision of a summary of the information in permanent form as acceptable to the applicant.

3.4 The FoI lead will consider all circumstances of the request for communication of information by a particular means, including the cost of doing so. If it is determined that it is not reasonably practicable to comply with the preference of the requestor in their request they will be notified of the reason for this determination and the information will then be provided by such means deemed reasonable. The UHB will have regard for other statutory obligations placed upon it such as those established under the Disability Discrimination Act 1995 together with the UHB's duty of Provision of Advice and Assistance requirements under the FoI.

3.5 The database will be updated to reflect the date information provided and compliance with the time limits within the Act

3.6 If the request is of media interest, a copy of the response will be issued to the communications team

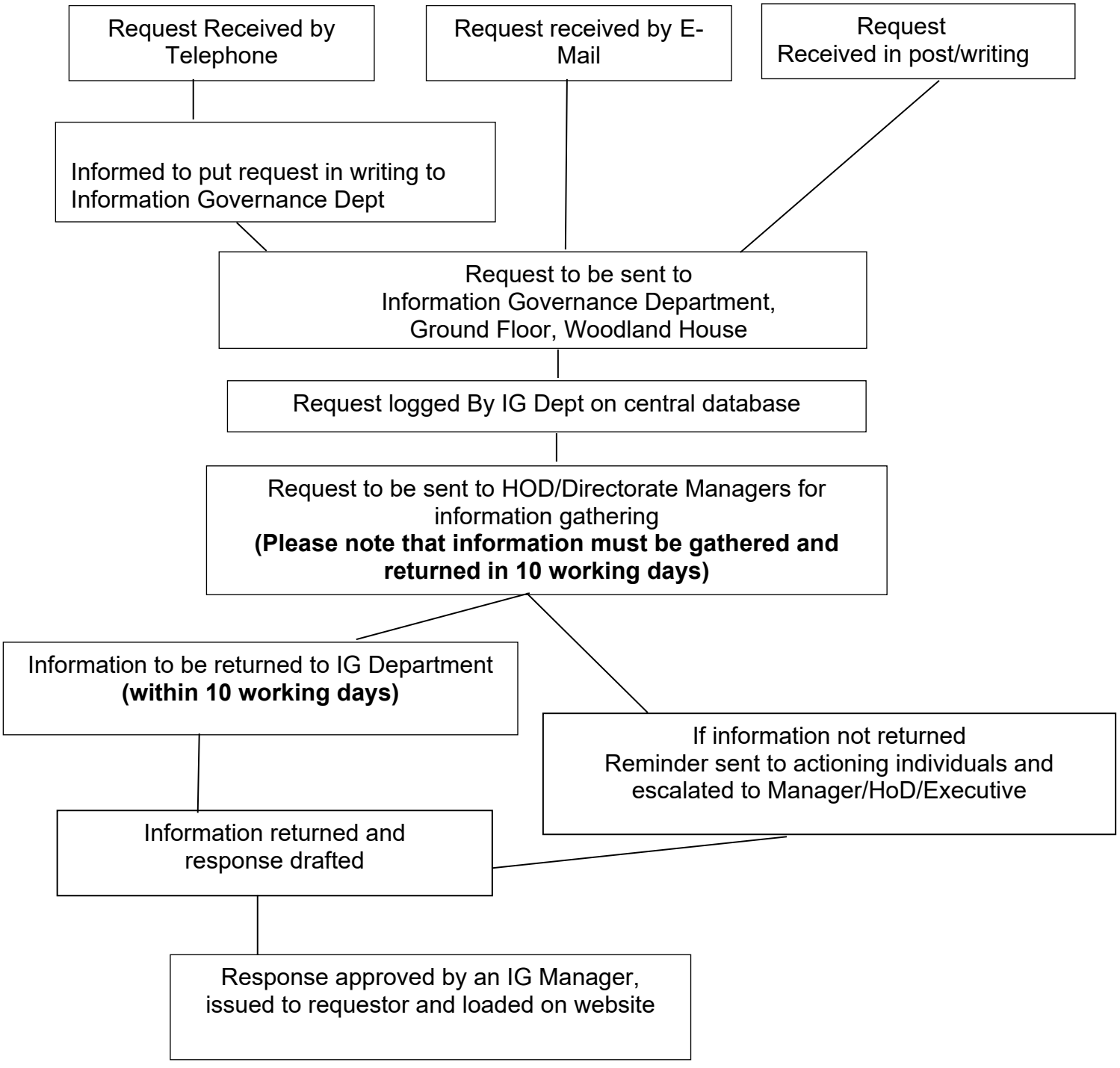
3.7 If an exemption or exception is identified as valid, the refusal notice must be issued detailing the relevant exemptions under the Act.

Stage 4 – Disclosure Log

4.1 The Information Governance Team will update the disclosure Log on the UHB Internet site on a regular basis, at the very least monthly, providing a copy of all requests issued or indicating any refused requests with the reasons for refusal.

Attachment 2

FLOWCHART TO PROCESS REQUESTS UNDER FREEDOM OF INFORMATION & ENVIRONMENTAL INFORMATION REGULATIONS



Report Title:	**Information Governance Compliance**								
Meeting:	**Digital Health Intelligence Committee**						**Meeting Date:**	**3rd December 2019**	
Status:	**For Discussion**		**For Assurance**	**x**	**For Approval**		**For Information**		
Lead Executive:	**Director of Digital Health Intelligence**								
Report Author (Title):	**Information Governance Manager**								

SITUATION

This report considers key information governance issues considered by the responsible Executive Director, Senior Information Risk Owner (SIRO) and Data Protection Officer (DPO). Specifically it provides information on the following areas of Information Governance within Cardiff and Vale University Health Board (the UHB).

- Information Governance (IG) Staffing levels and capacity
- Data Protection Act - Serious Incident Summary and Report
- Freedom of Information Act - Activity and Compliance
- Data Protection Act (DPA) - Subject access requests (SAR)
- Compliance monitoring/National Integrated Intelligent Auditing Solution (NIIAS)

Each individual report contains specific details relevant to the subject area, and includes updated information since the previous report to the Digital Health Intelligence Committee (DHIC) on how the UHB has complied with the obligations of each piece of legislation that satisfy the information governance requirements.

The draft Integrated IG policy and the GDPR Summary of Progress are presented in separate reports.

BACKGROUND

Cardiff and Vale University Health Board (the UHB) is required to ensure that it complies with all the legislative requirements placed upon it. In respect of Information Governance the relevant legislation which largely impacts on this work are the Data Protection Act 2018 (DPA), General Data Protection Regulation (GDPR) and the Freedom of Information Act 2000 (FOI).

Quarterly reports are produced for the DHIC to receive assurance that the UHB continues to monitor and action breaches of the GDPR / DPA 2018 and that FOI requests and subject access requests (SAR) are actively processed within the legislative time frame that applies and that any areas causing concern or issues are identified and addressed

ASSESSMENT

1. Information Governance Staffing Levels and Capacity

Information Governance staffing levels remain stable but still subject to the internal Digital Health Intelligence restructure. The department will need to consider how to progress the skills and development of its staff in order to keep pace with new initiatives. Two of the managers are in the process of working towards a Masters in Data Protection Law.

2. Data Protection Act – Serious Incident Report

Date reported: Q2 2019/2020

During Q2 of 2019/20, the Information Governance Department reviewed 263 IG related incidents via the UHBs e-Datix incident module.

The UHB felt it necessary to raise 4 incidents with the ICO. Following these discussions, the decision was made that 2 of the data breaches required formal reporting to the commissioner. Of the two breaches, one has been closed with no further action and we await the formal outcome of second breach.

In relation to a breach that we reported in June 2019, and referred to during the last committee, the case has been closed by the ICO with no regulatory action against the UHB. The UHB has also received notice of a complaint from the ICO following a complaint raised by a patient. No further action is required but it was considered the UHB has not with our data protection obligations.

3. Freedom of Information Act

The 20 day compliance rate for Q2 2019/2020 can be demonstrated as follows:

	Total requests	Compliant requests	Compliance %
Jul-19	40	35	87.5
Aug-19	44	33	75
Sep-19	48	44	91.7

The average compliance for Q1 was 86.0%. Whilst compliance has been sustained, it hasn't continued to increase as we anticipated. However there are only 5 overdue requests which is the lowest amount over the last 2 years. The UHB also has new arrangements in place with Procurement and Pharmacy that appear to be improving compliance in these two areas.

Internal reviews are currently processed by the department relevant to the FOI request. This hasn't resolved the flow of reviews and this process requires review. This process is currently under review.

Compliance across Wales for 2018/2019 is demonstrated below:

Organisation	Total requests	Compliant requests	Compliance %
Cwm Taf	502	463	92.3%
WAST	248	221	89.0%
Hywel Dda	526	494	93.9%
Powys	406	258	63.5%
Swansea Bay	561	469	83.6%
Betsi Cadwalladr	657	509	77.5%
Aneurin Bevan	547	429	78.5%
Cardiff & Vale	581	324	55.8%
Velindre	141	107	76.0%

Whist UHB compliance for 2018/2019 was the lowest in Wales, our position has increased significantly in 2019/2020 to the extent that we are currently 84.7% complete. ICO expectations are for all public authorities to achieve >90% compliance (it was previously 85%).

4. Subject Access Requests Processed

4.1 Health Records requests Q2 2019/2020

	Total requests	Compliant requests	Compliance %
Jul-19	357	278	77.9
Aug-19	399	268	67.2
Sep-19	316	264	83.5

The average compliance for Q1 was 60.5%. Q2 demonstrates another encouraging improvement with compliance moving upwards beyond 83%. The development of existing staff combined with the appointment of new staff has contributed to the improvements. The limiting factor continues to be the regulatory requirement for clinical sign off on all disclosures. In Q2 there were no complaints received from the ICO regarding subject access requests and only 10 requests remain outstanding.

Despite ongoing compliance improvement, the UHBs Subject Access Request improvement plan is attached as an Appendix.

4 .2 Non Health Records

There were a total of 19 subject access requests submitted for non-health records during Q2 2019/2020. All were completed and compliant within the regulatory timeframe.

5. Compliance Monitoring/NIIAS

Cardiff & Vale NIIAS obligations aren't currently being adhered to. When resource is available, NIIAS training will be provided by NWIS.

6. Information Mandatory Training

The UHBs Information Governance mandatory training compliance remains stable at 72%. A breakdown by Clinical Board is provided below:

Clinical Board	Compliance
All Wales Genomics Service	88%
Capital, Estates & Facilities	71%
Children & Women Clinical Board	76%
Clinical Diagnostics & Therapeutics Clinical Board	77%
Corporate Executives	79%
Medicine Clinical Board	69%
Mental Health Clinical Board	72%
Primary, Community Intermediate Care Clinical Board	75%
Specialist Services Clinical Board	71%
Surgical Services Clinical Board	63%
uHB	**72%**

A classroom IG training module has been developed to be used in Cardiac Services.

ASSURANCE is provided by:

- Reports detailing compliance against legislative requirements.

RECOMMENDATION

The Digital Health and Intelligence Committee is asked to:

- **RECEIVE** and **NOTE** a series of updates relating to significant Information Governance issues

Shaping our Future Wellbeing Strategic Objectives

This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	x
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention		Long term	x	Integration		Collaboration		Involvement	

Equality and Health Impact Assessment Completed:	Not Applicable If “yes” please provide copy of the assessment. This will be linked to the report when published.

Report Title:	**CDF Schedule (Policies & Procedures)**						
Meeting:	Digital and Health Intelligence Committee			**Meeting Date:**	3rd December 2019		
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**	**x**
Lead Executive:	**Director of Digital and Health Intelligence**						
Report Author (Title):	**Information Governance Manager**						

SITUATION

The CDF Schedule (Policies & Procedures) highlights all Policies & Procedures which the Digital and Health Intelligence Committee are responsbile for approving.

BACKGROUND

There are a number of policy and procedure documents that require review and updating. A number of these are being submitted to the Digital and Health Intelligence Committee for approval / ratification, as listed below:

Overarching Information Governance Policy which comprises of specific policies:

- Information Governance policy
- IT Security policy
- Email policy
- Internet policy

Freedom of Information Procedure
Dealing with Subject Access Request (SAR)

The remainder of the controlled documents will be reviewed and updated during the remainder of the year 2019/20.

RECOMMENDATION

The Board is asked to:

- **APPROVE** the attached policies and procedures and to **NOTE** the status and planned actions for the remainder of the documents within the CDF schedule.

Shaping our Future Wellbeing Strategic Objectives
This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	x
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered
Please tick as relevant, click here for more information

Prevention		Long term		Integration	x	Collaboration		Involvement	

Equality and Health Impact Assessment Completed:	Yes / No / Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

UHB Ref Number	Previous organisation Ref no	Version Number	Title of Document	Type of Document
~~Ref 1~~		~~4~~		~~Policy~~
			~~Protection of Pay and Conditions of Service~~	
~~Ref 39- Superceeded by UHB 349~~			~~Prevention and Control of Spongiform Encephalopathies (CJD) Policy~~	~~Policy~~
~~Ref 103~~		~~2~~	~~CCTV Data Protection Policy~~	~~Policy~~
~~Ref 133~~		~~1~~	~~IT Security Policy~~	~~Policy~~
~~Ref 141~~			~~Ectoparasitic Infestations/Infections: Fleas, Lice and Mites (Scabies) Pol & Procedure~~	~~Policy and Procedure~~
~~Ref 143~~		~~1~~	~~Vancomycin Resistant Enterococcus Pol & Procedure~~	~~Policy and Procedure~~

Ref 173	1	Non-Medical Practitioners to Refer for Diagnostic Imaging Investigations (Excluding	Policy
Ref 189		Lease Car Policy	Policy
Ref 190		National Institute for Clinical Excellence Guidelines Protocol	Protocol
Ref 195		Complaints Management Procedure	Procedure
Ref 196	1	Child Protection Strategy 2005 - 2008 Duplicate ref no issued on Review re-allocate new number	Strategy
Ref 227		Redeployment Policy	Policy
Ref 299	2	Safe use of Non-ionising Radiation	Policy

Ref 309		1	**Promotion of Physical Activity in the Workplace Guidelines**	Guidelines
	1			Policy
Ref 340			**Internet and E-mail Policy**	
UHB 010	N/A	1	**Making Decisions on Individual Requests for Treatment**	Policy
UHB 026	N/A	1	Consent in Research procedure to be followed when delegated to Nurse/Midwives	Procedure
UHB 027	N/A	2.1	**R&D Amendments to a CTIMP SOP**	Standard Operating Procedure
UHB 028	N/A	1	**R&D Amendments to a Non-CTIMP SOP**	Standard Operating Procedure

UHB 029	N/A	1	R&D Escalation of Monitoring Results Research & Development Office	Guidelines
UHB 032		1	Advanced Care & Emergency Pathway	Policy
T	336	2	Maternity, Adoption & Paternity Guidelines	Guidelines

UHB 107	3	1	Claims Management Policy	Policy
UHB 108	3	1	Claims Management Procedure for Personal Injury	Procedure
UHB 109	3	1	Claims Management Procedure for Clinical Negligence Claims	Procedure
UHB 128	329	1	Policy	Policy & Procedure

UHB 135	New	1	Monitoring of Externally Sponsored Clinical Trials of Investigational Medicinal Products Hosted by Cardiff and Vale UHB: Standard Operating Procedure	Standard Operating Procedure
UHB 136	New	1	Monitoring of Cardiff and Vale UHB Sponsored Clinical Trials of Investigational Medicinal Products: Standard Operating Procedure	Standard Operating Procedure
UHB 150	N/A	2	Nursing and Midwifery Rostering Policy	Policy

UHB 162	365	1	Administration of Nebulised Ribavirin in Adults (Haematology) Procedure	Procedure
UHB 165	17	1	Time Off & Facilities for Accredited Representatives	Policy
UHB 168	63	1	Working Time Regulations Policy	Policy

UHB 265	N/A	4	Infection Control Viral Hepatitis Procedure	Procedure
~~UHB 015~~	~~New~~	~~2~~	**~~Good Clinical Practices Training for Persons Undertaking Clinical Research~~**	~~Policy~~

Ref 47	1		Isolation for Infectious Diseases Procedure	Policy

UHB 031	N/A	1	Safe Use of Ionising Radiation Policy	Policy

Ref 244		1	Telephone prescribing in an emergency (verbal order) Previously DAG 1.2v2	Procedure
Ref 250		1	Faxing of prescriptions previously DAG 2.5v2	Procedure
~~Ref 110~~		~~1~~	**~~Breaking Bad News to Patients, Their Relatives and/or Carers~~**	~~Policy~~

Ref 288		1	Guidance in the event of unexpected death (Mental Health)	Procedure
UHB 046	315	2	The Ordering, Storage, Disposal and Safe Prescribing and Administration of Controlled Drugs In Secondary Care Policy	Policy
UHB 091	150	1.1	Control of Legionella Policy	Policy
UHB 112	282 & 283	1	Patient Orientated Medicines Procedure (POMS)	Procedure
UHB 123	New	1	Renewal of Detention and Consultation with the Second Professional Policy	Policy

UHB 125	245	1	Prescribing for Staff	Policy & Procedure
UHB 151	T/252	1	provision of discharge prescriptions when the pharmacy is closed	Procedure
UHB 152	T/316	1	In-Patient Prescription Monitoring, Endorsement And Supply	Procedure
UHB 176	T/248 & T/249	1	Access Medicines when Pharmacy is Closed Procedure	Procedure
UHB 187	T/251	1	Prescribing, Ordering, Storage and Administration of Strong Potassium Injections Procedure	Procedure
UHB 195	Trust 247, 253, 265, 267	1.1	Safe Administration of Medicine in Secondary Care Procedure	Procedure

UHB 204	Tmc212	1	Complimentary Medicines Guidelines	Guidelines
UHB 219	N/A	1	Safe and Secure Handling of Medicines Policy	Policy
UHB 225	243	2	Take Home Medication (TTH) on Adult Short Stay Surgical and Gynaecology Areas Procedure	Procedure
UHB 226	318	1	Use of Unlicensed Medicines and Medicines used Outside their Product License Procedure	Procedure
UHB 245	N/A	1	Organ Donation from the Emergency Unit Standard Operating Procedure	Procedure
UHB 261	N/A	1	Medicines Reconciliation Policy	Policy
UHB 266	T322	1	Non Medical and Dental Prescribing Policy	Policy
UHB 086	355	1	Pre and Post Registration 04/11Student Nurse Placement Policy	Policy

~~UHB 103~~	~~132~~	~~1~~	~~**Occupational Health Policy**~~	~~Policy~~
UHB 139	V 1.0 Dec 09	2	Data Management in Clinical Trials: Guidelines for Researchers	Guidelines
~~UHB 315~~	~~N/A~~	~~1~~	~~**Entry Drug and Alcohol Services**~~	~~Policy~~
UHB 014	58	3	Retirement Policy	Policy

~~UHB 260~~	~~N/A~~	~~1~~	~~Insertion of Flocare Nasal Tube~~	~~Standard Operating Procedure~~
~~UHB 084~~	~~N/A~~	~~1~~	~~Health & Well Being Strategy~~	~~Strategy~~
~~UHB 211~~	~~N/A~~	~~1.2~~	~~Social Media Guidelines~~	~~Guidelines~~
~~UHB 120~~	~~74~~	~~2~~	~~Quality Policy of the Directorate of Laboratory Medicine of Cardiff and Vale University Local Health Board~~	~~Policy~~

