Bundle Digital Intelligence and Health Committee 15 August 2019

Agenda attachments

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3	Items for Approval/Ratification	
3.1	Terms of Reference	
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4	Items for Nothing and Information	
4.1	Minutes of Meetings:	
4.1.1	(a) Capital Management Group meeting on xxx	

4.1 (a)Minutes of Capital Management Group held May 20th 2019.docx

4.1.2 (b) NIMB meeting on 11 December 2018

4.1 (b) NIMB Minutes April 2019.docx

5 Items to bring to the attention of the Board

6 Review of the Meeting

7 Date and time of next Meeting

7.1 1 October 2019, time TBA, Meeting Room, Woodlands House

Digital & Health Intelligence Committee
Agenda
15th August 2019 at 8:30am - 11:30am
Nant Fawr 1&2, 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 29 January 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**	
2.1	Digital Strategy Presentation	David Thomas/Alan Wardaugh
2.2	Information Governance Presentation	David Thomas
2.3	Risk Register by exception	David Thomas
2.4	Exceptions and Issues	
	(a) GDPR Progress	David Thomas
	(b) IT Delivery Program	David Thomas
	(c) WLIMS	David Thomas
	(d) I.G Compliance	David Thomas
2.5	Audits:	
	(a) Welsh Government Review of Governance	David Thomas (verbal)
	(b) IMT Audit Assurance	David Thomas
	(c) Internal Audit – Information Governance	David Thomas
3.	**Items for Approval/Ratification**	
3.1	Terms of Reference	Nicola Foreman
3.2	Committee Work Programme	Nicola Foreman
3.3	Legacy Document	Nicola Foreman
4.	**Items for Nothing and Information**	
4.1	Minutes of Meetings:	
	(a) Capital Management Group meeting on 20th May 2019	David Thomas
	(b) NIMB meeting on 11 April 2019	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	1 October 2019, 9am, Woodlands House	

UNCONFIRMED MINUTES OF INFORMATION TECHNOLOGY AND GOVERNANCE SUB-COMMITTEE
ON 29th JANUARY 2019
MEETING ROOM, HEADQUARTERS

Present:

Michael Imperato	MI	Independent Member - Chair

In Attendance:

Joanne Brandon	JB	Director of Communications
Julie Cassley	JC	Assistant Director of Workforce
Nicola Foreman	NF	Director of Corporate Governance
Sharon Hopkins	DH	Deputy Chief Executive /Director of Transformation, Improvement, Informatics and Commissioning (TIIC)
Fiona Jenkins	FJ	Executive Director of Therapies and Health Science
Alan Wardaugh	AW	Consultant - PICU
Nigel Lewis	NL	Assistant Director of IT & Strategy
Andrew Nelson	AN	Assistant Director of Information and Performance
David Thomas	DT	Director of Digital and Health Intelligence
Graham Shortland	GS	Medical Director (Caldicott Guardian)
James Webb	JW	Information Governance Manager

Secretariat: Sheila Elliot

Apologies:

Eileen Brandreth	EB	Chair
Sian Rowlands	SR	Head of Corporate Governance
Chris Lewis	CL	Deputy Director of Finance
Paul Rothwell	PR	Senior Manager – Performance and Compliance

IT/19/01/001	**WELCOME AND INTRODUCTIONS** The Chair welcomed everyone to the private meeting.	**ACTION**
IT/19/01/002	**APOLOGIES FOR ABSENCE** Apologies for absence were noted.	
IT/19/01/003	**DECLARATIONS OF INTEREST** No declarations were declared.	
IT/19/01/004	**MINUTES OF THE COMMITTEE MEETING HELD ON 31st October 2018** **Resolved – that:** (a) ITGSC Committee noted true and accurate minutes of the meeting held on 31st October 2018	

IT/19/01/005 **ACTION LOG FOLLOWING THE LAST MEETING**

The IT&G Committee noted the Action Log from the last meeting

- CPIP – was discussed later in meeting
- Closure of Medical Records – to be discussed later in meeting
- Controlled Documents Framework – to be discussed later in meeting

IT/19/01/006 **RISK ASSURANCE FRAMEWORK:**

The Assistant Director of IT and Strategy introduced the report:

This was the second time the Risk Register has been produced and reflects a number of changes but shows a positive reflection of the work being carried out. Work was continuing on prioritisation. The following was discussed:

- There were no risks which have increased or decreased on the Joint IM&T Risk Register.
- There was a continuing project at both local and national level regarding upgrading to Windows 10. Windows 7 will reach the end-of-life at the beginning of 2020 and therefore this poses a risk. Upgrading was a large and complex project which might require additional funding to implement.
- The Director of Corporate Governance mentioned that all Risk Registers alongside BAF will be reported to the Board so that there was an overview of risks from all Committees.
- WLIMS will use event capital. This had been discussed with CD&T regarding migration of Tracked 2016 (6.8.12)
- The current platform that LIMS sits on has reached end–of-life. A new platform is being developed and Tracked 16 software will sit on the new platform. There will be testing to ensure that the new product is fit for purpose. This software is used for all laboratory services and could impact on patient care and flow if there is an issue. There is a possibility that extra staff will be needed to carry out the implantation of the new platform and Tracked 16.

Resolved – that:

(a) The IT&G Committee received and noted the report

IT/19/01/007 **Assurance Reports and Action Plans**

These were discussed:

IT/19/01/008 **The IMT Audit Assurance**

- The IMT Audit Assurance report had been combined with the GDPR plan and been regularly updated over the last year. It brought together all audits and pulled them into the overall plan.
- Most objectives had been reached
- The Team were to be commended on sticking with the recommendations and actions as a lot were longstanding as reliant on other parts of the organisation or third party suppliers.