UHB 276	N/A	1	Sonographer Reporting Protocol	Protocol
~~UHB 013~~	~~54~~	~~5~~	**~~Sickness Absence Policy (All Wales)~~**	~~Policy~~
~~Ref 117~~		~~4~~	~~Supplementary Statement of Main Terms and Particulars of Employment~~	~~General~~

UHB 066	N/A	1	Self Presentation at Adult Mental Health Premises Protocol	Protocol
UHB 158	N/A	3	Depot Medication procedure	Procedure
UHB 161	N/A	1	Management of Medication within CRHTT	Procedure
UHB 304	N/A	1	Self Adminstration of Medication for Service Users in the Community	Procedure
UHB 305	N/A	1	Integrated Care Pathway for Patient Safety Procedure	Procedure
UHB 306	N/A	1	Extra Care Area and Low Stimulus Room Procedure for	Procedure
UHB 307	N/A	1	Hafan Y Coed Adult Mental Health Unit Meeting Room Guideline	Guidelines
UHB 308	N/A	1	Vocational Opportunities Project (VOP) Procedure	Procedure
UHB 309	N/A	1	Therapeutic Kitchen Procedure	Procedure
UHB 310	N/A	1	Visitors at Hafan y Coed Guidance	Guidelines

UHB 311	N/A	1	Therapies Hub at Hafan-y-Coed	Procedure
UHB 312	N/A	1	Emergency Response Procedure for Hafan y Coed Adult Mental Health Unit.	Procedure
UHB 313	N/A	1	Reassurance Observations System Procedure	Procedure
UHB 314	N/A	1	Protocol for the Interface between the Medical Emergency Assessment Unit (MEAU)	Protocol
UHB 316	T236	2	Operational Procedure for Rapid Access Chest Pain Clinic	Procedure
UHB 318	T133	1	Information Technology Security Access Control Guidance	Guidelines
UHB 319	T133	1	Information Technoloy Security Authorised	Guidelines
UHB 320	T133	1	Information Technology Network Connection Guidance	Guidelines
UHB 321	T12/T288	1	Procedural Guidance on Unexpected Death in Adults within MHSOP	Guidelines
~~UHB 323~~	~~N/A~~	~~1~~	~~**Radioactive Waste Risk Management Policy**~~	~~Policy & Procedure~~

~~UHB 180~~	~~T/164 & 174~~	~~1~~	~~Reporting Research-Related Adverse Events (UHB Sponsored CTIMPs)~~	~~Procedure~~
~~UHB 181~~	~~T/164 & 174~~	~~1~~	~~Reporting Research-Related Adverse Events in Externally Sponsored Clinical Trials of Investigational Medicinal Products Hosted by Cardiff and Vale UHB (Procedure)~~	~~Procedure~~
~~UHB 074~~	~~N/A~~	~~5~~	~~Research & Development Gaining NHS Research Permission form C&V UHB~~	~~Guidelines~~
~~UHB 097~~	~~N/A~~	~~2~~	~~Human Tissue in Clinical Research Management Policy~~	~~Policy~~
~~UHB 023~~	~~34~~	~~1.1~~	~~Risk Management Policy~~	~~Policy~~
UHB 378- hold for Julia	not used			
UHB 401	duplication of UH 355		on hold for Julia pregnancy testing of girls of child bearing age	

Previous Organisation	Area of applicability	Status	Last review date	New review date	Original UHB Approving Committee
~~Trust~~	~~Trust Wide~~	~~Ratified~~	~~24/06/2009~~	~~01/06/2012~~	~~UHB Board~~
~~Trust~~	~~Trust Wide~~	~~Ratified~~	~~11/04/2002~~	~~11/04/2004~~	~~Quality & Safety Committee~~
~~Trust~~	~~Trust Wide~~	~~Ratified~~	~~26/05/2005~~	~~01/05/2006~~	~~Trust Board~~
~~Trust~~	~~Trust Wide~~		~~22/04/2005~~	~~01/04/2011~~	~~PGNC~~
~~Trust~~	~~Trust Wide~~		~~23/09/2004~~	~~01/09/2007~~	~~Infection Prevention Control~~
~~Trust~~	~~Trust Wide~~		~~23/09/2004~~	~~01/09/2007~~	~~Trust Board~~

Trust	Trust Wide		01/07/2005	01/07/2008	Infection Prevention Control
Trust	Trust Wide		28/04/2009	01/04/2012	People, Planning and Performance Committee
Trust	Trust Wide		01/02/2006	01/01/2007	Quality, Safety & Experience Committee
Trust	Trust Wide		26/05/2005	01/05/2007	Trust Board
Trust	Trust Wide		07/03/2006	01/03/2009	Child Protection Safe Guarding Group
Trust	trust wide		15/02/2008	01/02/2011	HR Committee
Trust	trust wide	Ratified	18/05/2009	01/05/2012	Clinical Governance Committee

Trust		trust wide	Ratified	01/01/2008	01/01/2010	Joint Management and Staff Side Health and Safety Committee
		Therapies Services		13/03/2008	01/03/2011	Information Governance sub-Committee
	New	Clinical Divisions; Executive; Public Health	Ratified	11/05/2010	11/05/2011	UHB Board
	New	UHB Wide	Ratified	01/12/2011	01/10/2013	Nursing & Midwifery Board/ Research Governance Group
	New	UHB Wide	Ratified	16/07/2013	16/07/2016	Research Governance Committee
	New	UHB Wide	Ratified	25/01/2011	25/01/2014	Research Governance Committee

New	Research & Development	Ratified	26/10/2010	26/10/2013	Research Governance Committee
New	UHB Wide	Ratified	20/02/2011	20/02/2013	Quality & Safety Committee
Trust	UHB Wide	Ratified	19/04/2012	19/04/2015	Workforce and Organisational Development Committee

~~Trust~~	~~UHB Wide~~	~~Ratified~~	~~21/02/2012~~	~~21/02/2015~~	~~Quality & Safety Committee~~
~~Trust~~	~~UHB Wide~~	~~Ratified~~	~~14/06/2012~~	~~01/05/2015~~	~~Quality & Safety Committee~~
~~Trust~~	~~UHB Wide~~	~~Ratified~~	~~14/06/2012~~	~~01/05/2015~~	~~Quality & Safety Committee~~
~~Trust~~	~~Medical Staff~~	~~Ratified~~	~~01/09/2015~~	~~01/09/2016~~	~~Workforce and Organisational Development Committee~~

New	Research & Development	Ratified	25/10/2011	25/10/2014	Research Governance Committee
New	Research & Development	Ratified	25/10/2011	25/10/2014	Research Governance Committee
N/A	Employment	Ratified	30/09/2012	30/09/2017	Workforce and Organisational Development Committee

~~Trust~~	~~Medicines Management~~	~~Ratified~~	~~17/10/2012~~	~~17/10/2015~~	~~Heamatology Quality & Safety~~
~~Trust~~	~~UHB Wide~~	~~Ratified~~	~~29/01/2013~~	~~29/01/2016~~	~~Workforce and Organisational Development Committee~~
~~Trust~~	~~UHB Wide~~	~~Ratified~~	~~29/01/2013~~	~~29/01/2016~~	~~Workforce and Organisational Development Committee~~

N/A	UHB	Ratified	23/06/2015	23/06/2018	Infection Control Procedure Group
~~New~~	~~UHB Wide~~	~~Ratified~~	~~23/09/2014~~	~~23/09/2017~~	~~Quality & Safety Committee~~

Trust	Trust Wide	Ratified	11/04/2002	11/04/2004	Quality & Safety Committee
	UHB Wide	Ratified	22/02/2011	01/02/2014	Quality & Safety Committee

Trust	trust wide	Ratified	01/11/2003	01/11/2006	Trust Medicine Committee
Trust	trust wide	Ratified	01/11/2003	01/11/2006	Trust Medicine Committee
~~Trust~~	~~Trust Wide~~	~~Ratified~~	~~24/02/2005~~	~~01/02/2006~~	~~Trust Board~~

Trust	trust wide	Ratified	01/07/2007	01/07/2010	Mental Health Clinical Board Quality, Safety and Environment
Trust	Clinical Divisions; Executive; Public Health	Ratified	01/01/2016	01/01/2019	Quality & Safety Committee
Trust	UHB Wide	Ratified	13/12/2011	13/12/2014	Quality & Safety Committee
Trust	UHB Wide	Ratified	23/04/2012	23/04/2014	Medicines Management Group
New	Mental Health		18/04/2012		Mental Health Act Monitoring Committee

~~Trust~~	~~UHB Wide~~	~~Ratified~~	~~09/04/2013~~	~~09/04/2016~~	~~Quality & Safety Committee~~
~~Trust~~	~~UHB Wide~~	~~Ratified~~	~~24/07/2012~~	~~24/07/2015~~	~~Medicines Management Group~~
~~Trust~~	~~UHB Wide~~	~~Ratified~~	~~24/07/2012~~	~~24/07/2015~~	~~Medicines Management Group~~
~~Trust~~	~~UHB Wide~~	~~Ratified~~	~~13/02/2013~~	~~13/02/2016~~	~~Medicines Management Group~~
~~Trust~~	~~UHB Wide~~	~~Ratified~~	~~21/05/2013~~	~~21/05/2016~~	~~Medicines Management Group~~
~~Trust~~	~~Secondary Care UHB~~	~~Ratified~~	~~20/09/2012~~	~~20/09/2015~~	~~Medicines Management Group~~

Trust	UHB Wide	Ratified	21/10/2013	21/10/2016	Medicines Management Group
N/A	UHB Secondary care areas and Community Hospitals	Ratified	01/04/2014	01/04/2017	Quality & Safety Committee
New	UHB Wide	Ratified	21/05/2013	01/06/2015	Medicines Management Group
New	UHB Wide	Ratified	17/12/2013	17/12/2015	Medicines Management Group
N/A	UHB Wide	Ratified	18/06/2014	18/06/2016	Quality & Safety Committee
N/A	UHB	Ratified	10/02/2015	10/02/2018	Quality Safety Experience Committee
Trust	UHB	Ratified	21/04/2015	21/04/2018	Quality Safety Experience Committee
Trust	UHB Wide	Ratified	13/09/2011	13/09/2014	Workforce and Organisational Development Committee

~~Trust~~	~~UHB Wide~~	~~Ratified~~	~~05/03/2012~~	~~05/03/2015~~	~~Workforce and Organisational Development Committee~~
Trust	Research & Development	Ratified	14/04/2015	14/04/2018	Research Governance Committee
~~N/A~~	~~UHB~~	~~Ratified~~	~~07/04/2016~~	~~07/04/2019~~	~~Mental Health Quality & Safety~~
Trust	UHB Wide	Ratified	31/03/2015	31/03/2018	Workforce and Organisational Development Committee

N/A	UHB	Ratified	26/03/2015	26/03/2018	Nutition and Catering
New	UHB Wide	Ratified	13/09/2011	13/09/2014	Workforce and Organisational Development Committee
N/A	UHB Wide	Ratified	04/03/2014	08/04/2016	Employment Policies Sub Group
Trust	Laboratory Medicine	Ratified	21/04/2015	21/04/2018	Quality & Safety Committee

N/A	UHB	Ratified	03/11/2015	03/11/2018	Quality, Safety Experience
~~Trust~~	~~UHB Wide~~	~~Ratified~~	~~28/09/2018~~	~~28/09/2021~~	~~Workforce and Organisational Development Committee~~
~~Trust~~	~~Trust Wide~~		~~23/09/2004~~	~~01/09/2007~~	~~People, Planning and Performance~~

N/A	Mental Health	Ratified	13/04/2011	13/04/2014	Mental Health Quality & Safety
N/A	Mental Health	Ratified	07/04/2016	07/04/2019	Mental Health Quality & Safety
N/A	Mental Health	Ratified	12/12/112	12/12/2015	Mental Health Quality & Safety
N/A	UHB	Ratified	10/12/2015	10/12/2018	Mental Health Quality & Safety
N/A	UHB	Ratified	07/04/2016	07/04/2019	Mental Health Quality & Safety
N/A	UHB	Ratified	07/04/2016	07/04/2019	Mental Health Quality & Safety
N/A	UHB	Ratified	07/04/2016	07/04/2019	Mental Health Quality & Safety
N/A	UHB	Ratified	07/04/2016	07/04/2019	Mental Health Quality & Safety
N/A	UHB	Ratified	07/04/2016	07/04/2019	Mental Health Quality & Safety
N/A	UHB	Ratified	07/04/2016	07/04/2019	Mental Health Quality & Safety

N/A	UHB	Ratified	07/04/2016	07/04/2019	Mental Health Quality & Safety
N/A	UHB	Ratified	07/04/2016	07/04/2019	Mental Health Quality & Safety
N/A	UHB	Ratified	07/04/2016	07/04/2019	Mental Health Quality & Safety
N/A	UHB	Ratified	07/04/2016	07/04/2019	Mental Health Quality & Safety
N/A	UHB	Ratified	01/09/2015	01/09/2018	Quality, Safety Experience Committee
N/A	UHB	Ratified	10/06/2016	10/06/2019	Information Governance
N/A	UHB	Ratified	10/06/2016	10/06/2019	Information Governance
N/A	UHB	Ratified	10/06/2016	010/06/2019	Information Governance Sub Group
N/A	UHB	Ratified	16/06/2016	16/06/2019	Mental Health policy Group
N/A	UHB	Ratified	~~28/06/2016~~	~~28/06/2019~~	~~Quality, Safety Experience Committee~~

~~Trust~~	~~Research & Development~~	~~Ratified~~	~~15/04/2012~~	~~15/04/2015~~	~~Research Governance Committee~~
~~Trust~~	~~Research & Development~~	~~Ratified~~	~~15/05/2012~~	~~15/05/2015~~	~~Research Governance Committee~~
~~New~~	~~UHB Wide~~	~~Ratified~~	~~7/12/2016~~	~~7/12/2019~~	~~Research Governance Committee~~
~~New~~	~~UHB Wide~~	~~Ratified~~	~~01/09/2015~~	~~01/09/2018~~	~~Quality & Safety Committee~~
~~Trust~~	~~UHB Wide~~	~~Ratified~~	~~26/11/2013~~	~~26/11/2016~~	~~UHB Board~~

Current UHB Approving Group/Committee	Minute Approval Number	Responsible Director UHB	Author(s) & Job Title	HCS Cross Ref	HCS Exec Lead Director
~~People, Planning and Performance Committee~~		~~Executive Director of Workforce Organisational Development~~	~~Lynda James, ESR Project Lead~~	~~20~~	~~JH~~
				~~18~~	~~PW~~
~~Quality, Safety & Experience Committee~~		~~Executive Director of Nursing~~			
~~Information Governance sub-Committee~~		~~Executive Director of Planning~~	~~Neil Paul Asst GM Facilities~~		
~~Information Governance sub-Committee~~		~~Medical Director~~	~~Nick Stickler IM&T Security Manager~~		
~~Quality, Safety & Experience Committee~~		~~Executive Director of Nursing~~			
			~~Dr I K Hosein~~		
~~Quality, Safety & Experience Committee~~		~~Executive Director of Nursing~~			

~~Quality, Safety & Experience Committee~~		~~Lesley Harris~~
~~People, Planning and Performance Committee~~	~~Executive Director of Workforce Organisational Development~~	~~Christine Richards Payroll Manager~~
~~Quality, Safety & Experience Committee~~	~~Medical Director~~	~~M Lucas & B Dickinson~~
~~Quality, Safety & Experience Committee~~	~~Executive Director of Nursing~~	~~Beryl Munkly Patient Experience Manager~~
~~Quality, Safety & Experience Committee~~	~~Executive Director of Nursing~~	~~Kathy Ellaway Dr Alison mott~~
~~People, Planning and Performance Committee~~	~~Executive Director of Workforce Organisational Development~~	~~Veronica Haskell Asst HR Manager~~
~~Quality, Safety & Experience Committee~~	~~Executive Director of Therapies and Health services~~	~~Dr G Carolan-Rees Principal Pharmicist~~

~~People, Planning and Performance Committee~~	~~Executive Director of Workforce Organisational Development~~	~~Liz John Superintendant Physiotherapist~~
	~~Medical Director~~	~~Nick Stickler IM&T Security Manager~~
~~UHB Board~~	~~Executive Director of Public Health~~	~~Interim Business Lead (Vale)~~
	Executive Director of Nursing	~~Katherine Craig CRF Operational Director Mental Health Act Capacity Manager~~
~~Research Governance Committee~~	~~Medical Director~~	~~Research & Development Co-Ordinator~~
~~Research Governance Group~~	~~Medical Director~~	~~Research & Development Co-Ordinator~~

~~Research Governance Group~~	Medical Director	~~Maureen Edgar Research and Development Co-ordinator~~
~~Quality, Safety and Experience Committee~~	~~Medical Director~~	~~Sian Moniyhan Consultant Comminuty Paediatrician~~
	Executive Director of Workforce Organisational Development	~~Rachel Pressley HR Policy and Compliance Officer Claire Bateman-Jones, RCN~~

~~Quality, Safety and Experience Committee~~	~~Executive Director of Nursing~~	~~Keith Hunt & Karen Lewis, Claims Managers~~
~~Quality, Safety and Experience Committee~~	~~Executive Director of Nursing~~	~~Keith Hunt & Karen Lewis, Claims Managers~~
~~Quality, Safety and Experience Committee~~	~~Executive Director of Nursing~~	~~Keith Hunt & Karen Lewis, Claims Managers~~
~~Workforce and Organisational Development Committee~~	~~Executive Director of Workforce Organisational Development~~	~~Angela Rackham, Medical Workforce Manager~~

~~Research Governance Group~~	Medical Director	~~Maureen Edgar Research and Development Co-ordinator~~

Medical Director

~~Research Governance Group~~		~~Maureen Edgar Research and Development Co-ordinator~~
~~Workforce and Organisational Development Committee~~	~~Executive Director of Workforce Organisational Development~~	~~Kathryn Elias, Recruitment Nurse Advisor~~

~~Heamatology Quality & Safety~~	~~Medical Director~~	~~Lorraine Donovan, Deputy Ward Manager, Haematology~~
~~People, Planning and Performance Committee~~	~~Executive Director of Workforce Organisational Development~~	~~Cheryl Parker, HRO / Rachel Pressley, Senior HR Policy and Compliance Officer / Mike Jones, UNISON / Nigel Gibbs, UNITE~~
	Executive Director of Workforce Organisational Development	~~Rod Hill, Business Manager, Workforce and OD / Bill Salter, Unison~~

Infection Prevention & Control Group	Executive Director of Nursing	Director of Infection Prevention Control
~~Quality, Safety and Experience Committee~~	Medical Director	~~Chris Shaw University Dr Kate Craig~~

Quality, Safety & Experience Committee		Executive Director of Nursing		5	SH

Quality, Safety and Experience Committee	Medical Director	Mrs L Harris/Mrs R Vaughan-Roberts/ Mrs S Bailey Superintendent Radiographer/

Quality, Safety & Experience Committee		Medical Director	Darell Baker		
Quality, Safety & Experience Committee		Medical Director			
~~Quality, Safety & Experience Committee~~		~~Executive Director of Nursing~~	~~Janice Lloyd PPI Project Coordinator~~		

~~Quality, Safety & Experience Committee~~		~~Chief Operating Officer~~	~~Helen Bennett Head of Mental Health Nursing~~		

~~Quality, Safety and Experience Committee~~	~~Medical Director~~	~~Darrell Baker Senior Pharmacist~~
~~Quality, Safety and Experience Committee~~	~~Director of Corporate Governance~~	~~Jonathan McGarrigle, Estate Asset Manager~~
~~Medicines Management Group~~	~~Medical Director~~	~~Louise Williams - Nurse Advisor for Pharmacy~~
~~Mental Health and Capacity Legislation Committee~~	~~Chief Operating Officer~~	~~Sunni Webb, Mental Health Act Manager~~

~~Quality, Safety and Experience Committee~~		~~Medical Director~~	~~Daryll Baker, Director of Medicines Management~~
~~Medicines Management Group~~		~~Medical Director~~	~~Adrian Davies Medicine Directorate Pharmacist~~
~~Medicines Management Group~~		~~Medical Director~~	~~Adrian Davies Medicine Directorate Pharmacist~~
~~Health & Safety Committee~~		~~Medical Director~~	
~~Medicines Management Group~~		~~Medical Director~~	~~Divisional Pharmicist Specialist Services~~
~~Medicines Management Group~~	~~QSE 16/013~~	~~Medical Director~~	~~Louise Williams, Nurse Advisor Medicines Management~~

~~Medicines Management Group~~		~~Medical Director~~	~~Senior Information Pharmacist~~
~~Quality, Safety and Experience Committee~~		~~Medical Director~~	~~Principal Pharmacist~~
~~Medicines Management Group~~	~~MMG 16/03/2017 4a~~	~~Medical Director~~	~~Medical Director~~
~~Medicines Management Group~~		~~Medical Director~~	~~Medical Director~~
~~Quality & Safety Committee~~		~~Medical Director~~	~~Clinical Lead for Organ Donation~~
~~Quality, Safety, Experience Committee~~		~~Medical Director~~	~~Medical Director~~
~~Quality, Safety and Experience Committee~~	~~QSE15/05 7.3~~	~~Medical Director~~	~~Medical Director~~
~~People, Planning and Performance Committee~~	~~S7D 05/03/21~~	~~Executive Director of Workforce Organisational Development~~	~~Kath Elias, Recruitment Nurse Advisor Lesley Jones LED~~

~~People, Planning and Performance Committee~~		~~Executive Director of Workforce Organisational Development~~	~~Rod Hill, Business Manager WOD~~
Research Governance Group		Director of Transformation and Informatics	Dr Kate Craig
~~Mental Health and Capacity Legislation Committee~~	~~CB Q&S 07/04/16~~	~~Chief Operating Officer~~	~~Mark Bates~~
People, Planning and Performance Committee		Executive Director of Workforce Organisational Development	Andrew Crook HR Policy and Compliance Manager & Nigel Gibbs Staff Representative

~~Nutition and Catering~~		~~Executive Director of Therapies and Health services~~	~~Adult Nutrition Support Group~~
~~People, Planning and Performance Committee~~		~~Executive Director of Workforce Organisational Development~~	~~Dr Clare Wright, Consultant Clinical Psychologist, Acting Head of Service~~
~~Employment Policies Sub Group~~		~~Executive Director of Workforce Organisational Development~~	~~Rachel Pressley Senior HR Policy and Compliance Officer~~
~~Quality, Safety and Experience Committee~~	~~QSE15/05 7.2~~	~~Executive Director of Therapies and Health services~~	~~Sue Bailey CD&T~~

Quality, Safety Experience		Executive Director of Therapies and Health services	Nerys Thomas / Leslie Harris Radiographer		
~~Strategy and Delivery Committee~~		~~Executive Director of Workforce Organisational Development~~	~~Welsh Partnership Forum Business Committee~~		
~~People, Planning and Performance Committee~~		~~Executive Director of Workforce Organisational Development~~	~~Jane Banks Senior HR Officer~~		

Mental Health and Capacity Legislation Committee		Chief Operating Officer	Jayne Tottle, Lead Nurse Asult Mental Health
Mental Health and Capacity Legislation Committee	CB Q&S 07/04/16	Chief Operating Officer	Tim Goosey, Senior Nurse Manager for Community
Mental Health and Capacity Legislation Committee		Chief Operating Officer	Jayne Tottle, Lead Nurse for Adult Mental Health Services
Mental Health and Capacity Legislation Committee		Chief Operating Officer	Medical Director
Mental Health and Capacity Legislation Committee	CB Q&S 07/04/16	Chief Operating Officer	Mark Bates
Mental Health and Capacity Legislation Committee	CB Q&S 07/04/16	Chief Operating Officer	Mark Bates
Mental Health and Capacity Legislation Committee	CB Q&S 07/04/16	Chief Operating Officer	Simone Joslyn
Mental Health and Capacity Legislation Committee	CB Q&S 07/04/16	Chief Operating Officer	Occ Health
Mental Health and Capacity Legislation Committee	CB Q&S 07/04/16	Chief Operating Officer	Jackie Phillips
Mental Health and Capacity Legislation Committee	CB Q&S 07/04/16	Chief Operating Officer	Mark Bates

Mental Health and Capacity Legislation Committee	CB Q&S 07/04/16	Chief Operating Officer	Dan Crossland
Mental Health and Capacity Legislation Committee	CB Q&S 07/04/16	Chief Operating Officer	Mark Bates
Mental Health and Capacity Legislation Committee	CB Q&S 07/04/16	Chief Operating Officer	Mark Bates
Mental Health and Capacity Legislation Committee	CB Q&S 07/04/16	Chief Operating Officer	Kelly Panniers
Quality, Safety and Experience Committee		Medical Director	Ceri Phillips
Information Governance sub-Committee		Information Governance Sub Group	Ann Morgan/Richard Williams
Information Governance sub-Committee		Information Governance Sub Group	Ann Morgan/Richard Williams
Information Governance sub-Committee	IGSC 17/035	Information Governance Sub Group	Ann Morgan/Richard Williams
Mental Health and Capacity Legislation Committee	CB Q&S 16/06/2016	Chief Operating Officer	Kelly Panniers
~~Quality, Safety and Experience Committee~~	~~QSE 16/092~~	~~Executive Director of Therapies and Health services~~	~~Clive Morgan~~

~~Research Governance Group~~	~~Medical Director~~	~~Maureen Edgar Research and Development Co-ordinator~~
~~Research Governance Group~~	~~Medical Director~~	~~Maureen Edgar Research and Development Co-ordinator~~
~~Research Governance Committee~~	~~Medical Director~~	~~Pat Tamplin, Governance Officer~~
~~Quality, Safety and Experience Committee~~	~~Medical Director~~	~~Pat Tamplin, Governance Officer~~
~~Audit Committee~~	~~Director of Corporate Governance~~	~~Melanie Westlake Governance & Risk Manager~~

Procedure	EQIA	EHIA	Intranet	Database	Internet	Internet Sub Category	Clinical Portal
	~~No~~	~~No~~	~~Yes~~	~~Yes~~	~~Yes~~		
	~~No~~	~~No~~		~~No~~			
	~~No~~						

~~No~~

~~Yes~~ ~~No~~

~~Yes~~

~~No~~

~~No~~

~~Yes~~

	No						
No	No	No	Yes	Yes	Yes	Patient Safety and Quality	Yes
No	Yes	No	Yes	Yes	Yes	Patient Safety and Quality	Yes
No	No	No	Yes	Yes	Yes	Patient Safety and Quality	Yes
No	No	No	Yes	Yes	Yes	Patient Safety and Quality	Yes

No	~~No~~	No	~~Yes~~	~~Yes~~	~~Yes~~	Patient Safety and Quality	~~Yes~~
~~No~~	~~Yes~~	~~No~~	~~Yes~~	~~Yes~~	~~Yes~~	~~Patient Safety and Quality~~	~~Yes~~
No	~~Yes~~		~~Yes~~	~~Yes~~	~~Yes~~	~~Workforce and Organisational Development~~	~~Yes~~

No	Yes	Angela Hughes reviewing - to complete by end of Jan 16 - update 09.02.16 advising close to finalising. Advised	Yes	Yes	Yes	Corporate	Yes
No	No	Policy has EQIA - Update as	Yes	Yes	Yes	Corporate	Yes
No	No	Policy has EQIA - Update as above	Yes	Yes	Yes	Corporate	Yes
No	Yes	No	Yes	Yes	Yes	Workforce and Organisational Development	Yes

No	~~No~~	~~Pat Tamplin advised - A new SOP combining both SOPs went to January RGG - awaiting final comments for Chair's action then will publish (030315)~~	~~Yes~~	~~Yes~~	~~Yes~~	Corporate	~~Yes~~
No	~~No~~	~~As above~~	~~Yes~~	~~Yes~~	~~Yes~~	Corporate	~~Yes~~
~~No~~	~~Yes~~	~~No~~	~~Yes~~	~~Yes~~	~~Yes~~	~~Workforce and Organisational Development~~	~~Yes~~

No	No	Hyperlinks to Management of parenteral cytotoxic chemotherapy policy; Wards and departments & Designated Personnel approved for the administration for cytotoxic chemotherapy’:	Yes	Yes	Yes	Health and Safety	Yes
No	No	E-mailed Rachel P. For EQIA 8/3/13	Yes	Yes	Yes	Workforce and Organisational Development	Yes
	Yes		Yes	Yes	Yes	Workforce and Organisational Development	Yes

Yes	Yes	No	Yes	Yes	Yes	Patient Safety and Quality	
No	~~Yes~~	No	~~Yes~~	~~Yes~~	~~Yes~~	Patient Safety and Quality	~~Yes~~

	No	No		Yes	Yes		

No	Yes	No	Yes	Yes	Yes	Health and Safety	Yes

	No						
	No						
	~~No~~	~~No~~	~~Yes~~				

~~No~~	~~Yes~~	~~No~~	~~Yes~~	~~Yes~~	~~Yes~~	~~Patient Safety and Quality~~	~~Yes~~
~~No~~	~~Yes~~	~~No~~	~~Yes~~	~~Yes~~	~~Yes~~	~~Health and Safety~~	~~Yes~~
~~No~~	~~Not required~~	~~No~~	~~Yes~~	~~Yes~~	~~Yes~~	~~Patient Safety and Quality~~	~~Yes~~
~~No~~		~~Sent to Wendy Gilbert 20/7 informed by Wendy 27/7 document needstogao bak to MHA Comm with EQIA for ratification~~					

No	Yes	Removed on 25/7/12 previous Trust version re-loaded ref 245. New Document under review. Chase up reminder sent to Alison Jones 28/3/13	Yes	Yes	Yes	Corporate	Yes
No	No	No	Yes	Yes	Yes	Patient Safety and Quality	Yes
No	No	No	Yes	Yes	Yes	Patient Safety and Quality	Yes
No		No				Patient Safety and Quality	
No	No	No	Yes	Yes	Yes	Patient Safety and Quality	Yes
No	No	Requested 22/8/14	Yes	Yes	Yes	Patient Safety and Quality	Yes

No	No	No	Yes	Yes	Yes	Patient Safety and Quality	
No	Yes	No	Yes	Yes	Yes	Patient Safety and Quality	Yes
No	No	No	Yes	Yes	Yes	Patient Safety and Quality	Yes
No	Yes	No	Yes	Yes	Yes	Patient Safety and Quality	Yes
Yes	Yes	No	Yes	Yes	Yes	Corporate	Yes
No	Yes	No	Yes	Yes	Yes	Patient Safety and Quality	Yes
No	Yes	No	Yes	Yes	Yes	Patient Safety and Quality	
No	Yes	No	Yes	Yes	Yes	Workforce and Organisational Development	Yes

~~No~~	~~Yes~~	~~No~~	~~Yes~~	~~Yes~~	~~Yes~~	~~Workforce and Organisational Development~~	~~Yes~~
No	No	No EQIA	Yes	Yes	Yes	Corporate	Yes
~~No~~	~~No~~	~~No~~	~~Yes~~	~~Yes~~	~~Yes~~	~~Corporate~~	
No	Yes	Uploaded v 2.1 Oct 12 - minor changes agreed by Mel and Adrew Crook	Yes	Yes	Yes	Workforce and Organisational Development	Yes

No	Yes	No	Yes	Yes	Yes	Corporate	Yes
No	Yes	No	Yes	Yes	Yes	Workforce and Organisational Development	Yes
No	Yes	All Wales Policy issued by NHS Employers for	Yes	Yes	Yes	Workforce and OD	Yes
No	Yes	Clive Morgan advised will go to April QSE for approval (030315)	Yes	Yes	Yes	Corporate	Yes

Yes	No	No	yes	yes	yes	Corporate	
~~No~~	~~no~~	~~No~~	~~Yes~~	~~Yes~~	~~Yes~~	~~Workforce and Organisational Development~~	~~Yes~~
	~~No~~	~~No~~					

No	No	No	Yes	Yes	Yes	Patient Safety and Quality	Yes
No	No	No	Yes	Yes	Yes	Patient Safety and Quality	Yes
No	No	No	Yes	Yes	Yes	Patient Safety and Quality	Yes
Yes	No	No	Yes	Yes	Yes	Patient Safety and Quality	
Yes	No	No	Yes	Yes	Yes	Patient Safety and Quality	
Yes	No	No	Yes	Yes	Yes	Patient Safety and Quality	
No	No	No	Yes	Yes	Yes	Corporate	
No	No	No	Yes	Yes	Yes	Patient Safety and Quality	
No	No	No	Yes	Yes	Yes	Patient Safety and Quality	
No	No	No	Yes	Yes	Yes	Corporate	

Yes	No	No	Yes	Yes	Yes	Corporate
Yes	No	No	Yes	Yes	Yes	Corporate
No	No	No	Yes	Yes	Yes	Corporate
No	No	No	Yes	Yes	Yes	Corporate
Yes	No	No	Yes	Yes	Yes	Patient Safety and Quality
No	No	No	Yes	Yes	No	Corporate
No	No	No	Yes	Yes	No	Corporate
No	No	No	Yes	Yes	No	Corporate
No		No	Yes	Yes	Yes	Corporate
~~Yes~~	~~Yes~~	~~No~~	~~Yes~~	~~Yes~~	~~Yes~~	~~Health and Safety~~

No	No	No	Yes	Yes	Yes	Corporate	Yes
No	No	No	Yes	Yes	Yes	Corporate	Yes
No	No	No	Yes	Yes	Yes	Corporate	Yes
No	Yes	No	Yes	Yes	Yes	Corporate	Yes
No	Yes	No	Yes	Yes	Yes	Corporate	Yes

Review Date expired	Date uploaded	Ratified April 12/13	Ratified April 13/14	Ratified April 14/15	Ratified April 15/16	Documents superseded

~~Yes~~

~~Yes~~

~~Yes~~

~~Yes~~

~~Yes~~

Yes

~~Yes~~

~~Yes~~

~~Yes~~

~~Yes~~

~~Yes~~

~~Yes~~

~~Yes~~

~~Yes~~

~~Yes~~

~~Yes~~ ~~9/1/2011~~

~~Complete~~	~~Document under review - received by RGG - Oct 2011. Comments requested by 25.11.11~~

~~8/22/2013~~ ~~Yes~~ ~~UHB V2~~

~~Yes~~

~~3/11/2011~~

~~Yes~~

Yes	3/11/2011		
Yes	8/26/2011		
			T336
Document nolonger required /replaced with another document	4/25/2012		

~~Yes~~	~~3/28/2012~~	~~Yes~~	~~Trust 3~~
~~Yes~~	~~8/2/2012~~	~~Yes~~	~~Trust 3~~
~~Yes~~	~~8/2/2012~~	~~Yes~~	~~Trust 3~~
~~Yes~~	~~11/1/2015~~	~~Yes~~	~~Trust 329-UHB 277~~

~~Document nolonger required /replaced with another document~~	~~9/21/2012~~	~~Yes~~		~~N/A~~
~~Document nolonger required /replaced with another document~~	~~9/21/2012~~	~~Yes~~		~~N/A~~
~~No~~	~~10/15/2014~~		~~Yes~~	~~v1~~

~~Yes~~	~~2/20/2013~~	~~Yes~~		~~T/365~~
~~Yes~~	~~3/8/2013~~	~~Yes~~		~~Trust 17~~
~~Document nolonger required /replaced with~~	~~3/15/2013~~	~~Yes~~		~~Trust 63~~

No	7/23/2015	Yes	T47
~~Yes~~	~~9/30/2014~~	~~yes~~	~~UHB version 1~~

Yes						

Yes	3/3/2011

Yes						
Yes						
~~Yes~~						

Yes						

Yes 3/24/2016

Yes 2/5/2015 v1

Yes 5/16/2012 Yes

Yes

Yes	~~5/22/2013~~		~~Yes~~		~~Ref T/245 Previously Dag 1.3 version 2~~
Yes	~~11/29/2012~~	~~Yes~~			~~Trust 252~~
Yes	~~11/29/2012~~	~~Yes~~			~~Trust 316~~
Yes	~~3/28/2013~~	~~Yes~~			
Yes	~~6/14/2013~~		~~Yes~~		~~T/251 v 2~~
Yes	~~8/29/2014~~		~~Yes~~	~~yes~~	~~Trust 247. 265. 253. 267~~

Yes	~~11/8/2013~~			
Yes	~~4/4/2014~~			
Yes	~~12/11/2017~~			
Yes	~~5/1/2014~~			
Yes	~~1/21/2015~~	~~Yes~~		~~N/A~~
Yes	~~5/11/2015~~	~~Yes~~		~~N/A~~
Yes	~~7/24/2015~~		~~Yes~~	~~T322~~
~~Yes~~	~~11/4/2011~~			

~~Yes~~	~~3/7/2012~~				
Yes	7/8/2015	Yes		Yes	No formal document. Informed Sarah Mann to replace
~~Yes~~	~~6/21/2016~~				
Yes	4/7/2015	Yes	Yes		UHB Version 2

Yes	10/16/2015		Yes	N/A
Yes	11/4/2011			
Yes	4/16/2015			v1.1
Yes	5/12/2015		Yes	Trust 74 - V1

Yes 11/3/2015

~~No~~ ~~11/7/2018~~ Yes ~~v4~~

~~Yes~~						

Yes	8/8/2011		
Yes	4/14/2016	Yes	No
Yes	1/31/2013	Yes	No
Yes			
Yes	6/16/2016		
Yes	6/16/2016		
Yes	6/16/2016		
Yes	6/16/2016		
Yes	6/16/2016		
Yes	6/21/2016		

Yes	6/21/2016
Yes	6/21/2016
Yes	6/21/2016
Yes	6/21/2016
Yes	7/12/2016
Yes	8/5/2016
Yes	8/5/2016
No	8/5/2016
Yes	10/9/2016
~~Yes~~	~~8/17/2016~~

~~Yes~~	~~2/5/2013~~	~~Yes~~		~~Trust 164 & 174~~
~~Yes~~	~~2/5/2013~~	~~Yes~~		~~Trust 164 & 174~~
				~~UHB V4~~
~~Yes~~	~~8/9/2016~~		~~Yes~~	
~~Yes~~	~~9/23/2015~~			
~~Yes~~	~~11/26/2013~~			~~UHB V1~~

Yes

6 month reminder date	Comments				
	~~Unable to review until new Organisational Change Policy is released.-will be rescinded once revised OCP approved(All Wales)~~				
	~~Old IPC version on intranet IPC ref 2. Database has new front page version in draft~~				
	~~04/02/15 - met with Eleri Davies. Intention to develop Document reviewed and discussed at H&S Committee on 061015. Awaiting document for Inc Appx. Appx 10 also ref 341~~	Updated UHB 303			
	~~Software Licencing~~	Updated UHB 254			
	~~04/02/15 - met with Eleri Davies. Document is in draft but is not considered a priority area. (MJW)~~	UHB 275			
	~~04/02/15 - met with Eleri Davies. Revised document currently under development. Agreed to remove procedure and replace with a single sheet directing staff to contact IP&C and~~				