	• This needs to be cleansed by the time of the next meeting • The virtualisation project is dependent on GDPR **Resolved – that:** (a) The IT&G Committee noted the action update (b) The IT&G Committee noted cleansing of recommendations to be carried out	NL
IT/19/01/009	**Combined ICO/GDPR Action Plan** • Work has been done and continues to be undertaken since GDPR. The detailed action plan can be found in the meeting bundle. • The Information Governance Team continues to develop and progress is noted. • An internal audit review of the progress of the design has been carried out and no high level issues have been identified. The issues left are operational and implementational. • NHS Wales and the ICO are working together, alongside the rest of NHS Wales. • GDPR will get as near to 'fit for purpose' as we can • The whole organisation needs upskilling and the mandatory training has gone well. We need to check that people are putting the training into practice. • Each piece of work needs an Asset Owner and this needs to be incorporated into a virtual hub of data. • Graham Shortland, Medical Director mentioned that staff should be asked questions such as 'is your ward PC kept on?', 'do you using pen drives?', 'do you save data to the C:\ drive?' etc. to see if staff have the practical understanding of the needs of GDPR. • Julie Cassley, Assistant Director of Workforce thought that having done some HR and disciplinary work for the Clinical Boards that some staff would and some staff wouldn't know the technology but may understand overall requirements. • Joanne Brandon mentioned that general public GDPR knowledge will assist with staff knowledge. **Resolved – that:** (a) The IT&G Committee noted the action update	
IT/19/01/010	**INTEGRATED GOVERNANCE REPORT / REPORT OF SIRO** • Staffing levels and team building are good, producing capable people with the correct expertise • Regarding serious incidents we have a good relationship with the ICO and neither of the two incidents we had were reportable • FOI statistics were not so good over the summer period but reached 82% in December which was good • Regarding access requirements, workloads are being prioritised FOI issues are being concentrated on and there was no need to	

	look at access requests. • We do need to take into account that a considerable amount of time has been taken up with the situation regarding blood work. • Continuing work is being undertaken on compliance NIA's. • It must be noted that the present system is able to detect inappropriate access to the national system and can audit devices. • Out of the whole Welsh community 3½ out of every 100 patients will be a member of staff **Resolved – that:** (a) The IT&G Committee noted the action update	
IT/19/01/011	**CONTROLLED DOCUMENTS FRAMEWORK / UPDATED IG POLICY** • This is a significant piece of work and includes a large amount of documents. • We are trying to use the policies set at a Welsh national level for local use and we are making progress overall. • There are 5 amber policies and 26 policies which have been updated or incorporated as standalone documents. • Not all updating is completed **Resolved – that:** (a) The IT&G Committee noted the action update	
IT/19/01/012	**INTERNAL AUDIT REPORT: INFORMATION GOVERNANCE** • Although solid foundations have been laid, limited assurance has been given that the design work has the capability and capacity, • The Committee will keep a close eye on this. • A report is to be presented at the next meeting setting out the response, actions of the issues. No timelines have been set. • Needs to go to Audit Committee for review later on **Resolved – that:** (a) The IT&G Committee noted the action update	SH
IT/19/01/013	**Report of the Caldicott Guardian** • Discussions are being carried out regarding the issue of digitalisation • There is a significant issue around storage, space and the offsite provision is growing. • Regarding restricted access to medical records, work has been successful and there is now a more functional medical records library. This will continue to be rolled out. • Regarding de-commissioning of Whitchurch Hospital, Graham Shortland, Medical Director was able to give reassurance that further work was of a high standard and there was no significant	

risk of material being left on site. He visited the areas at most risk previously and was satisfied that the secondary clean-up was successful.

- Graham Shortland, Medical Director has written to the Head of Estates and Planning regarding any future de-commissioning to state that proper attention is to be paid to information left behind.
- It is the Clinical Board's responsibility to remove all inappropriate material.
- Caldicott Guardian principles regarding self-assessment were discussed and our recent self-assessment was quite rigorous and we achieved a mark of 76%-90%

Resolved – that:

(b) The IT&G Committee noted the action update

IT/19/01/014 **STRATEGIC ISSUES**

Sharon Hopkins presented a short paper regarding Transformation Board Progress and direction was discussed

- A digitally-enabled workforce is critical work and fundamental. We are looking at what is required of the organisation and staff and will look at what is required for patients and the public when this section of work is completed.

Resolved – that:

(a) The IT&G Committee noted the report update

IT/19/01/015 **ACCESSIBLE INFORMATION FOR CLINICIANS**

- A couple of risks have been highlighted and we are working through access information. This is a huge program. Huge amounts of information need to become more accessible to front line and clinical staff. 4 key areas were raised with potential risks.
- A one-off payment of £1.7million has been made available and will be spent on maintenance and the transformation program. A £25million fund will be made available later this year for transformation.
- A common information store is vital.
- The Digital Design Group is an engagement group employed by the Clinical Boards with ideas regarding operational services engaging with core digital services.
- There is assurance at the design stage supporting work on prioritising and technical standards and information standards.
- £25million capital and £25million revenue to come
- There are 4 layers to the National Architect Review – Business Needs, Technical, Physical and data structures. The Welsh Government are reviewing this.
- We are meeting the process milestones

	Resolved – that: (a) The IT&G Committee noted the action update	
IT/19/01/016	**STRATEGIC ENGAGEMENT** • Alignment of national and local digital developments and direction • Verbal assurance that the teams are working well with the Welsh Government and we are constructing our programs locally • The strategic alignment paper will be available in 6 months to The ITGSC Committee	SH
	Resolved – that: (a) The IT&G Committee noted the action update	
IT/19/01/017	**UPDATE ON WELSH UPDATE ON WELSH GOVERNMENT REVIEW OF GOVERNANCE OF:** • NHS Informatics in NHS Wales - Chasing Welsh Government • Architecture of NHS informatics in Wales - We will report back to Welsh Government in 6 months • The Welsh Government have responded to PAC but not to Governance regarding the PAC report on Informatics in Wales	SH SH SH
	Resolved – that: (a) The IT&G Committee noted the updates and action points	
IT/19/01/018	**WORK PROGRAMME** **WCCIS** We are in a unique position in Wales. The product remains short of our advanced needs and the project is remarkably slow. The vendors are providing a new platform and a new offering. We are in the unenvious position that the product on offer is a backward step and unachievable because it is more costly that the incumbent product. It is frustrating as we cannot take this forward as timescales for the new platform are unknown. • Cardiff Council advised that we should get the system required rather than the system they want to give us. • There is an invite to Local Authority on 15/02/2019 and Sharon Hopkins Director of TIIC will guide the approach to this. • Helpful Update **Resolved – that:** (a) The IT&G Committee noted the WCCIS action update which it found very helpful	
IT/19/01/019	**WLIMS** • We should develop plans to upgrade software and hardware to	NL