Going to QSE in August 2016

Several attempts by AC to review but rules keep changing. May rescind and replace with new scheme (220915)	
Ref no duplicated with Acute Pain	
Outdated and no longer required - CE 08/02/2017	
Angela Hughes reviewing - to complete by end of Jan 16 - update 09.02.16 advising close to finalising. Advised of arrangements re	Been superceded and no longer relevant, see email in folder from CE 08/02/2017
Child Protection Supervision Protocol ref 377	Out of date to be removed CE 08/02/2017
Has not been updated pending review of Organisational Change policy. Revised document to EPSG on 230915	UHB 280
4 documents going to replace Ultrasound Governance Policy Laser Safety Policy MRI Safety Artificial Optical Radiation	UHB 031 - Superseed

~~Replaced by UHB 084~~

~~This will be rescinded and incorporated into the Health and Wellbeing Strategy.~~

Appx 5 ref 133- SUPERCEEDED BY 254

All Wales document issued. To PPP in Mar 16 (MJW 290216)

~~Currently on Intranet and portal in word received from Claire Donovan - Mel req EQIA-this is now UHB 333~~

Superseded by UHB 147

Superseeded by UHB 302

04/02/15 - Emailed Pat Tamplin and Maureen Edgar - MJW -Superseeded by UHB 302

Pat Tamplin advised under review and due for presentation to RGG in April 2015 (030315)

~~04/02/15 - Emailed Pat Tamplin and Maureen Edgar - MJW Pat Tamplin advised under review and due for presentation to RGG in April 2015 (030315)~~	~~This was reviewed April 2015 and the doc was archived as no longer applicable. I apologise for not letting you know at the time~~
Awaiting approval of All Wales Pathway (PAC-Plan) which will lead to review of UHB policy (MJW - see e-mails Feb 2015) replaced with UHB 334	Going to QSE IN Sept
~~This has been superceded by the Maternity, Adoption, Paternity and Shared Parental Leave Policy and shouldn't be on the list anymore WESTLAKE Melanie] Need to indicate what has superseded documents and keep on top of this.~~	

~~Drafted and to be finalised by the end of Aug2016~~

~~Drafted and to be finalised by the end of Aug2016~~

~~Drafted and to be finalised by the end of Aug2016~~

~~All Wales document in progress UHB 277~~

~~04/02/15 - Emailed Pat Tamplin and Maureen Edgar - MJW~~

~~UHB 247 will Supersede~~

~~04/02/15 - Emailed Pat Tamplin and Maureen Edgar - MJW~~

~~UHB 247 will supersede~~

Superceeded by UHB 339

~~Email in UHB folder Emailed Noreen Lewis 25/08/16~~	~~This drug is no longer available, therefore the policy is no longer viable~~
~~EQIA received and uploaded on 24/2/14- Being incorporated tinto Prtnership and Recogntion Agreeement~~	~~Rescinded at Board - Superceeded by UHB 025~~
Superseded by UHB 241	

Made obsolete - email in UHB 265 and removed to removed docs tab

Superseeded by UHB 317

	04/02/15 - met with Eleri Davies. Document currently being reviewed by Virologists. Will be circulated for comment shortly. (MJW)	Done - Superseeded by UHB 149 Standard Precautions & UHB 267 Standarad Transmission Based Precautions.			
	Clive Morgan advised Will Evans reviewing documet (030315)	Superseeded to UHB 344			
	This document will be removed once a new medicine policy/code is in place. EP220817	Superseeded by UHB 195			
	This document will be removed once a new policy/code is in place. EP220817	Superseeded by UHB 195			
	JRM advised that a group has been set up to decide on an appropriate way forward - Initial thoughts are that guidance will supersede the aged policy and it could possibly be All-Wales. Work still ongoing March 2016 (See e-				

		~~Superseded by UHB 321~~			

~~27/03/15 - Dean Whittle contacted re review of document. Advice provided by e-mail (see folder)-New Policy uploaded 24/3/16~~

~~Identified problems / policy register / don't match~~

~~04/02/15 - Met with Eleri Davies. Plan is to have overarching "Water Safety Plan" which is being developed under remit of Water Safety Group~~

~~091 Geoff – Legionella Policy – this will be~~

Email in UHB Folder - SEE UHB 388

~~Document not received. Further advice sought from Mental Health Act Office (MJW - 071015)~~

Email in folder- Daryl Baker -SEE UHB 388

Emailed Daryl copy in folder -SEE UHB 388

Emailed Daryl copy in folder -SEE UHB 388

Changed to H&S Committee as of 21/08/17, agreed by Charles Dalton, email

SEE UHB 388

Email in folder -SEE UHB 388

SEE UHB 388

see UHB 388

Email in UHB I think it was assumed that following on from MMG the document would automatically come to you and sending it me was Email in UHB Folder - SEE UHB 388

This Policy is superseeded by UHB 110

SEE UHB 388

SEE UHB 388

~~Rachel Pressley discussing with Lynda Jenkins re lead exec.=This needs to be agreed between Ruth and Raj it is not a big issue. We will update the Register and then ensure that we addit to the Nurse Directors list~~

~~Rescinded to be removed - 15/03/19~~

~~Under review - Rachel Pressley advised Occ Health waiting for new AD for OD to take up post to ensure going in right direction.- overdue~~

~~This policy was submitted to the Health and safety Committee at its October 2015 meeting. The Committee minutes item HSC;15/090 which was ratified by the Chair on the 26th January, confirmed that the CCTV policy was approved subject to amendments being made. These~~

~~To be recsinded after Board decision Rescinded S&D 05/03/19~~

04/02/15 - Emailed Pat Tamplin and Maureen Edgar - MJW

~~Requested minute number 20/12/16~~

Rescinded 01/05/2018
Nutrution group -
Sarah Galliford

~~Rachel Pressley queried as Strategy - advised still Written Control document and also has review date which has now expired- Ovedue to be revied by Claire Radley.~~ ~~I am not sure I am the lead for this but will discuss with my manager Claire Radley~~ ~~I have spoken to Claire Radley and she has confirmed she is the lead for this policy.~~	~~Email be completed by end of year rescinded at S&D committee 25/06/19~~
~~All Wales Policy issued by NHS Employers for consideration by PPP on 150316 (MJW)~~ ~~There is an All-Wales~~	~~On Hold ? Query All Wales - REPLACED BY~~

~~No longer a UHB document as its Directorate specific therefore it can be removed from this list~~

		We are looking to change the document and Hannah and Claire are working with the Radiologists to update the reporting remits which will allow extension within the reporting role. UHB276 is no longer a UHB document as it is Directorate specific as it relates to Radiology only, so can be removed from this list. This document is a protocol , not a policy. They are updating it for Sept 19			
		~~EQIA req Maggie Lewis 29/6/10 Previous Trust version and exploratory front page added alongside All Wales UHB version 4/3/11(2 docs in total) Trust doc removed 13/2/13. Rehabilitation policy~~			
	~~? Whether should be on database. Advice from WOD required.- Do you know when this should have been rescinded. If its an oversight on our part we can remove the document. It is availaible via the following link:http://nww.cardiffandvale.wales.nhs.uk/pls/portal/docs/PAGE/POLICY_PAGEGROUP~~				

E-mail sent to Keithley Wilkinson for advice 4/8/11	Yes to be reviewed by Dec
Requested minute number 20/12/2016	
Document reviewed by MH. JT to provide version for uploading (MJW 020216)	
Requested minute number 20/12/16	
Requested minute number 20/12/16	
Requested minute number 20/12/16	
Requested minute number 20/12/16	
Requested minute number 20/12/16	
Requested minute number 20/12/16	

Requested minute number 20/12/16

Requested minute number 20/12/16

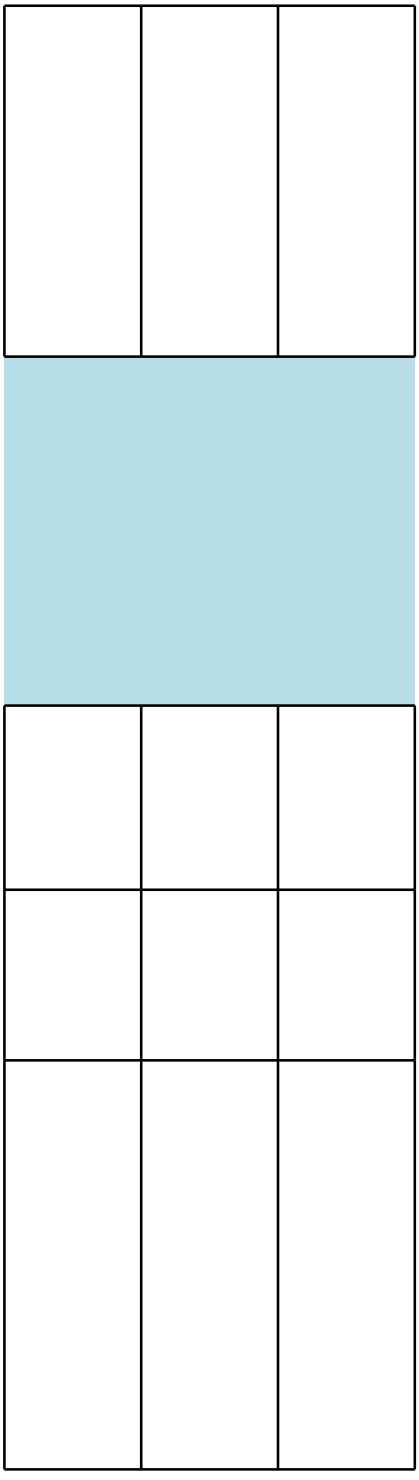
Requested minute number 20/12/16

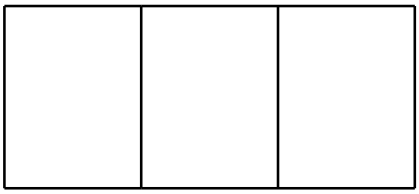
Requested minute number 20/12/16

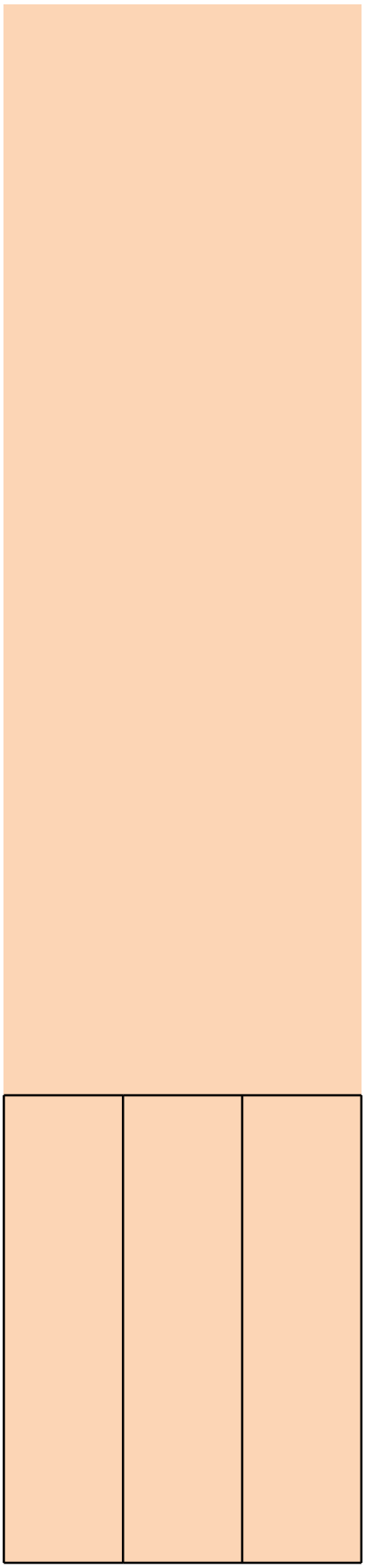
IG had failed to forward this for

Requested minute number 20/12/16. March 2018 found that 2 superceded documents were still ~~superseded by the Radioactive Substances Risk Management Policy and Procedure which was ratified at June~~

Email in UHB Folder Emails in UHB folder	Email sent to Marietto Clavo and Jane Jones 11.09.2019. Superseded by UHB 253
email in folder Emails in UH folder	Email sent to Marietto Clavo and Jane Jones 11.09.2019. Superseded by UHB
Ratified before end of V3 review date due to changes in guidance	Email sent to Marietto Clavo and Jane Jones
Mel	Email sent to Marietto Clavo and







UHB Ref Number	Previous organisation Ref no	Version Number	Title of Document	Type of Document	Previous Organisation	Area of applicability	Status	Last review date	New review date	Original UHB Approving Committee	Current UHB Approving Group/Committee	Minute Approval Number	Responsible Director UHB	Author(s) & Job Title	HCS Cross Ref	HCS Exec Lead Director	Procedure	EQIA	EHIA	Intranet	Database	Internet	Internet Sub Category	Clinical Portal	Review Date expired	Date uploaded	Documents superseded	6 month reminder date	12 month reminder date	Comments	
UHB 006	218	1	Data Protection Guidance For Researchers'	Guidelines	Trust	UHB Wide	Ratified	07/12/2015	07/12/2018	Research Governance Group	Research Governance Group		Director of Transformation and Informatics	Nic Drew Data Protection Officer			No	Yes	No	Yes	Yes	Yes	Corporate	Yes	Yes	5/19/2016				04/02/15 - Emailed Pat Tamplin and Maureen Edgar - MJW R&D advised not an R&D document. E-mailed AM and MM. MM responded to say would add to list of IG docs for review (030315)	To be reviewed in Q4 2019
UHB 007	208	1	Remote Access Software'	Protocol	Trust	IT	Ratified	9/29/2010	1/11/2012	Information Governance sub-Committee	Information Governance sub-Committee		Director of Transformation and Informatics	Nic Drew Data Protection Officer			No	Yes	No	Yes	Yes	Yes	Corporate	Yes	Yes	1/13/2011					To be reviewed in Q3 2019
UHB 048	N/A	1	Internet and E-mail Monitoring, administration and Reporting Protocol	Protocol	N/A	UHB Wide	Ratified	26/04/2011	01/04/2014	Information Governance sub-Committee	Information Governance sub-Committee	PPP16/113	Director of Transformation and Informatics	Medical Director			No	No	No	Yes	Yes	Yes	Corporate	Yes	Yes	5/26/2011				Currently IT Security and Information Governance are revising procedure, guidance and protocol documents that support the IT Security Policy A plan has been put in place for the IGSC meetings to review documents in stages The remaining review stages are scheduled for September, December and March 2017 I will be meeting with IG next week for a progress update and will ensure that this document is appended to the plan for December or March IGSC review Once again thank you for highlighting this document	To be reviewed in Q3 2019
UHB 049	N/A	1	Emailing Patients Template Protocol	Protocol	N/A	IT Security Office	Ratified	26/04/2011	01/01/2014	Information Governance sub-Committee	Information Governance sub-Committee		Director of Transformation and Informatics	Executive Director of Therapies and Health services			No	No	No	Yes	Yes	Yes	Corporate	Yes	Yes	5/26/2011					To be reviewed in Q3 2019
UHB 246	N/A	1	Information Governance Policy	Policy	N/A	UHB	Ratified	20/01/2015	20/01/2018	People Performance and Delivery Committee	Information Governance sub-Committee		Director of Transformation and Informatics	Head of Information Governance and Assurance			No	No	No	Yes	Yes	Yes	Corporate	Yes	Yes	1/30/2015	N/A				Complete and needs to be formally ratified - D&HI Committee Dec 19
UHB 254	T133	1	I.T Security Policy	Policy	Trust	UHB	Ratified	31/03/2015	31/03/2018	People Performance and Delivery Committee	Information Governance sub-Committee		Director of Transformation and Informatics	Head of Information Governance and Assurance			No	No	No	Yes	Yes	Yes	Corporate	Yes	Yes	4/10/2015	N/A				Complete and needs to be formally ratified - D&HI Committee Dec 19
UHB 255	T151	1	Freedom of Information Procedure	Procedure	Trust	UHB	Ratified	31/03/2015	31/03/2018	People Performance and Delivery Committee	Information Governance sub-Committee		Director of Transformation and Informatics	Senior Information Governance Officer			Yes	No	No	Yes	Yes	Yes	Corporate	Yes	Yes	4/13/2015	T151				Complete and needs to be formally ratified - D&HI Committee Dec 19
UHB 256	N/A	1	Freedom of Information Policy	Policy	N/A	UHB	Ratified	31/03/2015	31/03/2018	People Performance and Delivery Committee	Information Governance sub-Committee		Director of Transformation and Informatics	Senior Information Governance Officer			No	Yes	No	Yes	Yes	Yes	Corporate	Yes	Yes	4/14/2015	N/A				This has now been incorporated within the FOI procedure document
UHB 263	N/A	1	Transportation of Personal Identifiable Information	Procedure	N/A	UHB	Ratified	26/02/2015	26/02/2018	People Performance and Delivery Committee	People, Planning and Performance Committee		Director of Transformation and Informatics	Head of Information Governance and Insurance			Yes	No	No	Yes	yes	yes	Corporate		Yes	7/2/2015					To be reviewed in Q3 2019
UHB 286	N/A	1	Information Governance Corporate Training Policy	Policy	N/A	UHB	Ratified	21/07/2015	21/07/2018	People,Performance and Plannig Group	People,Performance and Plannig Group	PPP15/017	Director of Transformation and Informatics	Medical Director			No	Yes	No	Yes	Yes	Yes	Corporate		Yes	4/5/2016					To be reviewed in Q3 2019
UHB 287	N/A	1	Information Risk Managment Procedure	Procedure	N/A	UHB	Ratified	18/09/2015	18/09/2018	Information Governance Sub Group	Information Governance sub-Committee		Director of Transformation and Informatics	Medical Director			Yes	No	No	Yes	Yes	Yes	Corporate		Yes	4/6/2016					To be reviewed in Q3 2019
UHB 288	N/A	1	Data Quality Management Procedure	Procedure	N/A	UHB	Ratified	15/09/2015	15/09/2018	Information Governance Sub Group	Information Governance sub-Committee		Director of Transformation and Informatics	Medical Director			Yes	No	No	Yes	Yes	Yes	Corporate		Yes	4/6/2016					To be reviewed in Q3 2019
UHB 289	N/A	1	Information Asset Procedure	Procedure	N/A	UHB	Ratified	22/06/2015	22/06/2018	Information Governance Sub Group	Information Governance sub-Committee		Director of Transformation and Informatics	Medical Director			Yes	No	No	Yes	Yes	Yes	Corporate		Yes	4/6/2016					To be reviewed in Q3 2019
UHB 290	N/A	1	Personal Information use and Disclosure of and the Duty to Share Guidance	Guidelines	N/A	UHB	Ratified	22/06/2015	22/06/2018	Information Governance Sub Group	Information Governance sub-Committee		Director of Transformation and Informatics	Medical Director			No	No	No	Yes	Yes	Yes	Corporate		Yes	4/6/2016					To be reviewed in Q3 2019
UHB 291	N/A	1	Dealing with Subject Access under Data Protection Act Procedure	Procedure	N/A	UHB	Ratified	18/12/2015	18/12/2018	Information Governance Sub Group	Information Governance sub-Committee		Director of Transformation and Informatics	Medical Director			Yes	No	No	Yes	Yes	Yes	Corporate		Yes	4/6/2016					Complete and needs to be formally ratified - D&HI Committee Dec 19
UHB 298	N/A	1	Data Quality Policy	Policy	N/A	UHB	Ratified	15/09/2015	15/09/2018	People,Performance and Plannig Group	People,Performance and Plannig Group		Director of Transformation and Informatics	Medical Director			No	No	Yes	Yes	Yes	Yes	Corporate		Yes	4/6/2016					To be reviewed in Q3 2019
UHB 301	N/A	1	Information Goverance Operational Management Responsibilities Procedure	Procedure	N/A	UHB	Ratified	19/01/2016	19/01/2019	People,Performance and Plannig Group	People, Planning and Performance Committee		Director of Transformation and Informatics	Medical Director			Yes	Yes	No	Yes	Yes	Yes	Corporate		Yes	5/17/2016					To be reviewed in Q3 2019
UHB 335	N/A	1	All Wales Internet Use Policy	Policy	N/A	All Wales	Ratified	07/01/2016	07/01/2018	People,Planning and Performance committee	People,Planning and Performance committee	PPP 16/113	Director of Transformation and Informatics	Marie Mantle			No	Yes	No	Yes	Yes	Yes	Corporate		Yes	11/8/2016					Complete and needs to be formally ratified - D&HI Committee Dec 19
UHB 336	N/A	1	All Wales Social Media Policy	Policy	N/A	All Wales	Ratified	07/01/2016	07/01/2018	People,Planning and Performance committee	People,Planning and Performance committee	PPP 16/113	Director of Transformation and Informatics	Marie Mantle			No	Yes	No	Yes	Yes	Yes	Corporate		Yes	11/8/2016					To be reviewed in Q3 2019
UHB 337	N/A	1	All Wales Email Use Policy	Policy	N/A	All Wales	Ratified	07/01/2016	07/01/2018	People,Planning and Performance committee	People,Planning and Performance committee	PPP 16/113	Director of Transformation and Informatics	Marie Mantle			No	Yes	No	Yes	Yes	Yes	Corporate		Yes	11/8/2016					Complete and needs to be formally ratified - D&HI Committee Dec 19
UHB 356	N/A	1	Contractual Clauses and Arrangements Procedure	Procedure	N/A	UHB	Ratified	22/06/2015	22/06/2018	IGSC	IGSC	IGSC 15/039	Director of Transformation and Informatics	Ann Morgan				Yes	No	Yes	Yes	Yes	Corporate		Yes	7/27/2017				Contractual claims and arrangement procedure. This is all about Information Governance and hasn't been in the DOF portfolio of responsibilities for years. This is probably the responsibility of David Thomas.	To be reviewed in Q4 2019
UHB 357	N/A	1	Clauses within Employment Contracts Procedure	Procedure	N/A	UHB	Ratified	22/06/2015	22/06/2018	IGSC	IGSC	IGSC 15/039	Director of Transformation and Informatics	Ann Morgan				Yes	No	Yes	Yes	Yes	Corporate		Yes	7/27/2017					To be reviewed in Q4 2019

UHB Ref Number	Previous organisation Ref no	Version Number	Title of Document	Type of Document	Previous Organisation	Area of applicability	Status	Last review date	New review date	Original UHB Approving Committee	Current UHB Approving Group/Committee	Minute Approval Number	Responsible Director UHB	Author(s) & Job Title	HCS Cross Ref	HCS Exec Lead Director	Procedure	EQIA	EHIA	Intranet	Database	Internet	Internet Sub Category	Clinical Portal	Review Date expired	Date uploaded	Documents superseded	6 month reminder date	12 month reminder date	Comments	

UHB Ref Number	Previous organisation Ref no	Version Number	Title of Document	Type of Document	Previous Organisation
Ref 18		£ 3.00	Collective Disputes Policy	Policy	Trust
~~Ref 137~~		~~2~~	~~**Alert letters procedure**~~	~~Procedure~~	~~Trust~~
Ref 291			Being Open Policy	Policy	Trust
Ref 294		1	Off-site Mobile Computing Policy (previously ref isosp19 vers 2	Policy	Trust
~~Ref 298~~		~~1~~	~~**Covert administration of medicines**~~	~~Policy and Procedure~~	~~Trust~~
Ref 300		1	Verification of expected Death in Critical Care by Senior Nurses	Procedure	Trust

Ref 302		1	Verification of expected death by qualified nursing staff (Mental Health and Medicine Rehabilitation Services)	Guidelines	Trust
Ref 306		1	Clinical Supervision Policy	Policy	Trust
Ref 312		1	Communication with Partner Services/Agencies regarding Vulnerable Adult Patient Transfer/Discharge from Hospital	Procedure	Trust
Ref 313		1	Community MH Nurses acting as Mentors	Guidelines	Trust
Ref 320		1	Supplementary procedure for Controlled drug receipt, administration and reconciliation within Anaesthetic rooms previously DAG 6.8	Procedure	Trust

Ref 321		1	Safe and effective use of medical gases previously DAG 6.9	Procedure	Trust
Ref 325		1	Electro Convulsive Therapy Procedure	Procedure	Trust
Ref 328		1	Dealing with Visitors who are Violent/Abusive or Vexatious Procedure	Procedure	Trust
Ref 334		1	Prescribing, dispensing and administration of oral anticoagulant therapy (OAT) Procedure	Procedure	Trust
~~Ref 337~~		~~1~~	**~~Management of therapies Health Records Procedure~~**	~~Procedure~~	~~Trust~~
Ref 341		1	Software Licensing Policy	Policy	Trust

~~Ref 342~~			~~**Anti Virus Policy**~~	~~Policy~~	~~Trust~~
Ref 344			Intranevous Ketamine Adjuvant for short term use in acute pain Procedure	Procedure	Trust
Ref 345		1	Representative Policy - contact Trust staff and company representatives including free and trial goods	Policy	Trust
Ref 354		1	Preceptorship of Newly qualified Nurses	Policy	Trust
Ref 358		1	Managing Young People who are Sexually Active Protocol	Protocol	Trust
Ref 366		1	Topical Adrenaline and Cocaine Gel Administration in the Emergency Unit	Procedure	Trust
Ref 373		1	Safe Handling of Administration of Vinca Alkaloid Chemotherapy		
Ref 377		1	Child Protection Supervision Protocol	Protocol	Trust
~~Ref 381~~		~~1~~	~~**Safe administration of medicines to adult patients with swallowing difficulties**~~	~~Procedure~~	~~Trust~~

		1	Continuing NHS Health Care		cLHB
			Operational Policy for LHBs on the Management of Performance Procedures for Doctors on the Performance List		cLHB

Area of applicability	Status	Last review date	New review date	Original UHB Approving Committee
Trust Wide	Ratified	£ 39,722.00	£ 41,153.00	UHB Board
~~Trust Wide~~		~~01/11/2004~~	~~01/05/2005~~	~~People, Planning and Performance Committee~~
trust wide	Ratified	01/05/2007	01/05/2010	Clinical Standards and Patient Experience Team
trust wide	Ratified	01/07/2007	01/01/2010	Strategic Planning Committee
~~trust wide~~	~~Ratified~~	~~14/01/2008~~	~~01/01/2011~~	~~Clinical Standards and Patient Experience Team~~
Critical Care Directorate	Ratified	01/05/2007	01/05/2010	Critical Care Clinical Governance committee

trust wide	Ratified	01/11/2007	01/11/2008	Rehabilitation Clinical Governance Management Team Meeting
trust wide	Ratified	27/07/2009	01/07/2012	Clinical Governance Committee
trust wide	Ratified	14/01/2008	01/01/2011	Clinical Standards and Patient Experience Team
trust wide	Ratified	16/07/2007	16/07/2010	Mental Health Clinical Governance
trust wide	Ratified	01/09/2004	01/09/2007	Medicines Management Group

trust wide	Ratified	01/09/2004	01/09/2007	Clinical Standards and Patient Experience Team
Trust Wide	Ratified	01/02/2008	01/02/2011	Mental Health Clinical Governance
Trust Wide	Ratified	16/07/2008	01/07/2011	Health and Safety Committee
Trust Wide	Ratified	01/10/2007	01/10/2008	Trust Medicine Committee
~~**Therapies Services**~~	~~Ratified~~	~~01/06/2008~~	~~01/06/2009~~	~~Therapies Clinical Governance~~
	Ratified			Information Governance sub-Committee

	~~Ratified~~	~~13/03/2008~~	~~13/01/2011~~	~~Information Governance sub-Committee~~
		09/07/2008	01/07/2009	
Trust wide	Ratified	21/09/2009	01/09/2012	Clinical Governance Committee
Trust Wide	Ratified	18/11/2008	01/11/2010	Clinical Standards and Patient Experience
Trust Wide	Ratified	18/11/2008	01/11/2010	Clinical Standards and Patient Experience Team
Trust Wide	Ratified	01/05/2009	01/05/2011	Trust Medicine Committee
Trust wide	Ratified	01/09/2008	01/09/2011	Safeguarding Children Steering Group
~~Trust wide~~	~~Ratified~~	~~07/09/2009~~	~~01/09/2012~~	~~Clinical Standards and Patient Experience Team~~

		01/06/2005	01/04/2008	Board
		03/05/2007	30/06/1905	Clinical Governance and Quality committee

Current UHB Approving Group/Committee	Minute Approval Number	Responsible Director UHB	Author(s) & Job Title	HCS Cross Ref	HCS Exec Lead Director
People, Planning and Performance Committee		Executive Director of Workforce Organisational Development	Jayne Dando	21-24	JH
~~People, Planning and Performance Committee~~		~~Executive Director of Workforce Organisational Development~~	~~Sue Barrow HR Projects and Compliance manager~~		
Quality, Safety & Experience Committee		Medical Director			
Information Governance sub-Committee		Medical Director	Nic Drew Data Protection Officer		
~~Quality, Safety & Experience Committee~~		~~Medical Director~~	~~Darell Baker Principal Pharmicst~~		
Specialist Services Clinical Board Quality, Safety and Environment Group		Executive Director of Nursing			

Quality, Safety & Experience Committee		Executive Director of Nursing	Head of Mental Health Nursing		
Quality, Safety & Experience Committee		Medical Director	Maggie Lucas HR Manager		
Information Governance sub-Committee		Chief Operating Officer	Simon O'Donovan Clinical Director		
People, Planning and Performance Committee		Executive Director of Nursing	Mathew Nute Clinical Teacher		
Medicines Management Group		Medical Director	Darryl Baker Pharmacy		

Medicines Management Group		Medical Director	Darryl Baker Pharmacy		
Mental Health and Capacity Legislation Committee		Medical Director	Consultant Psychiatrist & Clinic Manager		
Health and Safety Committee		Executive Director of Planning	Simon Williams Named Nurse for Vulnerable Adult Protection		
Medicines Management Group		Medical Director	Daryl Baker		
~~Information Governance sub-Committee~~		~~Medical Director~~	~~Theresa King Chief 111 Podiatrist~~		
		Medical Director			

			~~IT Manager Nick Stickler~~		
		Medical Director			
Audit Committee		Director of Corporate Governance	Maggie Lucus Manager Medical Directors office		
Quality, Safety & Experience Committee		Executive Director of Nursing	Alex Nute Clinical Teacher		
Quality, Safety & Experience Committee		Executive Director of Nursing	Linda Hughes-Jones		
Medicines Management Group		Medical Director	Suzanne Davies		
		Medical Director			
Quality, Safety & Experience Committee		Executive Director of Nursing	Kathy Ellaways		
~~Medicines Management Group~~		~~Medical Director~~	~~Dr D Sastry~~		

Quality, Safety & Experience Committee		Executive Director of Nursing			
Quality, Safety & Experience Committee		Medical Director			

Procedure	EQIA	EHIA	Intranet	Database	Internet	Internet Sub Category	Clinical Portal
	No	No	Yes	Yes			
	~~No~~	~~No~~					

	No						
	Yes						
	No						
	Yes						
	No						

	No						
	Yes						
	Yes						
	Yes						
	No						

	No						
	Yes						
	Yes						
	No						
	No						
	No						
	~~Yes~~						

Review Date expired	Date uploaded	Ratified April 12/13	Ratified April 13/14	Ratified April 14/15	Ratified April 15/16	Documents superseded	6 month reminder date
Yes							
~~Yes~~							
Yes							
Yes							
~~Yes~~							
Yes							

Yes							
Yes							
Yes							
Yes							
Yes							

Yes							
Yes							
Yes							
Yes							
~~Yes~~							
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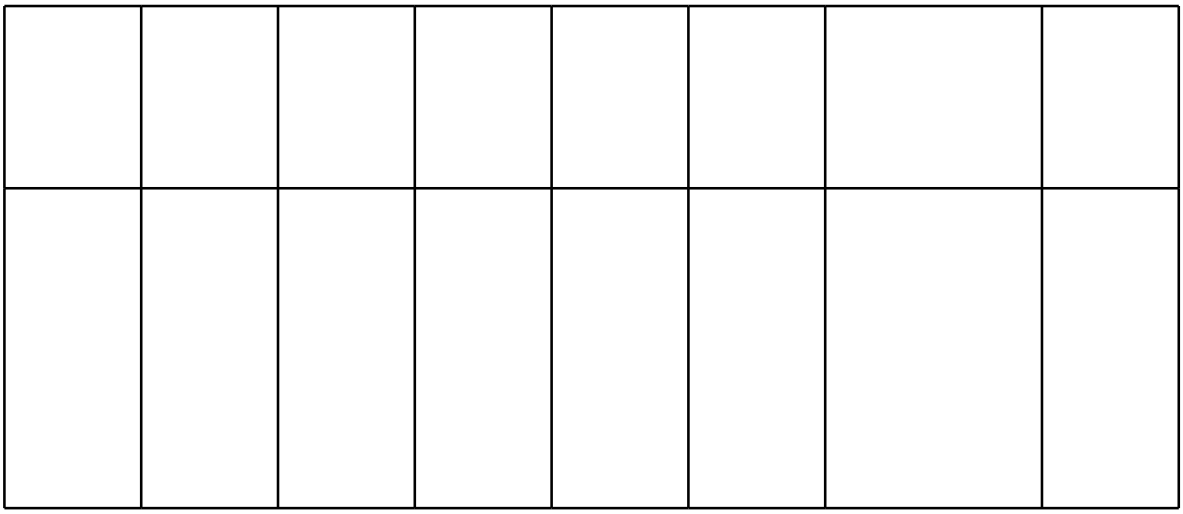


Comments	
- 2019 - being flagged as part of All Wales Grievance policy review	
~~2 doc's on intranet one hidden -Not fit for pirpose in its current format and should be rescinded.All Wales approach needed. Discussions taking place with shared~~	
This document will be removed once a new policy/code is in place. EP220817 SEE UHB 388	

2.07.15 - Emailed Carol Evans to ask if update re who would be reviewing as Maggie Lucas had been approached by Nick Drage re status of	

This policy is now under C Dalton with Peter Welsh as the Exec serving under the H&S Committee-Car Ball currently reviewing 09/11/17	
Query need to cross ref with ref 362	
Appx 10 in ref 133 IT Security Policy	

~~appx 8 ref 133- superceeded by UHB 422~~	
Duplicate number issued ref 305 - need to cross reference with NWSSP policy	
Expected at QSE Dec 2017	
Replaced ref 284 See also ref 196. Still need to know status for UHB.	
SEE UHB 388	

Title	Contact Name	Comments	Completed Action & date
Overseas Patients Policy	Paul Emmerson, Finance/Kathryn Thomas	New document. Trust Document developed but not centrally approved (need to cross ref with Lorna's info). Advice provided in e-mail 150714. Was working to 18 Nov PPD which was not achieved. 10.12.14 advised by PE that there is a query over whether this is finance or operational. CL asked to advise re relative priority. Added to planner for PPD so will not get lost (MW)	
Healthy Retail Policy	Rhianon Urquhart, Public Health	New document. Rebecca Cushen approached Peter saying Board had approved policy and looking for advice re format. Julia informed re QSE agenda for June. E-mail sent advising of need to consult. Board has also not formally accepted policy. 06/02/15 MJW SH Responded advising that policy would be to formally adopt standards set by Board. ?? need for EQIA and HIA. I advised EQIA def and HIA for her team to advise. 20/03/015 - Met with Rhianon Urquhart and discussed timeline. To go to LPF in April and QSE in June. Template for Committee report provided with dates. RU advised that it had been agreed that a HIA was not required by an EQIA was and meeting with Keithley same day re this. See S Drive via hyperlink.	To QSE for approval on 1st Sept
Pregnancy Testing of women of child bearing age before procedures	Cath Heath (although not author - see emails)	Enquiry made by Sian Rowlands re existence of document. No record of anything being developed centrally or who author is. Provided advice and link to Intranet pages re guidance to Cath Heath.	
Lync Acceptable Use Policy (NWIS)	Bryn Harries	Advic provided re formal adoption of this document via IM&TSC and PPP	
All Wales Lost Hearing Aids Policy	Wendy Rabiaotti/Jackie Harding	Policy in use a couple of years but not formally adopted by UHB. Advised for this to go to QSE in December as Oct meeting is not a business meeting.	E-mail sent - 12.08.15 - see folder.
Clinical Guidelines for Assessing and Managing Suicide Risk in Cancer Patients	Janice Rees	Document developed by another organisation but for adoption across a number of HBs in South Wales. Advice given via e-mail re steps to be taken. ? Re approving group. See Documents in Progress Folder - MJW 06.11.15	

Children and Young Person's Continuing Healthcare	Laura Hutchinson	Policy/Procedures required to implement All Wales Guidance. In very early stages. advice issued via e-mail and saved in folder - MJW 260216	
Management of Patients with suspected or confirmed MERS-CoV in the Emergency Medicine Directorate Guideline	Sian Catherine.Jones	e-mail sent 290216 with comments - MJW	
Blended diets for children	Ceri Dolan/Paula Davies	Previously discussed at ethics committee (when I wasn't present). Quite a contentious issue but have decided a document is needed to guide staff. See e-mail sent and response 100216 - MJW	

Keep on list for 6 months following uploading onto Intranet. CP FONT COLOUR = PURPLE MW FONT COLOUR = GREEN			

Completed Yes/ No	Folder
	S:\Governance Directorate\Policy Information & Master copies\UHB Documents April 2010\Documents in progress\Overseas Patients
	S:\Governance Directorate\Policy Information & Master copies\UHB Documents April 2010\Documents in progress\Health Retail Policy
	S:\Governance Directorate\Policy Information & Master copies\UHB Documents April 2010\Documents in progress\Pregnancy Testing
	S:\Governance Directorate\Policy Information & Master copies\UHB Documents April 2010\Documents in progress\Lync Acceptable Use Policy
	S:\Governance Directorate\Policy Information & Master copies\UHB Documents April 2010\Documents in progress\Hearing Aids (All Wales)

	S:\Governance Directorate\Policy Information & Master copies\UHB Documents April 2010\Documents in progress\Children and YP's CHC Feb 2016
	S:\Governance Directorate\Policy Information & Master copies\UHB Documents April 2010\Documents in progress\MERS Guideline
	S:\Governance Directorate\Policy Information & Master copies\UHB Documents April 2010\Documents in progress\Blended Diets