	reduce risks and give some contingency • The new blood transfusion system needs a stable platform of 90 days. Unfortunately we have never had a 90 day stable platform since inception of the system. • We need to take forward an alternative upgrade path to mitigate risks. • Support Contracts have been re-negotiated • Currently we are not using the Cellular Path Module – an upgrade of software will allow this to be used. However, we don't believe that this service will meet our requirements. • Upgraded software and hardware will mitigate risks by providing a resilient platform until the new LIMs can be delivered (for the blood requirements) • Paper to be presented to Board regarding the replacement. Replacement not likely to be available for three years • Additional Capital allocation from Welsh Government of £17million allocated in December for planned programme of priority spending plans • Linked to priorities set out in Welsh Government • All items are broken down in the appendix and the diagram is explanatory **Resolved – that:** (a) The IT&G Committee noted progress on exception areas for assurance on progress and mitigations (b) The IT&G Committee noted progress on mitigating risks with LIMS	NL NL
IT/19/01/020	**ANY OTHER URGENT BUSINESS** There was no other business to raise	
IT/19/01/021	**DATE OF THE NEXT MEETING OF THE BOARD** 28th May 2019, 9.00am – 12.00pm Corporate Meeting Room, Headquarters	

ACTION LOG
FOLLOWING INFORMATION TECHNOLOGY AND GOVERNANCE SUB COMMITTEE
29th JANUARY 2019 MEETING

MINUTE REF	SUBJECT	AGREED ACTION	LEAD	DATE	STATUS
Actions Completed					
ITGSC 18/057	IT/IG Risk Assurance Framework	Clarity on which service outages were required to be reported to Welsh Government to be sought	Nigel Lewis	January 2019	COMPLETE
ITGSC 18/063	WLIMS Report	Report to be presented to the Management Executive on how the service could be maintained through the existing Telepath Solution	Fiona Jenkins	December 2018	COMPLETE
Actions In Progress					
ITGSC 18/059, 18/029 IGSC 17/028	CPiP report	Submit final 2017/8 compliance report to ITGSC	Paul Rothwell	October 2018	COMPLETE
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
ITGSC 18/059, IGSC 17/031& 17/010	(v) Closure Of Medical Records Libraries	Review whether the unavailability of medical records/lost records were given the correct risk rating	Graham Shortland	January 2019	COMPLETE
ITGSC 18/052, 18/025	Review of Information Governance function	Management Executive to consider review. Include risk assessment in relation to delivery of FOI 20 day response target	Sharon Hopkins	January 2019	Report to be presented in MAY
ITGSC 18/069	Controlled Documents Framework	The Deputy Chief Executive to present the Controlled Documents Framework and draft IG Policy	Sharon Hopkins	January 2019	COMPLETED

MINUTE REF	SUBJECT	AGREED ACTION	LEAD	DATE	STATUS
	IMT Audit Assurance	Recommendations to be cleansed	Nigel Lewis	January 2019	MAY
IT/19/01/017	Welsh Government Review of Governance	Architecture of NHS informatics in Wales	Sharon Hopkins	January 2019	MAY
IT/19/01/019	wLIMS	Produce plan to upgrade hardware and software	Nigel Lewis	January 2019	MAY
IT/19/01/019	wLIMS	Report on alternative upgrade path	Nigel Lewis	January 2019	MAY
Actions referred to committees of the Board					
IT/19/01/012	Internal Audit Report: Information Governance	Needs to go to Audit Committee for review later on	Sharon Hopkins	January 2019	MAY
IT/19/01/016	Strategic Engagement	The strategic alignment paper will be available in 6 months to The IT & G Committee	Sharon Hopkins	January 2019	MAY
IT/19/01/019	wLIMS	Paper to be presented to Board regarding the replacement	Nigel Lewis	January 2019	MAY

DAVID THOMAS
DIRECTOR OF DIGITAL AND HEALTH INTELLIGENCE

Digital Strategy

August 15th 2019

Context

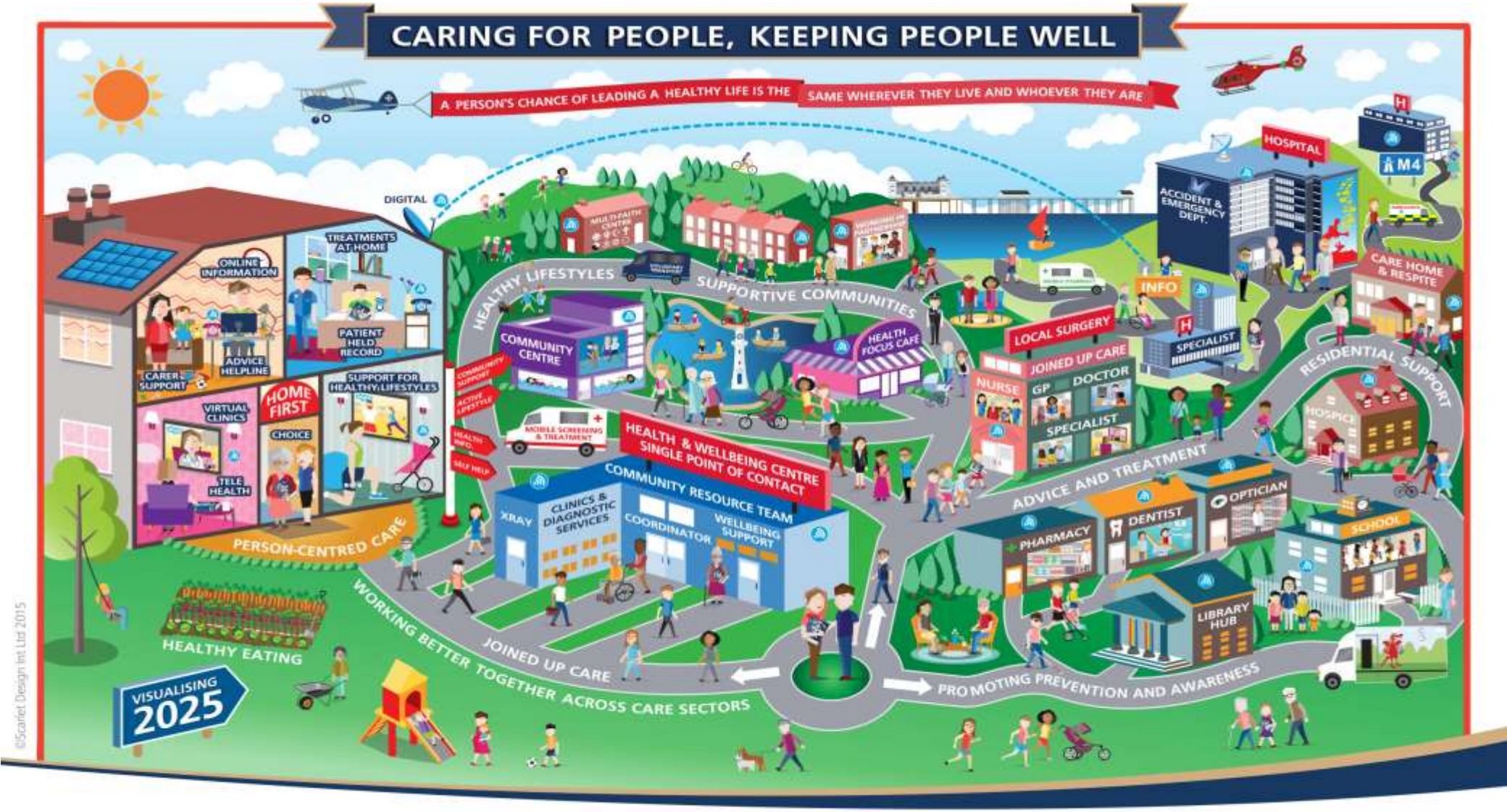
Digital Team

- The Cardiff and Vale Digital Team comprises of IT, business analytics and information, information governance, and specific IT project teams (e.g. PARIS team and WCP team) and clinical coding

Our Aim

- To provide enabling services across the Health Board to support delivery of clinical services. We see ourselves as a team integrated with all the service delivery boards rather than as a stand-alone entity. In achieving this we work closely with the Transformation board and Continuing service improvement.

The Draft Informatics Strategic Outline Programme to deliver:



Cardiff and Vale University Health Board

Shaping Our Future Wellbeing Strategy

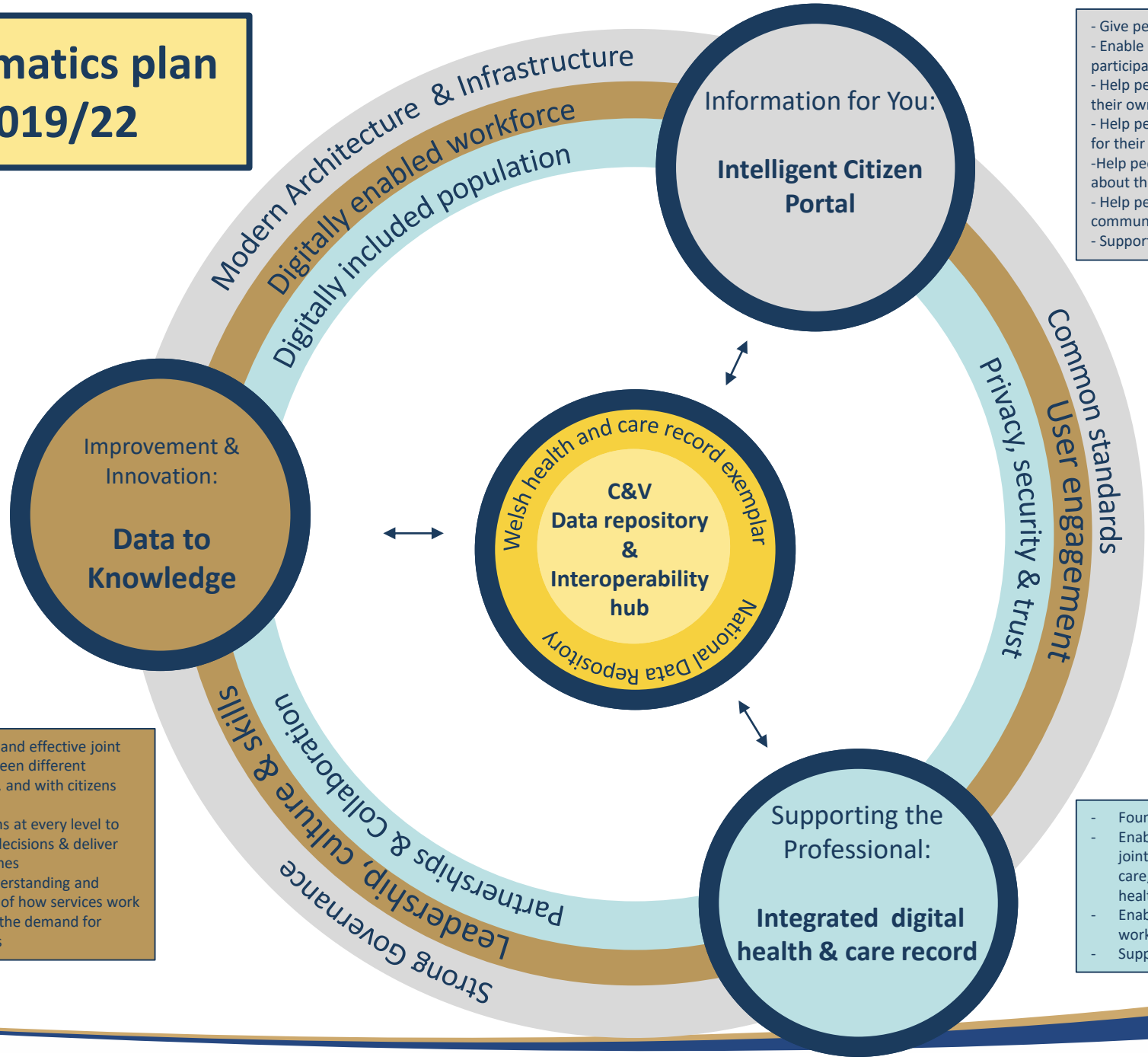
2015 - 2025

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro

Cardiff and Vale University Health Board

Informatics plan 2019/22



- Give people greater control
- Enable people to become more active participants in their own health and well-being
- Help people to make informed choices about their own treatment, care and support
- Help people find the most appropriate service for their needs
- Help people contribute to and share information about their health and care
- Help people manage their appointments and communications with professionals
- Support the co-ordination of care

- Provides safe and effective joint working between different organisations, and with citizens directly
- Helps clinicians at every level to make better decisions & deliver better outcomes
- Improves understanding and management of how services work together and the demand for those services

- Foundation for safe, high quality care
- Enable health and social care to undertake joint decision making and provide joined-up care, benefiting everyone who receives health services, care and support
- Enable and accelerate multidisciplinary workforce under new models of care
- Support the co-ordination of care

IMTP- 2019 /2022

Some of the key headlines for delivery in year one are shown below, with the full operational plan to deliver the digital plan and the anticipated benefits.

- - Widening the availability of the citizen portal to share information with patients.
- - Development of a Clinical Data Repository (CDR) and interoperability *Hub.*
- - Enabling virtual care and outpatient Transformation.
- - Real Time Clinical Data Availability.
- - Clinical Mobility and Cluster Working.
- - Digitally included Population.
- - Digitally enabled Workforce.
- - Upgrading our infrastructure to enable and support the rapid adoption and expectations on digital.

Through our programmes we want to put real-time data in a consistent format directly into the hands of frontline clinicians to support operational planning, decision making and data led clinical discussion. We want the transformation of our services to be driven by our data.

Work Plan Deliverables 2019 -20

HOW

Accessible Data C&V

Enable the sharing and wider clinical use of the data stored in GP, Community, Mental Health, EU, Outpatient, Theatre & Maternity information systems

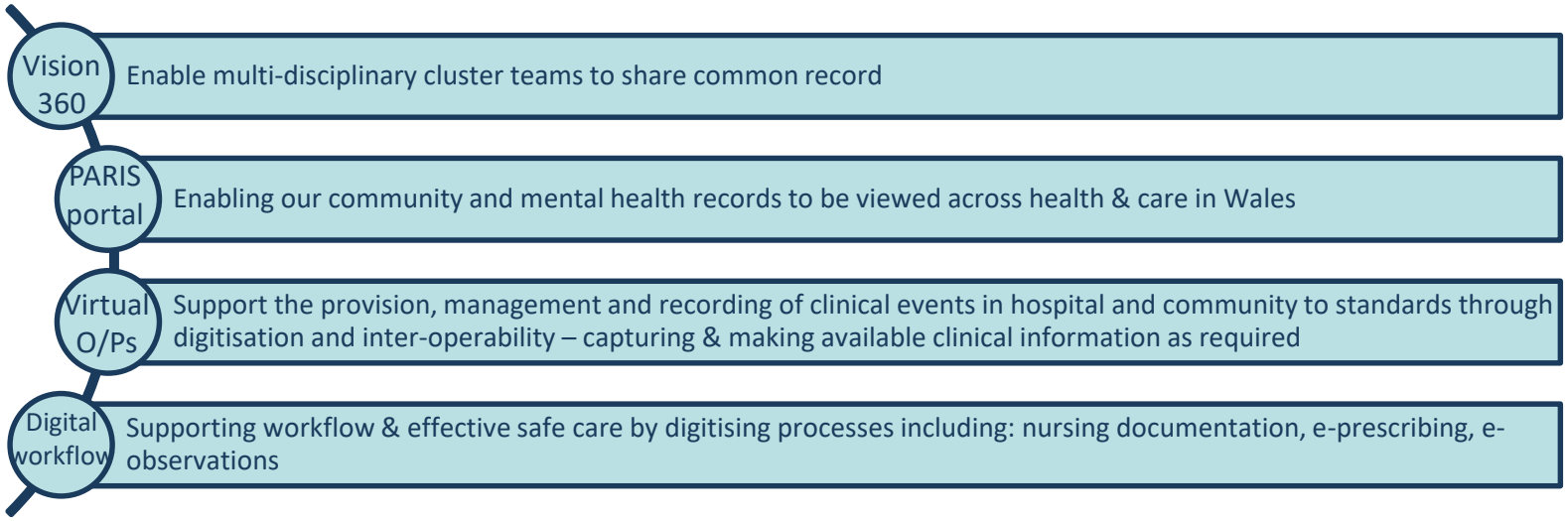
Accessible Data National

Enable our patients and residents to benefit from the availability of their: cancer, test results, community & GP data recorded from across Wales (& potentially England)

- Clinical Data Repository (CDR) Phase 1 inc Interoperability
- National Data Repository (NDR)
- Welsh Results & Reports Service (WRRS)
- Upgrade of Muse system to enable ECGs to be accessible anywhere