Name of Document Uploaded	Date Uploaded	Consultation Period (To)
Information Governance Policy and EQIA	11/24/2014	12/22/2014
Delivering Interpreter Services Policy and EQIA	4/16/2014	5/9/2014
Fixed Term Contract and Policy and EQIA	4/16/2014	4/30/2014
Working Time Policy and EQIA	4/17/2014	5/6/2014
Conducting PADRs Policy and EQIA	4/23/2014	4/30/2014
Alcohol, Drug and Substance Misuse Policy and EQIA	5/1/2014	5/12/2014
Nursing and Midwifery Rostering Policy	5/1/2014	5/12/2014
Flexible Working Policy	5/2/2014	5/12/2014
Flexible Working Policy EQIA	7/8/2014	7/11/2014
Management of Stress and Wellbeing in the Workplace Policy	5/8/2014	5/22/2014
Rostering Policy EQIA	5/14/2014	5/28/2014
Bedrails Procedure and EQIA	5/15/2014	5/29/2014
Discharge against Clinical Advice (DACA) Procedure and EQIA	5/15/2014	5/29/2014
Asbestos	6/6/2014	6/24/2014
Health & Safety	6/6/2014	6/24/2014
First Aid	6/6/2014	6/24/2014
VVIP/VIP Guidelines	7/15/2014	7/28/2014
Equality Diversity & HR	7/7/2014	7/28/2014
Risk Assessment & Risk Register Procedure	8/5/2014	9/4/2014
Section 5 of the falls procedure	8/11/2014	9/12/2014
Intervention not Normally Undertaken	8/18/2014	8/29/2014
Countermeasures Framework	8/29/2014	9/26/2014
Civil Strategic Framework	10/3/2014	10/24/2014
Severe Weather Strategey	10/6/2014	10/27/2014
Viral Gastro Procedure	10/9/2014	11/5/2014
Study Leave Guidelines	10/17/2014	11/13/2014
Infection control for MRSA	11/3/2014	11/24/2014
Infection control for MRSA -EQIA	11/3/2014	11/24/2014
Information Security Policy	11/24/2014	12/22/2014
Information Governanace transport PII draft	11/24/2014	12/22/2014
Domestic Abuse Procedure	12/16/2014	1/14/2015
Domestic Abuse Policy	12/16/2014	1/14/2015
Domestic Abuse EQIA	12/16/2014	1/14/2015
Maternity, Paternity, Adoption shared Parental leave	12/19/2014	1/16/2015
Maternity Leave	12/19/2014	1/16/2015
Paternity and Pay Procedure	12/19/2014	1/16/2015
Adoption leave and Pay	12/19/2014	1/16/2015
Maternity, Paternity, Adoption shared Parental leave EQIA	12/19/2014	1/16/2015
Maternity Leave and Pay procedure	12/19/2014	1/16/2015

Risk assessment for New Expectant mothers	12/19/2014	1/16/2015
Shared Parental Leave Procedure	12/29/2014	1/16/2015
Retirement Policy	1/27/2015	2/24/2015
Retirement Policy EQIA	1/27/2015	2/24/2015
Freedom of Information Flowchart	2/10/2015	3/10/2015
Freedom of Information EQIA	2/10/2015	3/10/2015
Freedom of Information Procedure	2/10/2015	3/10/2015
Freedom of Information Policy	2/10/2015	3/10/2015
Retirement Procedure	3/10/2015	4/6/2015
http://nww.cardiffandvale.wales.nhs.uk/pls/portal/url/ITEM/1423C4B38134CFDAE0500489923C41E0	3/11/2015	4/8/2015
New Procedures Policy	3/11/2015	4/8/2015
New Procedures EQIA	3/16/2015	4/8/2015
IPC Viral Hepatitis Procedure	3/23/2015	4/24/2015
Ectoparasitic Procedure	3/23/2015	4/24/2015
Varicella IPC Procedure	4/1/2015	5/1/2015
Contractual clauses and Arrangements Procedure	4/20/2015	5/11/2015
Contractual clauses in Employment Contracts	4/20/2015	5/11/2015
Research Misconduct Procedure	5/14/2015	6/13/2015
Information Governance Training Policy	5/19/2015	6/18/2015
Information Asset Management	5/19/2015	6/18/2015
Guidance on Transferring Deceased Babies or Child & EQIA	5/21/2015	6/12/2015
Confidentiality Code of Conduct for Staff	5/27/2015	6/24/2015
Personal Information Duty to Share & Disclose	5/27/2015	6/24/2015
Dealing with SAR under DPA consultation document	5/27/2015	6/24/2015
Human Tissue in Clinical Research Management Policy	6/11/2015	7/9/2015
Fire Policy	6/11/2015	7/9/2015
Supporting Transgender Staff Procedure	6/16/2015	7/14/2015
Supporting Transgender Staff Procedure EQIA	6/16/2015	7/14/2015
Research Study Files & Filing Standard Operating Procedure	6/18/2015	7/16/2015
Policy Oral Anti Cancer Therapy	7/7/2015	8/4/2015
CCTV Policy and Procedure	7/13/2015	7/24/2015
EQIA Cleaning Strategy	7/15/2015	8/12/2015
Cleaning Strategy	7/15/2015	8/12/2015
Staff Flu Policy	7/16/2015	13/08/215
Sharps Policy	7/17/2015	8/1/2015
Naming Buildings Policy	7/24/2015	8/21/2015
Data Quality Policy	7/28/2015	8/25/2015
Information Risk Management Procedure	8/19/2015	9/16/2015

Redeployment EQIA	8/20/2015	9/18/2015
Redeployment Procedure	8/20/2015	9/18/2015
Redeployment Policy	8/20/2015	9/18/2015
Restraint Policy	9/3/2015	9/30/2015
EQIA Restraint Policy	9/3/2015	9/30/2015
Procedure Welsh Patients Treatment in Countries in EEA	10/8/2015	10/22/2015
Treatment in Countries in EEA EQIA	10/8/2015	10/22/2015
Patient Leaflet - Treatment in Countries in EEA	10/8/2015	10/22/2015
Web Information - Treatment in Countries in EEA	10/8/2015	10/22/2015
Management of Throat Packs	10/15/2015	11/11/2015
EQIA Management of Throat Packs	10/15/2015	11/11/2015
Swab Instrument & Sharps Count Policy	10/15/2015	11/11/2015
Swab Instrument & Sharps Count EQIA	10/15/2015	11/11/2015
Replacement of Balloon Retained Gastrostomy Procedure	10/26/2015	11/23/2015
Draft Records Management Policy	11/5/2015	12/2/2015
Data Quality Policy	11/5/2015	12/2/2015
Academic Malpractice Eqia	11/10/2015	12/6/2015
Academic Malpractice Policy	11/10/2015	12/6/2015
Data Protection Guidance for Reasearchers	11/17/2015	12/16/2015
Information Technology Security Procedure	12/8/2015	1/19/2016
Consent for Examination and Treatment Policy	12/9/2015	1/9/2016
Consent for Examination and Treatment EqIA	12/9/2015	1/9/2016
Decontamination of Medical Devices Policy	12/9/2015	1/9/2016
Decontamination of Medical Devices Procedure	12/9/2015	1/9/2016
Decontamination of Medical Devices EqIA	12/9/2015	1/9/2016
Procedure for Prevention,Control and Management of Multidrug Resistant Organisms including Carbapenemase producing organisms	1/6/2016	2/12/2016
Infection Conrol Procedure for Infectious and outbreaks in UHB Hospitals	1/6/2016	2/12/2016

Thromboembolism in Adults and Teenage Inpatients	2/17/2016	3/15/2016
Thromboembolism in Adults and Teenage Inpatients	2/17/2016	3/15/2016
Partnership and Recognition Agreement	2/17/2016	3/18/2016
Partnership and Recognition Agreement EqIA	2/17/2016	3/18/2016
Managing Ammendments for Sponsored Research	4/5/2016	5/3/2016
Chaperone Policy	4/29/2016	5/16/2016
Chaperone Policy Eqia	4/29/2016	5/16/2016
Research Governance Policy	5/3/2016	6/3/2016
Research Governance EqIA	5/3/2016	6/3/2016
Ultrasound Risk Man Policy	5/9/2016	6/7/2016
Ultrasound Risk Man Procedure	5/9/2016	6/7/2016
Ultrasound Risk Man EqIA	5/9/2016	6/7/2016
Laser Risk Management Policy	12./05/2016	6/10/2016
Laser Risk Management Procedure	5/12/2016	6/10/2016
Laser Risk Management EqIA	5/12/2016	6/10/2016
Professional Abuse Policy	5/18/2016	6/20/2016
Professional Abuse Procedure	5/18/2016	6/20/2016
ProfessionaL Abuse Policy EqIA	5/18/2016	6/20/2016
Radioactive Waste Management Policy	5/19/2016	6/17/2016
Radioactive Waste Management Procedure	5/19/2016	6/17/2016
Radioactive Waste Management EqIA	5/19/2016	6/17/2016
Training Requirements fo Reasearch Staff inc Good Clinic Practice	4/24/2016	6/23/2016
Patient Access (Elective Care) Policy	6/8/2016	7/6/2016
Research and Development Gaining NHS Research Permission	6/8/2016	7/8/2016
Non Medical Referrer Referral for Diagnostic Imaging Investigation Policy	6/9/2016	7/6/2016
Non Medical Referrer Referral for Diagnostic Imaging Investigation Procedure	6/9/2016	7/6/2016
Non Medical Referrer Referral for Diagnostic Imaging Investigation EqIA	6/9/2016	7/6/2016
Control of Contractors Policy	6/9/2016	7/1/2016
Control of Contractors Policy EqIA	6/9/2016	7/1/2016
Optimising Outcomes Policy	6/10/2016	6/24/2016
Optimising Outcomes Procedure	6/10/2016	6/24/2016
Optimsing Outcomes EqIA	6/10/2016	6/24/2016
Investigational Medicinal Products SOP	14.06.2016	28.06.2016
Investigational Medicinal Products SOP EqIA	14.06.2016	28.06.2016
Patient Access (Elective Care) Policy EqIA	22.06.2016	06.07.2016

Patient Property Policy	28.06.2016	13.06.2016
Patient Property Policy EqIA	28.06.2016	13.06.2016
Falls Policy and Procedure	08.07.2016	02.08.2016
Falls Policy and Procedure EqIA	08.07.2016	02.08.2016
CJD	7/20/2016	8/19/2016
Multidrug Organisms Resistants	7/20/2016	8/19/2016
Intellectual Property Rights Policy	7/22/2016	8/15/2016
Paeds Care Plan EqIA	8/5/2016	8/25/2016
Paeds Care Plan	8/5/2016	8/25/2016
IPFR	8/9/2016	9/8/2016
IPFR EqIA	8/9/2016	9/8/2016
Care of Deceased	8/9/2016	9/1/2016
Care of Deceased EqIA	8/9/2016	9/1/2016
Rostering Policy for Nursing and Midwifery	8/17/2016	9/12/2016
Rostering Policy EqIA for Nursing and Midwifery	8/17/2016	9/12/2016
Rostering Procedure for Nursing and Midwifery	8/17/2016	9/12/2016
Ionising Radiation Risk Management Policy	9/1/2016	9/30/2016
Ionising Radiation Risk Management Procedure	9/1/2016	9/30/2016
Ionising Radiation Risk Management Policy EqIA	9/1/2016	9/30/2016
Witness Preparation Guidance	9/13/2016	10/12/2016
Incident,Hazard and Near Miss Reporting Policy	9/20/2016	9/30/2016
Health and Safety policy	9/22/2016	10/8/2016
Academic Malpractice for Fair Assessment Procedure	9/27/2016	10/24/2016
Academic Malpractice for Fair Assessment Procedure EqIA	9/27/2016	10/24/2016
Health and Safety policy EqIA	9/27/2016	10/8/2016
Parental Leave Guidance	10/3/2016	10/31/2016
Information Governance Policy	11/1/2016	11/28/2016
Information Governance Procedure	11/1/2016	11/28/2016
Information Governance Policy EqIA	11/1/2016	11/28/2016
Policy for Safe Working on Electricity	12/2/2016	12/23/2016
Policy for Safe Working on Electricity EqIA	12/2/2016	12/23/2016
Hand Decontamination Procedure	2/16/2017	3/15/2017
Hand Decontamination Procedure EqIA	2/16/2017	3/15/2017
Lone Worker Policy	3/7/2017	4/7/2017
Lone Worker Procedure	3/7/2017	4/7/2017
V and A Policy	3/7/2017	4/7/2017
V and A Procedure	3/7/2017	4/7/2017
V and A EHIA	3/7/2017	4/7/2017
Water Safety policy	3/9/2017	4/8/2017
Donation of Organs Policy	3/9/2017	4/3/2017
Donation of Organs Procedure	3/9/2017	4/3/2017
Donation of Organs Policy EHIA	3/9/2017	4/3/2017
Minimal Manual Handling Policy EHIA	3/14/2017	4/7/2017
Minimal Handling Procedure	3/14/2017	4/7/2017

Waste Management Policy	3/16/2017	4/7/2017
Waste Management Procedure	3/16/2017	4/7/2017
Waste Management Policy EHIA	3/16/2017	4/7/2017
Vioent Warning Marker Procedure	3/30/2017	4/29/2017
Disclosure Barring Service Policy	3/30/2017	4/30/2017
Disclosure Barring Service Policy EHIA	3/30/2017	4/30/2017
Disclosure Barring Service Procedure	3/30/2017	4/30/2017
Foetal Remains Policy	4/18/2017	5/17/2017
Foetal Remains Procedure/EHIA	4/18/2017	5/17/2017
Sponsorship Assessment Process	4/27/2017	5/25/2017
Lost Hearing Aid Policy	5/3/2017	5/31/2017
Lost Hearing Aid Policy EHIA	5/3/2017	5/31/2017
Lost Hearing Aid Procedure	5/3/2017	5/31/2017
Skyguard Lone Working Procedure	5/9/2017	5/25/2017
Venepuncture Policy	5/18/2017	6/16/2017
Venepuncture Policy EHIA	5/18/2017	6/16/2017
Sharps Policy and EHIA	6/6/2017	6/30/2017
Sharps Procedure	6/6/2017	6/30/2017
Lasting Power of Atotorney	6/15/2017	7/14/2017
Independent Mental Capacity	6/15/2017	7/14/2017
Preceptorship for Newly Registered Nurses and Midwives Policy	7/11/2017	8/9/2017
Preceptorship for Newly Registered Nurses and Midwives Procedure	7/11/2017	8/9/2017
Research Funding involving Cardiff and Vale UHB	7/21/2017	8/19/2017
Research, Consent and Mental Capacity SOP	7/25/2017	8/22/2017
Point of Care Testing Policy	8/3/2017	8/30/2017
Point of Care Testing Procedure	8/3/2017	8/30/2017
Point of Care Testing Policy EHIA	8/3/2017	8/30/2017
Discharge Policy	8/18/2017	8/16/2017
Discharge Procedure	8/18/2017	8/16/2017
Discharge SOP	8/18/2017	8/16/2017
Safety Notices and Important Docuements Management Policy	8/22/2017	9/16/2017
Safety Notices and Important Documents Management Procedure	8/22/2017	9/16/2017
Policy on Policies	8/24/2017	9/22/2017
Written Control Procedure	8/30/2017	9/28/2017
CJD Procedure	9/20/2017	10/18/2017
Clostrium Difficile	9/20/2017	10/18/2017
Business Continuity Policy	10/4/2017	11/1/2017
Recruitment and Selection Policy	10/5/2017	11/3/2017
Recruitment and Selection Procedure	10/5/2017	11/3/2017
Recruitment and Selection Policy EHIA	10/5/2017	11/3/2017
Tracheostomy Guidelines	11/18/2017	11/16/2017
Tracheostomy Guidelines EHIA	11/18/2017	11/16/2017
Completing Data	11/19/2017	11/17/2017
Participant Idenification	11/19/2017	11/17/2017
Research Audit-SOP	10/24/2017	11/20/2017
Good Clinical Practice SOP	10/24/2017	11/20/2017

Community Treatment Order Policy	11/6/2017	12/4/2017
EHIA Community Treatment Order Policy	11/6/2017	12/4/2017
EHIA Scheme of Delegation	11/6/2017	12/4/2017
EHIA Section 5(2) Doctors Holding Power	11/6/2017	12/4/2017
EHIA Section 5(4) Nurses Holding Power	11/6/2017	12/4/2017
Final Hospital Managers Scheme of Delegation	11/6/2017	12/4/2017
Section 5(2) Doctors Holding Power	11/6/2017	12/4/2017
Section 5(4) Nurses Holding Power	11/6/2017	12/4/2017
Counter Fraud and Corruption Policy	11/22/2017	12/20/2017
Counter Fraud and Corruption Procedure	11/22/2017	12/20/2017
Counter Fraud and Corruption Policy EHIA	11/22/2017	12/20/2017
Carers Prcedure	12/1/2017	12/28/2017
Viral Gastroenteritis Procedure	12/1/2017	12/15/2017
Pressure Ulcer Policy/Procedure/EHIA	1/12/2018	1/26/2018
Missing Patient	2/2/2018	3/1/2018
PADR Policy	2/13/2018	3/14/2018
PADR Procedure	2/13/2018	3/14/2018
PADR EHIA	2/13/2018	3/14/2018
Safety Reporting in CTIMP'S	2/19/2018	3/16/2018
Oversight in Research and Monitoring SOP	2/19/2018	3/16/2018
Archiving of Research and Clinical Trial Data	2/19/2018	3/16/2018
Human Isuue Policy	3/13/2018	4/9/2018
Human Isuue Policy EHIA	3/13/2018	4/9/2018
Human Tissue Procedure	2/13/2018	4/9/2018
Reporting Requirement SOP	4/26/2018	5/22/2018
Research,Consent, MH SOP	4/26/2018	5/22/2018
Cell Salvage Policy	5/1/2018	5/29/2018
Cell Salvage Procedure	5/1/2018	5/29/2018
Safety Reporting in CTIMP's	5/9/2018	6/4/2018
Fire Safety Policy	5/29/2018	6/25/2018
Fire Safety Procedure	5/29/2018	6/25/2018
Asbestos Managment Policy	5/29/2018	6/25/2018
Financial Procedure for Non Commercial	5/29/2018	6/25/2018
INNU Policy & EHIA	6/7/2018	6/29/2018
INNU EHIA	6/7/2018	6/29/2018
INNU list by Cardiff & Vale	6/7/2018	6/29/2018
Family Friendly Policies	6/12/2018	7/10/2018
Working Times Procedure EHIA	6/20/2018	7/10/2018
Parental Nutrition in Paediatrics	6/20/2018	7/18/2018
MRSA	7/12/2018	8/13/2018
Incident Reporting Policy & EHIA	8/7/2018	9/4/2018
Incident ReportinG Procedure	8/7/2018	9/4/2018
Labelling of Specimens Policy	8/24/2018	9/21/2018
Labelling of Specimens Procedure	8/24/2018	9/21/2018
Fetal Remains	8/28/2018	9/24/2018
Data Management for Clinical Trials	8/30/2018	9/26/2018