Work Plan Deliverables 2019 -20

HOW

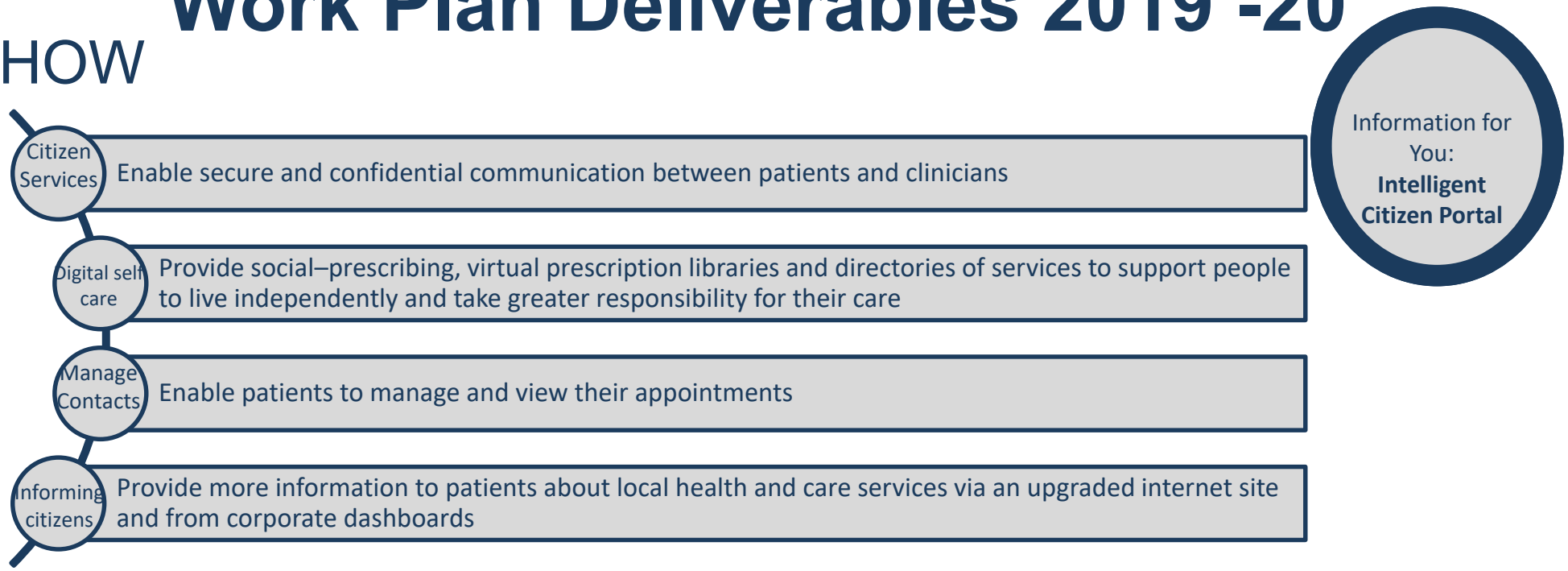


Supporting the Professional: **Integrated digital health and care record**

- Mobilisation Programme
- eNursing Documents – Pilot June 2019
- ePatient Flow – eObservation Programme – bench marking exercise
- Welsh Electronic prescribing and Medicines Administration (WEPMA)
- Eye Care System
- Accelerated Cluster Model (Me, my home, my community)

Work Plan Deliverables 2019 -20

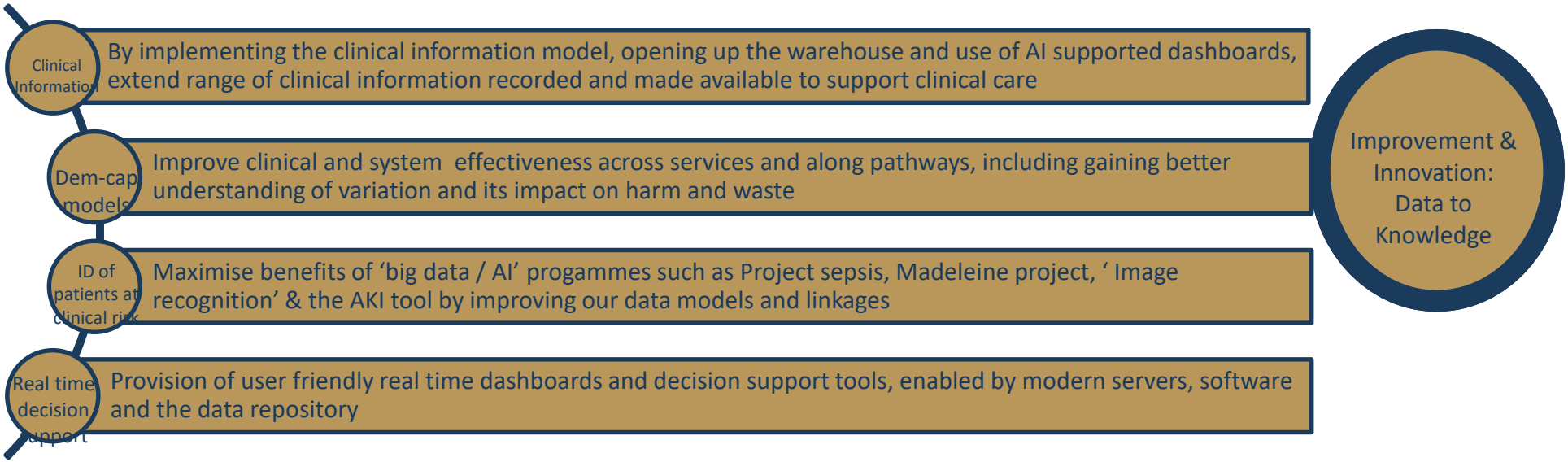
HOW



- National Citizen access portal
- Patient Knows Best (PKB)
- Seamless Social Prescribing (Me, my home, my community)
- Developing a single point of access for GP Triage (Me, my home, my community)