Alcohol and Substance Misuse Procedure	9/12/2018		10/12/2018
Admission to Hospital under Part II of the MHA 1983 Policy	10/2/2018		10/30/2018
Admission to Hospital under Part II of the MHA 1983 Procedure	10/2/2018		10/30/2018
Patient's Rights Information to Detained/Community Patients under the MHA 1983 Policy	10/2/2018		10/30/2018
Patient's Rights Information to Detained/Community Patients under the MHA 1983 Procedure	10/2/2018		10/30/2018
Review of Detention and Community Treatment Order MHA 1983 Policy	10/2/2018		10/30/2018
Review of Detention and Community Treatment Order MHA 1983 Procedure	10/2/2018		10/30/2018
Parental Nutition Procedure	10/19/2018		11/16/2018
Parental Nutrition Procedure EHIA	10/19/2018		11/16/2018
Maternity Procedure	10/30/2018		11/27/2018
Paternity Procedure	10/30/2018		11/27/2018
Adoption Proicedure	10/30/2018		11/27/2018
Maternity, Adoption, Paternity Shared Policy	10/30/2018		11/27/2018
Maternity Risk assessment	10/30/2018		11/27/2018
Being Open Policy & EHIA	11/21/2018		12/19/2018
Being Open Procedure	11/21/2018		12/19/2018
Fetal Remains	12/5/2018		1/2/2019
Management of Stress and Mental Health Wellbeing in the workplace	12/6/2018		1/2/2019
Fixed Term Contract Procedure	12/6/2018		1/2/2019
Environmental Policy	12/13/2018		1/9/2019
Environmental Policy EHIA	12/13/2018		1/9/2019
CCTV Policy	12/13/2018		1/9/2019
CCTV Procedure	12/13/2018		1/9/2019
Study Leave Procedure	12/13/2018		1/9/2018
Mandatory Training	12/13/2018		1/9/2018
Radioactive Substance Risk Management Policy	1/8/2019		2/5/2019
Radioactive Substance Risk Management Procedure	1/8/2019		2/5/2019
Ionising Radiation Risk Management Policy	1/8/2019		2/5/2019
Ionising Radiation Risk Management Procedure	1/8/2019		05/02/20019
Exposure of staff and members of the public to Ionising Radiation Procedure	1/8/2019		2/5/2019
Venepuncture for Non Clinicall Policy	1/16/2019		2/13/2019
Venepuncture for Non Clinicall EHIA	1/16/2019		2/13/2019
Venepuncture for Non Clinical Procedure	1/16/2019		2/13/2019
Written Information for patients guidance	1/24/2019		2/21/2019
Retirement Procedure	1/29/2019	26/02/219	
Working Times Procedure	2/7/2019		3/4/2019
Parenteral Pump Infusion Policy	2/26/2019		3/26/2019

Parenteral Pump Infusion Policy	2/26/2019	3/26/2019
Obtaining Capacity and Capability Confirmation for Research to start	3/11/2019	4/8/2019
Ectoparasitic Procedure	3/11/2019	4/8/2019
Agile Workforce Policy	3/14/2019	4/15/2019
Agile Workforce EHIA	3/14/2019	4/15/2019
Employee Health and Wellbeing Policy & EHIA		
Occasional Homeworking Mobile guideline	3/14/2019	4/15/2019
Applying for Cardiff & Vale UHB Sponsorship Standard Operating Procedure	4/2/2019	4/30/2019
LED Policy	4/29/2019	5/9/2019
LED Policy EHIA	4/29/2019	5/9/2019
Research and Development Human Resources arrangements for Researchers Working in the NHS Guidelines	5/10/2019	6/7/2019
Organisational Welsh Language Policy	5/13/2019	6/10/2019
Domestic Abuse Procedure & EHIA	5/21/2019	6/14/2019
research governance procedure	5/31/2019	6/28/2019
Research Governance Policy	5/31/2019	6/28/2019
Patients Property Policy	6/3/2019	30/06/019
AMENDMENTS FOR UHB SPONSORED AND CO-SPONSORED RESEARCH	6/3/2019	6/30/2019
Information about Research Training Requirements	6/4/2019	6/30/2019
Breastfeeding and return to work	6/11/2019	7/8/2019
Supporting Trans Staff	6/11/2019	7/8/2019
Varicellar Zoster Procedure	7/1/2019	7/20/2019
Needlestick Procedure	7/2/2019	7/20/2019
Standards of Behaviour Policy	7/4/2019	7/31/2019
Managing Amendments Research SOP	7/18/2019	8/15/2019
Human Tissue in clinical research management procedure	7/18/2019	8/15/2019
Health and Safety Risk Assessment	8/2/2019	8/9/2019
Control of Contractors Policy	8/9/2019	9/9/2019
Thermal Comfort Procedure	8/15/2019	8/28/2019
Hand Arm Vibration Procedure	8/15/2019	8/28/2019
Child Abduction Policy	8/21/2019	9/18/2019
Display Screen Equipment Procedure	8/15/2019	8/28/2019
Loyalty Award Procedure	8/19/2019	9/18/2019
Consent to Examination or Treatment Policy	8/29/2019	9/26/2019
Consent to Examination or Treatment EHIA	8/28/2019	9/26/2019
Health and Safety Policy	8/24/2019	9/21/2019
PADR Procedure	10/3/2019	10/31/2019
Strandards of Behaviour Policy	10/18/2019	11/15/2019
Receipt of application for detention under the MHA	10/18/2019	11/25/2019
Laser Risk Policy	11/1/2019	11/29/2019

Laser Risk Procedure	11/1/2019	11/29/2019

Comments To	Final Document Approved and Uploaded
Marie Mantle	1/30/2015
Lorna Williams	6/23/2014
Rachel Pressley	9/15/2014
Rachel Pressley	9/15/2014
Rebecca Corbin	10/9/2014
Rachel Pressley	9/15/2014
Kath Elias	1/7/2015
Rachel Pressley	9/15/2014
Rachel Pressley	9/15/2014
Clare Wright	
Kath Elias	10/15/2014
Denise Shanahan	8/18/2014
Denise Shanahan	10/31/2014
Zoe Brooks	.
Zoe Brooks	11/10/2014
Zoe Brooks	
Angela Stephenson	9/8/2014
Keithley Wilkinson	10/15/2014
Melanie Westlake	12/2/2014
Denise Shannahan	1/23/2015
Fiona Kinghorn	11/28/2014
Angela Stephenson	
Angela Stephenson	
Angela Stephenson	4/10/2015
Reanne Refell	1/22/2015
Rebecca Corbin	4/22/2015
Reanne Refell	12/9/2014
Reanne Refell	12/9/2014
Marie Mantle	
Marie Mantle	6/29/2015
Rachel Pressley	4/7/2015
Rachel Pressley	4/7/2015
Rachel Pressley	4/7/2015
Rachel Pressley	4/8/2015
Rachel Pressley	4/9/2015
Rachel Pressley	4/9/2015
Rachel Pressley	4/9/2015
Rachel Pressley	4/8/2015
Rachel Pressley	4/9/2015

Rachel Pressley	8/20/2015	
Rachel Pressley	4/15/2015	
Rachel Pressley	4/15/2015	
Rachel Pressley	4/15/2015	
Ann Morgan	4/13/2015	
Ann Morgan	4/13/2015	
Ann Morgan	4/13/2015	
Ann Morgan	4/13/2015	
Andrew Crook	4/15/2015	
Joy Whitlock		
Joy Whitlock		
Joy Whitlock		
Reanne Refell	7/23/2015	
Reanne Refell		
Reanne Refell	8/24/2015	
Marie Mantle		
Marie Mantle		
Pat Tamplin	9/30/2015	
Marie Mantle		
Marie Mantle		
Jane Rowlands-Mellor	7/9/2015	
Ann Morgan		
Ann Morgan		
Ann Morgan		
Pat Tamplin	9/22/2015	
Zoe Brooks	8/6/2015	
Keithley Wilkinson		
Keithley Wilkinson		
Joanne Milner		
Louise Govier	Should be submitted to QSE in Dec 15	
Carl Ball		
Neil Paul	10/2/2015	
Neil Paul	10/2/2015	
Tom Porter	9/23/2015	
Charles Dalton	9/18/2015	
Peter welsh	9/18/2015	
Marie Mantle		
Marie Mantle		

Rachel Pressley	
Rachel Pressley	
Rachel Pressley	
	Consultation finished. Document being reformatted. To submit to MHCLC in Feb 16
Denise Shanahan	
Denise Shanahan	As above
Melanie Wilkey	
Melanie Wilkey	
Melanie Wilkey	
Melanie Wilkey	
	Should be submitted to QSE in Dec 15
Bab Jones	
Bab Jones	
	Should be submitted to QSE in Dec 15
Bab Jones	
Bab Jones	
Fiona Jenkins	
Marie Mantle	
Paul Rothwell	
Rebecca Corbin	
Rebecca Corbin	
Marie Mantle	
Gareth Bulpin	
	Should be submitted to QSE in Feb 16
Julia Barrell	
	Should be submitted to QSE in Feb 2016
Julia Barrell	
Clive Morgan	
Clive Morgan	
Clive Morgan	
Reanne Reffell	
Reanne Reffell	

Marilyn Rees

Marilyn Rees

Andrew Crook

Andrew Crook

Jemma Cross
Bev Evans
Bev Evans
Pat Tamplin
Pat Tamplin
Kate Bryant
Kate Bryant
Kate Bryant
Kate Bryant
Kate Bryant
Kate Bryant
Rachel Pressley
Rachel Pressley
Rachel Pressley

Will Evans

Will Evans
Will Evans

Jemma Cross

Paul Rothwell

Jemma Cross

Lesley Harris

Lesley Harris

Lesley Harris
Caroline Murch
Caroline Murch
Sian Griffiths
Sian Griffiths
Sian Griffiths

Angela Hallam

Angela Hallam

Paul Rothwell

Bev Evans	
Bev Evans	
Denise Shanahan	
Denise Shanahan	
Reanne Refell	
Reanne Refell	
Maureen Fallon/Rebecca David	
Richard Hain	11/1/2016
Richard Hain	11/1/2016
Elinor Hammond	10/19/2016
Elinor Hammond	10/19/2016
Tracey Skyrme	9/23/2016
Tracey Skyrme	9/23/2016
Lynda Jenkins	
Lynda Jenjkins	11/3/2016
Lynda Jenkins	11/3/2016
Wil Evans	12/13/2016
Wil Evans	12/13/2016
Wil Evans	12/13/2016
Catherine Evans	
Zoe Brooks	
Zoe Brooks	
Rachel Rushforth	11/9/2016
Rachel Rushforth	11/9/2016
Zoe Brooks	12/7/2016
Rachel Pressley	11/9/2016
Marie Mantle	
Marie Mantle	
Marie Mantle	
Jon McGarrigle	
Jon Mcgarrigle	
Reanne Reffell	
Reanne Reffell	
Emma Foley	
Emma Foley	
Emma Foley	
Emma Foley	
Emma Foley	
Jon McGarrigle	
Katja Empson	
Katja Empson	
Katja Empson	
Sarah Mortimer	
Sarah Mortimer	

Andrew Phillips
Andrew Phillips
Andrew Phillips
Carl Ball
R Pressley

R Pressley
R Pressley
S Gable
S Gable
G Cross
J Harding
J Harding
J Harding
E Foley
Jemma Cross
Jemma Cross
Rachael Daniel
Rachael Daniel
Julia Barrell
Julia Barrell

Patricia Brown

Patricia Brown

Jemma Cross

Jemma Cross
Annette Thomas
Annette Thomas
Annette Thomas
Tanya Balch
Tanya Balch
Tanya Balch

Julia Harper

Julia Harper
Julia Harper
Julia Harper
Reanne Refell
Reanne Refell
Huw Williams
Rachel Pressley
Rachel Pressley

Rachel Pressley
Paul Twose
Paul Twose
Jemma Cross
Jemma Cross
Jemma Cross
Jemma Cross

Sunni Webb

Sunni Webb
Sunni Webb

Sunni Webb

Sunni Webb

Sunni Webb
Sunni Webb
Sunni Webb
Craig Greenstock

Craig Greenstock

Craig Greenstock
Bev Evans
Reanne Refell
Kirsty Mahoney
Julia Barrell
Rebecca Corbin
Rebecca Corbin
Rebecca Corbin
Jemma Cross

Jemma Cross

Jemma Cross
Jemma Cross
Jemma Cross
Jemma Cross
Jemma Cross
Jemma Cross
Barbara Jones
Barbara Jones
Jemma Cross
Frank Barrett
Frank Barrett
Owen Davies

Jemma Cross
Anne Hinchliffe
Anne Hinchliffe
Anne Hinchliffe
Rachel Pressley
Rachel Pressley
Emma Trow
Yvonne Hyde
Maria Roberts
Maria Roberts
Lisa Griffiths
Lisa Griffiths
Judith Cutter
Jemma Cross

Robert Parr

Sunni Webb

Sunni Webb

Sunni Webb

Sunni Webb

Sunni Webb

Sunni Webb
Amelia Jukes
Amelia Jukes
Rachel Pressley
Rachel Pressley
Rachel Pressley

Rachel Pressley
Rachel Pressley
Maria Roberts
Maria Roberts
Judith Cutter

Nicola Bevan
Judith Harrhy
Jon McGarrigle
Jon McGarrigle
Damian Winstone
Damian Winstone
Rebecca Corbin
Rebecca Corbin

Dr John Rees

Dr John Rees

Dr John Rees

Dr John Rees

Dr John Rees
Zoe Boult
Zoe Boult

Zoe Boult

Suzanne Becquer Moreno
Andrew Crook
Rachel Pressley
Anthony Powell

Anthony Powell

Rachel Norman
Derek King
Rachel Pressley
Rachel Pressley

Rachel Pressley

Rachel Pressley

Maureen Edgar
Rebecca Corbin
Rebecca Corbin

Rachel Norman
Alun Williams
Lizzie Lewis
Pat tamplin
Pat tamplin
Bev Evans

Rachel Norman

Zoe Boult
Keithley Wilkinson
Keithley Wilkinson
Robyn Leatheam
Robyn Leatheam
Mandy Collins

Rachel Norman

Pat Tamplin
Rachel Sykes/ Ceri Pell
Philip Mackie
Ceri Pell
Ceri Pell
Alice Fairman
Ceri Pell
Rachel Pressley

Zoe Brookws
Rebecca Corbin
Laura Tolley

Sunni Webb
Kate Bryant

Kate Bryant

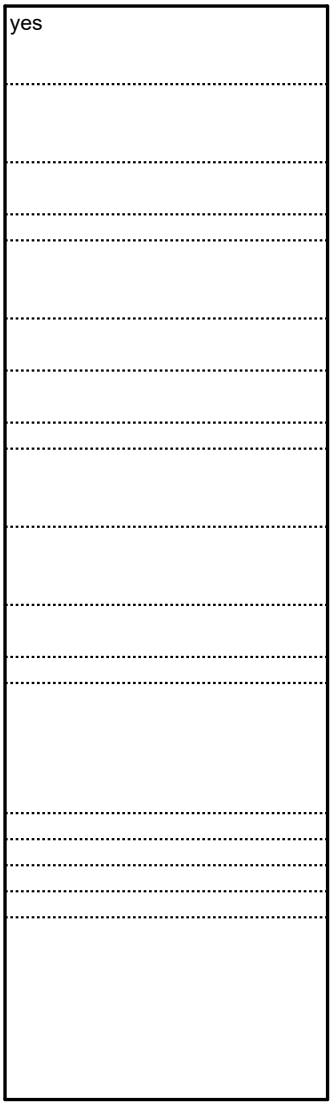
Title	Contact Name	Comments	Completed Action & date
~~Research Governance Policy~~		~~Submitted to Q&S Committee but not yet approved. Jonathan Bisson to discuss with Sharon Hopkins Jan 11~~ Uploaded 27/2/12	
Prescribing for Staff	Alison Jones/Darrel Baker	chased 16/5 & 13/6/12	No update re allocate ref no
~~All Wales Dignity at Work Policy~~			Uploaded 26.10.11 LB
All Wales Special Leave Policy			
All Wales Rehabliation Policy			
Occupational Health Policy	Rod Hill/ Ceri Dolan	Policy under review to go to WOD committee Sept 11 E-mail in pending 10/10/11 @ 13:12	
~~PADR Policy~~	~~Becky Corbin/Les Jones/Ceri Dolan~~	~~Policy under review to go to WOD committee Sept 11~~	Uploaded 27th October 2011 LB
~~Retirement Policy~~	~~Sue Barrow/Peter Bentley~~	~~Policy under review to go to WOD committee Sept 11~~	Uploaded April 12
Statutory Registration Policy	Rachel Pressley /Nigel Gibbs TBC	Policy under review to go to EPSG Aug 11	
~~Adverse Weather Policy~~	~~Jenny Collett?~~	~~Appendix PDF waiting for final version 1/2/12~~	Uploaded 28/2/12
Lease Car Policy	Andrew/Stuart	Policy under review to go to EPSG Aug 11	
Agency Workers Policy	Rachel Pressley/Claire Smith	Policy under review to go to LPF Aug 11	
~~Education Malpractice Policy~~	~~Tessa Callaghan/Nigel Gibbs~~	~~Policy under review to go to EPSG Aug 11~~	Uploaded
~~Pre & Post Registration Nursing Student Placement Policy~~	~~Rachel/Kath/Elias/Claire B-J~~	~~Policy under review to go to WOD committee Sept 11~~	Uploaded 4.11.11 LB
~~Equality & Human Rights Policy~~	~~Keithley Wilkinson/Vincent Cain/ Dorothy Turner~~	~~Policy under review to go to LPF Aug 11~~	Uploaded 1st November 2011 CP
Supplementary Statement	Rachel Pressley /Nigel Gibbs	Document Under Review to go to LPF Aug 11	
Honorary Contract	Rachel Pressley /Peter Hewin	Document Under Review to go to LPF Aug 11	
Work Life Balance	Claire Smith		
~~Study Leave~~	~~Becky Corbin /Les Jones Ceri Dolan~~	~~Policy under review to go to EPSG Aug 11~~	Uploaded 14/3/12
Fixed Terms Guidelines	Nicola Evans	Policy under review to go to EPSG Aug 11	
Recruitment & Selection Procedure	Kelly Skeene	Policy under review to go to EPSG Aug 11	
~~Security Services Policy~~	~~Simon Williams/Phil Cable~~	~~Under Review~~	Uploaded see comments on register
Rapid Access Chest Pain Operational Procedure	Catherine Langdon	Under Review 18/08/11. Comments provided. Chased to check progres - 09.11.11 (MW)	
~~DKA Guideline~~	~~Aled Roberts~~	~~Under review. Taking to the Q&S Committee 20.09.11~~	Uploaded Feb 2012
~~Procedure For The Insertion Of A Nasogastric Tube, Confirmation Of Correct Position And Ongoing Patient Care In Adults, Children And Infants (Not Neonates)~~	~~Amelia Jukes~~	~~Currently Updating Document 08.09.11~~	Uploaded 13 June 2012
~~Child Abduction Policy~~	~~Mel & Anne Morgans~~	~~Copy in pending paper file to go to Nov 11 Q&S Cmtte. Further comments provided 11.11.11. Was not presented to Q&S in Nov ?? December meeeting~~	Uploaded 6/3/12