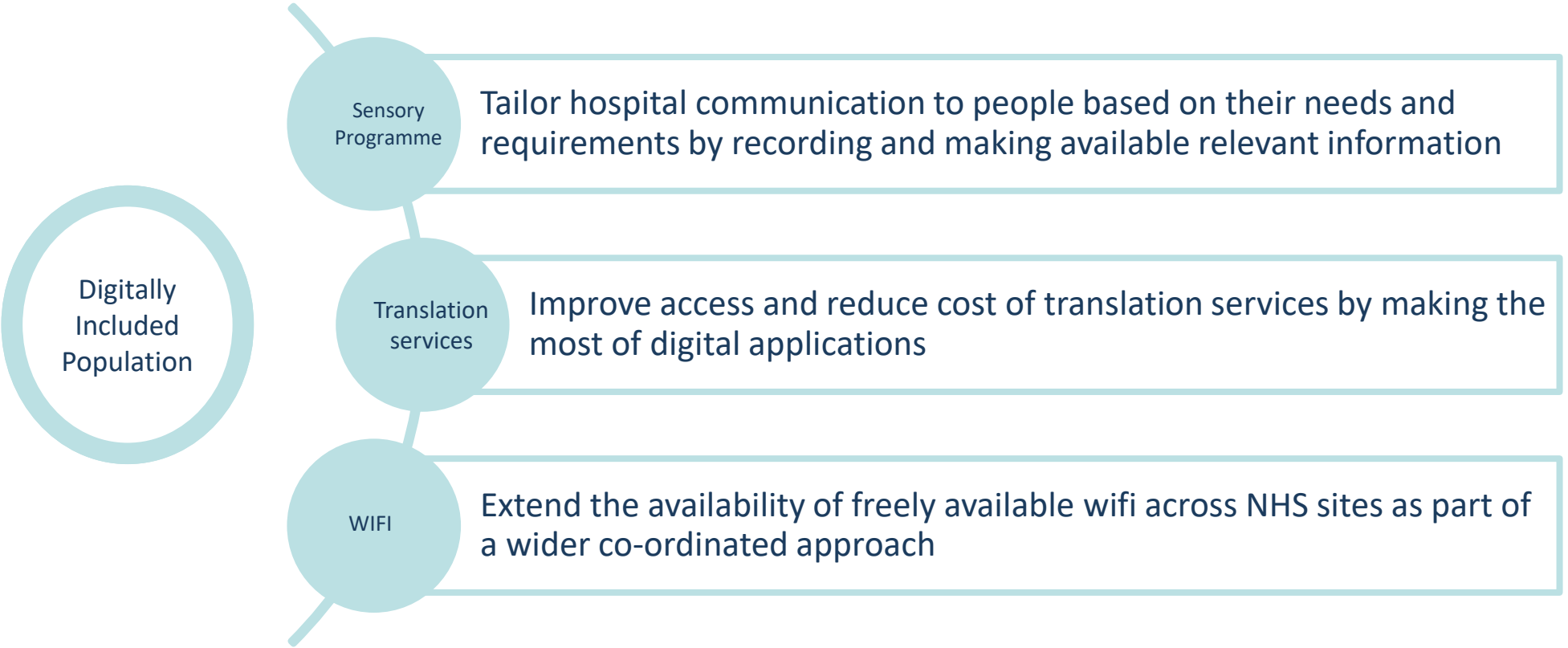
Work Plan Deliverables 2019 -20

HOW

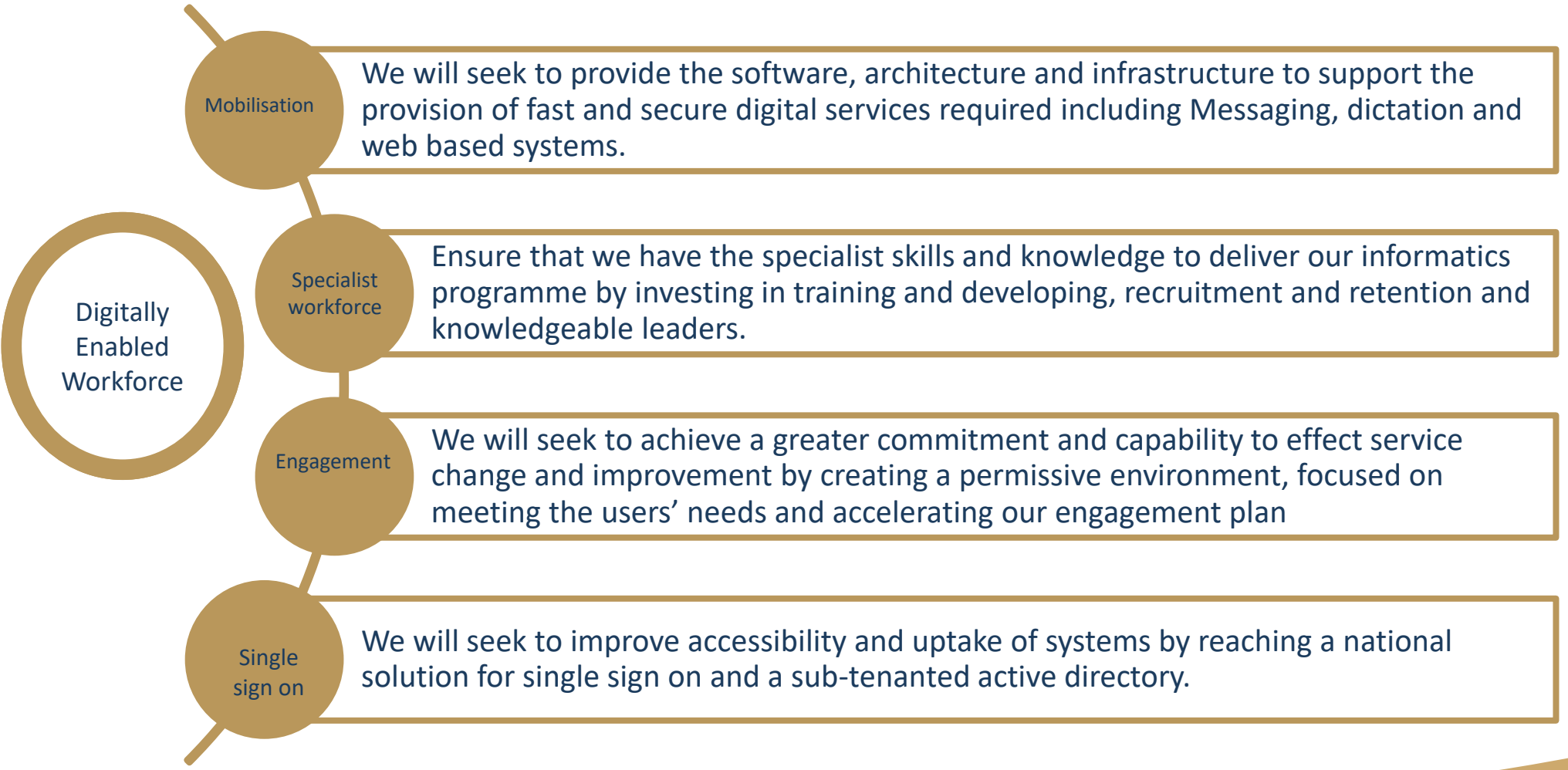


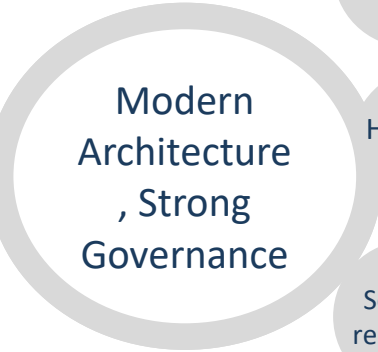
- Increasing the scope and accessibility of clinical information
- PARIS - Making available CRT data
- Child Psychology App
- Extending use of PROMs

Enablers


Digitally Included Population
Sensory Programme
Tailor hospital communication to people based on their needs and requirements by recording and making available relevant information
Translation services
Improve access and reduce cost of translation services by making the most of digital applications
WIFI
Extend the availability of freely available wifi across NHS sites as part of a wider co-ordinated approach

Enablers


Digitally Enabled Workforce
Mobilisation
We will seek to provide the software, architecture and infrastructure to support the provision of fast and secure digital services required including Messaging, dictation and web based systems.
Specialist workforce
Ensure that we have the specialist skills and knowledge to deliver our informatics programme by investing in training and developing, recruitment and retention and knowledgeable leaders.
Engagement
We will seek to achieve a greater commitment and capability to effect service change and improvement by creating a permissive environment, focused on meeting the users' needs and accelerating our engagement plan
Single sign on
We will seek to improve accessibility and uptake of systems by reaching a national solution for single sign on and a sub-tenanted active directory.



Storage	We will provide an additional 2 TB of on-premise fast storage to meet the forecasted annual requirements for new records, back up and data sharing
Servers & networks	We will enable faster run time of applications and the availability of information, ensuring our products are supported and are safe from known cyber threats