Quality Assurance of Newly Purchased Surgical Equipment	Judith Smith/Linda Walkker - Surgical Svs	Presented to Surgery Q&S Group - 09.11.11 - needs further work and to consider if needs to cover other areas. Linda Walker to investigate - Mel commented to JS and LW - 09.11.11 - In file	
Data Management in Clinical Trials: Guidelines for Clinical Researcher	Fiona Dunn/Maureen Edgar, R&D	Document previously developed but not in UHB format. Requested advice re interim update. Suggested that bring review date forward from Sept to Jan 2012 and then process as UHB document. Currently on R&D Intranet pages. (MW 11.11.11)	Check if ref UHB 070
~~Mental Health Risk Assessment and RM Policy~~	~~Helen Bennett~~	~~Comments provided 11.11.11~~ ~~Posted on Consultation pages on intranet~~ ~~Sent to Q&S T&F Group for comment~~ ~~For submission to Q&S in Dec if goes to plan.~~	Uploaded 4/7/12
~~Guidance for the Evaluation of Service Evaluation Projects~~	~~Maureen Fallon~~	~~Document developed. Final Draft to be circulated to Research Governance Group Membership prior to submission to Q&S Committee - RGG minutes indicated would happen in time for Q&S Committee in December but hasn't happened (15.11.11)~~	Uploaded 27/6/12
~~Choice Protocol~~	~~Vicky Warner~~	~~MW requested documents 16/12/12 document sent without EQIA reminder to Mel 27/2/12 waiting for time to review doc~~ ~~Info provided re approval - to try to add footer before uploading (06..03.12).~~	Uploaded 9/3/12 with template letters as seperate doc in word
~~Lasting Power of Attorney and Court Appointed Deputy Procedure~~	~~Julia Barrell~~	~~Document sent to Q&S Leads for consultation - definitely circulated to Medicine, Surgery, CD&T, C&W~~ ~~Posted on Intrnet for consultation - closes 14.03.2012~~ ~~Intention = to take for approval to Q&S Committee in April (16.03.12)~~	Presented and agreed at Q&S Committee but awaiting agreement of GS re scope before uploading. MW - 17.05.12 Uploaded 18 May 12
Policy for New Interventional Procedures	Robert Williams	Revision of former Trust document. Comments provided to Robert on first draft - 07.03.2012.	
~~Care Programme Appraoch Policy~~	~~Helen Bennett~~	~~Document posted on intranet and sent to Q&S T&F Group for consultation - April 2012. Plan to take to June Q&S Cttee.~~ ~~Circulated via C&W for comment~~	Comments provided May ready for June Committee - Agreed with Helen Bennett to hold off approving document and look to develop appropriate documents in line with Mental Health Measure - agreed to meet Dave Semmens to support. MW 17.05.12 sent to HB & DS 4/7/12 to confirm queries before Uploading 4/7/12
~~Specimen Labelling Policy~~	~~Mike Creasey~~	~~First review - to present to Q&S Committee - June 2012~~	Circulated by C&W Division for comment Uploaded 4/7/12

~~Laboratory Medicine Quality Policy~~	~~As above~~	~~Circulated for comment - to present to June Q&S Committee~~	Uploaded 4/7/12
~~Incident Reporting Policy & Procedure~~	~~Robert Williams~~	~~Circulated for comment - to present to June Q&S Committee~~	Circulated by C&W Division for comment Uploaded
~~Latex Allergy Policy~~	~~Rachael Daniel~~	~~Circulated for comment - to present to July H&S Committee~~	Uploaded 1/8/12
~~Volunteer Strategy~~	~~Michelle Fowler~~	~~reminder sent 6/7/12~~	
~~Records Management Policy~~	~~Mel/Ann~~	~~Circulated for comment and on intranet - comments by 28th Sept.~~	Circulated via Medicine Q&S, Uploaded
~~Records Retention & Disposal Protocol~~	~~As above~~	~~As above~~	As above Uploaded
~~Disposal of Clinical results~~	~~As above~~	~~As above~~	As above Uploaded
Pressure Ulcer Policy	Ceri Harris, Wound Healing	Comments by 21st Sept	As above + Specialist Svs Q&S
~~Independent Mental Capacity Advocacy Procedure~~	~~Julia Barrell~~	~~Uploaded for Consultation 1/3/13 / removed from consultation page 27/3/13~~	Uploaded 14/6/13
Fire Safety Policy	Charles Dalton / Rachael Daniel	Uploaded for consultation 13/3/13 removed from consultation 5/4/13	
Case Management Framework	Carl Ball	Uploaded for consultation 27/3/13	
~~Missing patient UHB premises~~	~~Lynda Jenkins~~	~~awaiting final documents~~	Uploaded 19/7/13
Fetal remains and still birth policy and procedure	Bernie Steer	Comments provided 250713- plan is to take final draft and supporting paper to HSMB in September and Board in November.	
Keep on list for 6 months following uploading onto Intranet. LS FONT COLOUR = PURPLE MW FONT COLOUR = GREEN			

Completed Yes/ No
yes
Yes
yes
yes
Yes
yes
Yes
yes
yes
yes
yes
yes
yes
yes

Yes
yes
yes
yes
Yes
yes


yes

CAPITAL MANAGEMENT GROUP
MINUTES OF THE MEETING HELD MONDAY 21ST OCTOBER 2019
TAFF ROOM, 1ST FLOOR, WOODLAND HOUSE

Present:
Robert Chadwick, Executive Director of Finance (Chair)
Geoff Walsh, Director of Capital, Estates and Facilities
Marie Davies, Deputy Director of Strategic and Service Planning
Nigel Mason, Business Manager
Richard Hurton, Assistant Finance Director
Chris Lewis, Deputy Finance Director
Edward Hunt, Programme Director
Nigel Lewis, Assistant Director of IT
Mike Bourne, CD&T
Fiona Jenkins, Executive Director of Therapies and Health Science

In Attendance: Zoe Riden Phillips, PA Director of Capital, Estates and Facilities

1.	**APOLOGIES FOR ABSENCE** Apologies were received from Abigail Harris, Steve Curry, Clive Morgan
2.	**MINUTES FROM THE PREVIOUS MEETING** The minutes of the previous meeting were accepted as a true and accurate record
3.	**ACTIONS FROM THE PREVIOUS MEETING** **Jungle Ward** GW reported that Noah's Ark (NA) Charity had directly appointed an architect to produce the artistic images. On discussion GW advised RC that development of ward had no financial impact on the discretionary capital programme. Funding to be provided by the NA Charity. **CRI Links** Options to provide accommodation for the DATT Service following the water ingress at CRI Links are being considered, which will include any associated costs. GW had met with Welsh Government (WG) colleagues prior to CMG, Ian Gunney (IG) advised that money had been earmarked to support the UHB with the links building.

4.	**CAPITAL REPORT** **Capital Resource Limit (CRL)** GW reported that there was no change to £14.428m Discretionary Capital Funding, advising the group that the following items had been added to group 3, 'Forecast Capital projects without approved funding' • Pharmacy Equipment - £0.448m • Replacement Imaging Equipment - £4.500m WG had issued letters of funding award to the UHB which were awaiting the signature of the Director of Finance and the Chief Executive prior to the funding being confirmed. **CAPITAL PROGRAMME SUMMARY** GW presented the Capital Summary Programme and provided an overview of the schemes that were considered a risk to Capital Programme. **Neo-Natal Phase 2 works** GW advised that the monthly Project Manager (PM) report confirmed £87,940.00 remained in the contingency allowance. Fit out works for the MRI had commenced but close monitoring of the budget would be required given the limited level of contingency available. **Rookwood Relocation** At the time of reporting, the scheme had identified a £60k overspend against the £20m total outturn cost. GW advised that the team were not concerned with the projection of cost at present but confirmed that close scrutiny continued. The level of overspend would fluctuate as risks were realised or closed with no implications. **Community Buildings – Re-roof Riverside** GW reported that £500k had been allocated to the community buildings, PCIC had advised that a priority was to re-roof Riverside. GW advised that during the financial year PCIC had requested to utilise a portion of the allocation to deliver the Out Of Hours call handlers base at CRI, in a permanent facility. This would include relocating staff from Barry. However; no Business Case (BC) had been developed to date. On discussion, MD agreed to liaise with the Clinical Board (CB) to identify the service requirements and assist with development of a BC. The CMG confirmed that the capital scheme could not progress until the BC had been approved. **Haematology Day Unit** Further delay had been reported and an early warning notice had been issued by the contractor indicating a completion date of December 13 2019, circa 5 weeks after the anticipated completion date. GW advised that the delay may impact on the UHB winter bed plan due to the Haematology day service having to remain in Heulwen South ward.

Lift replacement scheme
Resource issues with the contractor had impacted on the programme. RC queried the options of sourcing another contractor, GW advised that the procurement process for the engagement of lift contractors resulted in 50% of the order value being paid prior to the contractor commencing construction. This cost covered the design and pre manufacturing of components required for the refurbishment.

CRI Links 1st Floor
Works were ongoing to the first floor, which was previously occupied by PCIC to accommodate staff from the links offices. GW confirmed that since the issue of his report, the locality team had relocated to allow the development to progress.

Schemes associated with the closure of Global Link
A paper was being drafted to describe the works and costs required for Brecknock House and Western Services to enable the vacation of Global Link.

Radiopharmacy
GW met with Ian Gunney, WG, to discuss issues around the location of the Radiopharmacy Unit and in particular the position with the facility at the former LG site in Newport (IP5). The group discussed the challenges that would be faced with the location, along with logistical issues and revenue implications.

MB advised the CMG that a meeting was scheduled for 24 October with WG colleagues to clarify a number of issues, including the inclusion of the Radiopharmacy facility in the TRAMS project and the use of IP5.

FJ had met with Rob Orford, WG, to discuss and identify the changes to the needs and confirmed that TRAMS project was considered separate to Radiopharmacy due to the clinical services implications. It was understood that the Radiopharmacy remained out of scope in relation to TRAMS and that the intention was to continue with a separate Business Case for the replacement of the C&V facility to included capacity to support Velindre.

The CMG agreed to continue at risk with the development of the BC until the outcome of the meeting of the 24/10/2019 was known and consideration by Management Execs (ME) on 28/10/2019.

R&D Facility
GW advised that AH and Alison Hanbury, Cardiff University had discussed and agreed to a maximum budget of £500k, £250k per organisation to deliver a Joint Research and Development Facility at Lakeside UHW.

CRI Block 11 2nd Floor
A final solution had been identified and agreed to relocate the staff from Global Link, with the BJC scheduled to be submitted to WG by end of November 2019.

Aroma @ Barry
The tenders had been returned and the lowest submission was £325k. GW advised that a paper had been drafted for the Charitable Funds Committee for consideration of financial support. RC agreed to discuss with the Chief Executive.

Major Trauma /Vascular Hybrid Theatres
Options for the development had been reviewed with the SCP and design team as the logistics and building in the courtyard significantly exceeded the target date. An option to construct the facility as a Phase of the proposed Academic Avenue Development could deliver the facility in less time and a slightly reduced cost. The MTVH would be situated on the 3rd floor, linked into the existing theatres.
WG colleagues were scheduled to attend site, Tuesday 29th October 2019 to meet with GW & MD to review the option and also to consider the SOC scrutiny questions.

Central Funded Schemes
MD raised concerns that the replacement of the CT scanner in EU could not be commenced until April 2020, as the Chief Operating Officer was concerned about the impact on the service during the winter months. MD pointed out that this would be after the implementation date for MTC. RC queried the impact undertaking the works during the winter period would have on the service. MB advised that there would be no CT available in EU for approximately 4-6 weeks and that the contingency plan would be to utilise the CT scanner in the main Radiology department.

GW advised that it had also been suggested that works to provide an additional Resus bay could not commence until after the winter period.

MD confirmed that it was understood that the most important facility to have available when MTC 'goes live' was the Polytrauma unit.

WG had requested that a more detailed breakdown of the capital costs was required for the various elements of the proposal. GW confirmed that subject to the Medicine CB finally agreeing the location of the resus bay he would collate the information and issue accordingly.

CAPITAL DEVELOPMENT MATRIX

The detailed capital development matrix, item 3.0 was presented for noting.

LETTERS OF APPROVAL

Confirmation of approved funding had been received for the following schemes;

- UHW 3rd MRI and EU CT Scanner. Letter of acceptance received by the UHB, required signature and return
- Use of the gain share for UHW MRI 'fit out' as part of the Neonatal Scheme. (email confirmation issued by Ian Gunney)
- ICF funding for the CRI Chapel redevelopment

5.	**MEDICAL EQUIPMENT** FJ presented the monthly medical equipment report; the CMG approved the following requests, • The procurement of 2 cystoscopes and endoscopes tracking system - £32k+VAT FJ presented a Medical Equipment Scrutiny of Capital Plan. As an action for Strategy and Delivery Group the lead of Clinical Engineering had drafted a report to categorise the equipment maintained up to £5k. The recommendation of the report included IM&T and Medical Equipment. Welsh Audit Office (WAO) also requested that kit was recorded under £5k that was not centrally managed. FJ expressed concerns of the difficulties of tracking such equipment on a database due to the budget lines with the CBs. RC advised to discuss at the next Strategy and Delivery Group, and highlight that the critical equipment is managed.
6.	**IM&T** NL presented the revised IM&T report and highlighted the proposed national funding programme for 2019/20 and advised that following All Wales negotiations with other organisations the confirmed allocation for Cardiff and Vale UHB was as follows; • Cyber Security £0.250m Cap / £0.186m Rev • NIS Directive £0.075 Rev • Infrastructure £1.2m Cap / £1.15m Rev • Office 365 £0.165m Rev The funding letters from WG we anticipated to be received imminently. CL requested if the UHB had an indication of the funding that was anticipated to be received in the next financial year? NL advised that proposals had been issued for the financial years up to 2022, confirmation had only been received of the current financial year. FJ advised that funding allocation had been given for the Eye Care Digitalisation programme that is hosted by Cardiff and Vale on behalf of Wales, an increase allocation will be received to confirm.
7.	**CAPITAL PROJECT ENQUIRIES (PIE)** There were no enquiries submitted in the reporting month.
8.	**ANY OTHER BUSINESS** There was no other business raised at the meeting

9.	**TIME AND DATE OF NEXT MEETING** Monday 18th November 2019, Taff Room, 1st Floor Woodland House

NHS WALES INFORMATICS MANAGEMENT BOARD

Minutes of the meeting
Thursday 12 August 2019 – 14:30-17:00

Attendees:

Andrew Goodall (Chair)	Welsh Government
Ifan Evans	Welsh Government
Craig Stevens (Secretariat)	Welsh Government
Nicola Prygodzicz	Aneurin Bevan University Health Board
Dylan Williams	Betsi Cadwaladr University Health Board
Sharon Hopkins	Cardiff and Vale University Health Board
David Thomas	Cardiff and Vale University Health Board
John Palmer	Cwm Taf University Health Board
Richard Cahn	Cwm Taf University Health Board
Anthony Tracey	Hywel Dda University Health Board
Andrew Griffiths	NHS Wales Informatics Service
Ruth Chapman	NHS Wales Informatics Service
Helen Thomas	NHS Wales Informatics Service
Claire Osmundsen-Little	NHS Wales Informatics Service
Rhydian Hurle	NHS Wales Informatics Service
Neil Frow	NHS Wales Shared Services Partnership
Huw George	Public Health Wales
Sian Richards	Swansea Bay University Health Board
Steve Ham	Velindre NHS Trust
Daniel Phillips	Velindre NHS Trust
Chris Turley	Welsh Ambulance Service Trust
Claire Bevan	Welsh Ambulance Service Trust

Apologies:

Frank Atherton	Welsh Government
Albert Heaney	Welsh Government
Caren Fullerton	Welsh Government
Evan Moore	Betsi Cadwaladr University Health Board
Karen Miles	Hywel Dda University Health Board

1. Welcome, introductions and apologies

The Chair welcomed members to the meeting, and noted apologies.

2. Minutes and actions of previous meeting

The minutes of the April meeting were approved by members

3. Chair's opening remarks

The outcomes of the governance and architecture reviews meant there would be a number of changes across the system, including to NIMB meetings and other meetings in respect of digital decision making and governance. The Chair re-iterated from the previous meeting that it was important not to abandon progress made to date, however there is an expectation that meaningful change would take place following both the reviews and their recommendations.

The Chair also commented that there is a focus on how we deliver Digital across the system from Ministers and a new Ministerial Board which meets regularly to discuss digital delivery across Welsh Government portfolios.

4. Discussion items

Recommendations from WAO, PAC

Members received updates on the status of activity against WAO and PAC recommendations. Several actions were expected to be closed in September, subject to Ministerial decision. Other actions were expected to be completed over the next few months, with the delay caused by a need to undertake the Governance and Architecture reviews and to confirm decisions following their work.

Members noted the challenge of driving change on many fronts simultaneously in a large and complex system which delivers critical digital services. There is also a key question around addressing the behaviour change needed alongside technical and governance reorganisation. Members noted the public scrutiny of digital, particularly through the Public Accounts Committee, which would be holding its next scrutiny session early in November.

It was noted that the Architecture and Governance reviews were both commissioned as advice to Welsh Government and that Welsh Ministers were not obliged to respond to recommendations in the same way as for WAO and PAC.

Architecture Review and Governance Review

Recommendations from the Architecture and Governance reviews were presented to members, along with the feedback from the stakeholder groups who considered them. IE proposed the response from Welsh Government, which was to accept the Architecture Review recommendations as presented but to respond to the Governance review as a whole rather than to each individual recommendation.

Members commented that this was a useful summary of the reviews and welcomed the balanced approach to responding to the recommendations from each of the two reviews. They recognised that the key driver here is to inject pace and agility into the system to support delivery and to meet wider expectations of change.

Members noted the need to increase investment in digital and informatics, and also the need to strengthen digital and informatics leadership at all levels across the system, including executive boards.

Digital Transformation Programme

Members were introduced to the plans for the Digital Transformation Programme. The intention was to utilise this programme to start to deliver some of the other key elements contained within the advice, namely setting up the Digital Business Case Delivery Unit, recruitment of the Chief Digital Officer and overseeing the Infrastructure, Workforce, Communications and Commercial reviews.

The proposed purpose of the CDO was to have a whole system remit and the intention was to locate them within the future NHS National Executive.

Digital Investment process

Members assessed the current position of the £50m Digital Priorities Investment funding. The Chair emphasised that the significant additional funding was to deliver ambitions set out in A Healthier Wales. Members noted that the system behaviour around funding needs to change if we are to fully utilise this funding to achieve transformational digital changes. Members also noted the need to be transparent in delivering the digital agenda and that any help they could provide to deliver this would be welcome.

Members commented that there is already national reporting in place for delivery progress but this may need to be re-visited to ensure it is fit for purpose. It was noted that there is a need for the system to come together to give a single report on All Wales programmes and priorities, rather than provide individual reports from each organisation.

Strategic Reviews

The key objectives of the four proposed reviews were considered, and it was explained that the Infrastructure and Workforce reviews are key delivery items that Welsh Government expect to take forward this quarter, with the Communications and Stakeholder and Commercial reviews to be undertaken early in 2020. These are short sharp tightly focussed reviews and will need suitable resource involved from across the system to help deliver.

Summary

Members noted again the challenges of delivering such a wide range of activity at the same time, and particularly highlighted staffing and recruitment challenges. IE encouraged members to consider how they might be able to release resources from their own organisation, including as development opportunities, in order to support key aspects of the proposals. For example, the digital transformation programme, digital business case delivery unit, and leads for strategic reviews.

Action: share Governance Review to Members
Action: share Digital Next Steps slides to Members
Action: Members to look at what resources could be made available to support delivery

Blaenavon Data Centre

The data centre outage at Blanaevon was significant, and Members sought detailed assurances that the failover processes had engaged correctly. They were taken through the draft report and its key findings. Members noted that the interim report did not include wider issues across the system. They highlighted specific concerns with the report in capturing the scale of the issue around resilience of our Data Centres and whether the current arrangements are appropriate for the demand of the service. Members also raised concerns over the resilience and failover of systems and how business continuity measures are addressing the gap between 24/7 demand for services against the current maintenance and support SLA's. With more assurance needed, it was requested that the full final report be shared at the next NIMB meeting.

Action: NIMB members to look at what resources were across the system that could be made available to help.
Action: Final Report to be shared with Members at October NIMB meeting

5. Any other business

Members asked for an update on progress relating to the Networks and Information Security Directive work. It was confirmed that there was provision within the Digital priorities Investment Fund for a team to be located in NWIS to support Welsh ministers in meeting the requirements of the NIS-D.

NIMB will meet next on 14 October 2019.