Software & DBs	We will upgrade our core software to enable mobile working, real time data sharing and enhance our data protection capability
Hardware	We will support new ways of working by improving the speed, connectivity & portability of the devices staff are reliant upon.
Service resilience	By strengthening our cyber, staff training, digital architecture and national collaborations we will improve the overall availability of our digital services
Coding & Standards	We will maximise the value of data and the accessibility of information by extending the adoption of Snomed-CT, technical standards across our applications
Data Protection	We will seek to maintain the confidence of our population that we are good custodians of their most sensitive and personal data and can be trusted to only share it where it is necessary and brings benefit.

Work Programme Enablers

- **Essential Infrastructure Sustainability and Modernisation Program…e.g**
  - PC
  - WiFi
  - Replacement of Telecoms
  - Server replacement / backups
  - Networks

- **Priority Digital Transformation Projects Including:**
  - Clinical Data Repository (CDR) - Phase 1 – including Interoperability
  - O/P Transformation and Real Time Clinical Data Duplication
  - Support to Clinical Mobility and Cluster Working
  - Patient Knows Best

- **National Program**
  - Enable wider deployment and uptake of national program functionality associated with WCP, WRRS, TRRR and WCRS.

National Digital Architecture Review

- External Consultants engaged by WG and NHS Wales to undertake a review of Digital Architecture
- To assess whether ready to meet the ambition set out in ‘A Healthier Wales’, and whether its scalable to support digital transformation

Key Findings:

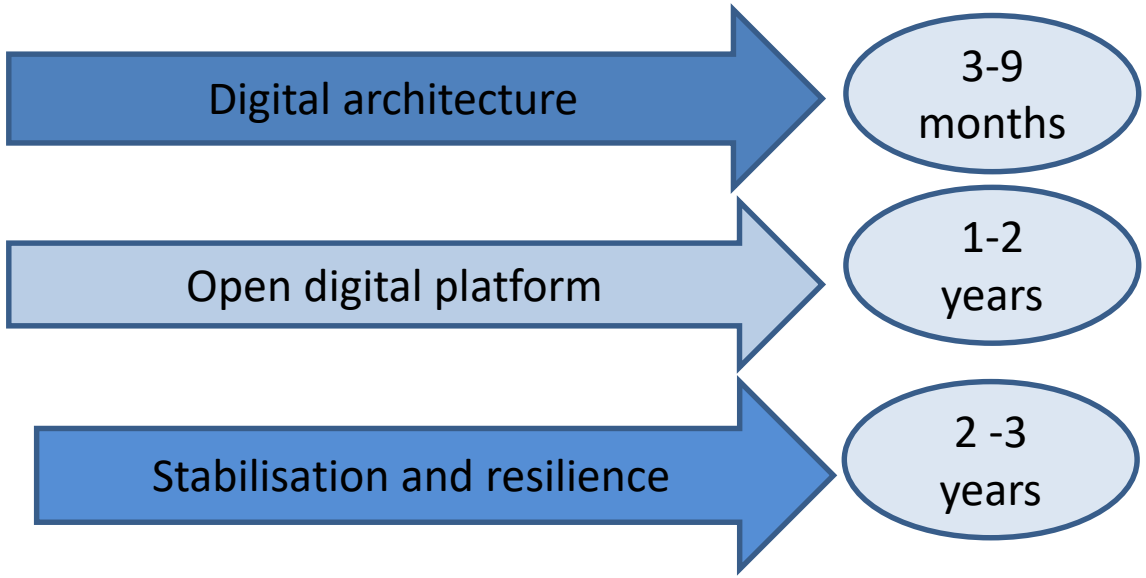
1. Current State - current approach is unsustainable will not enable the ambition set out in A Healthier Wales to be achieved as things stand

2. Opportunity - a significant opportunity for digital transformation

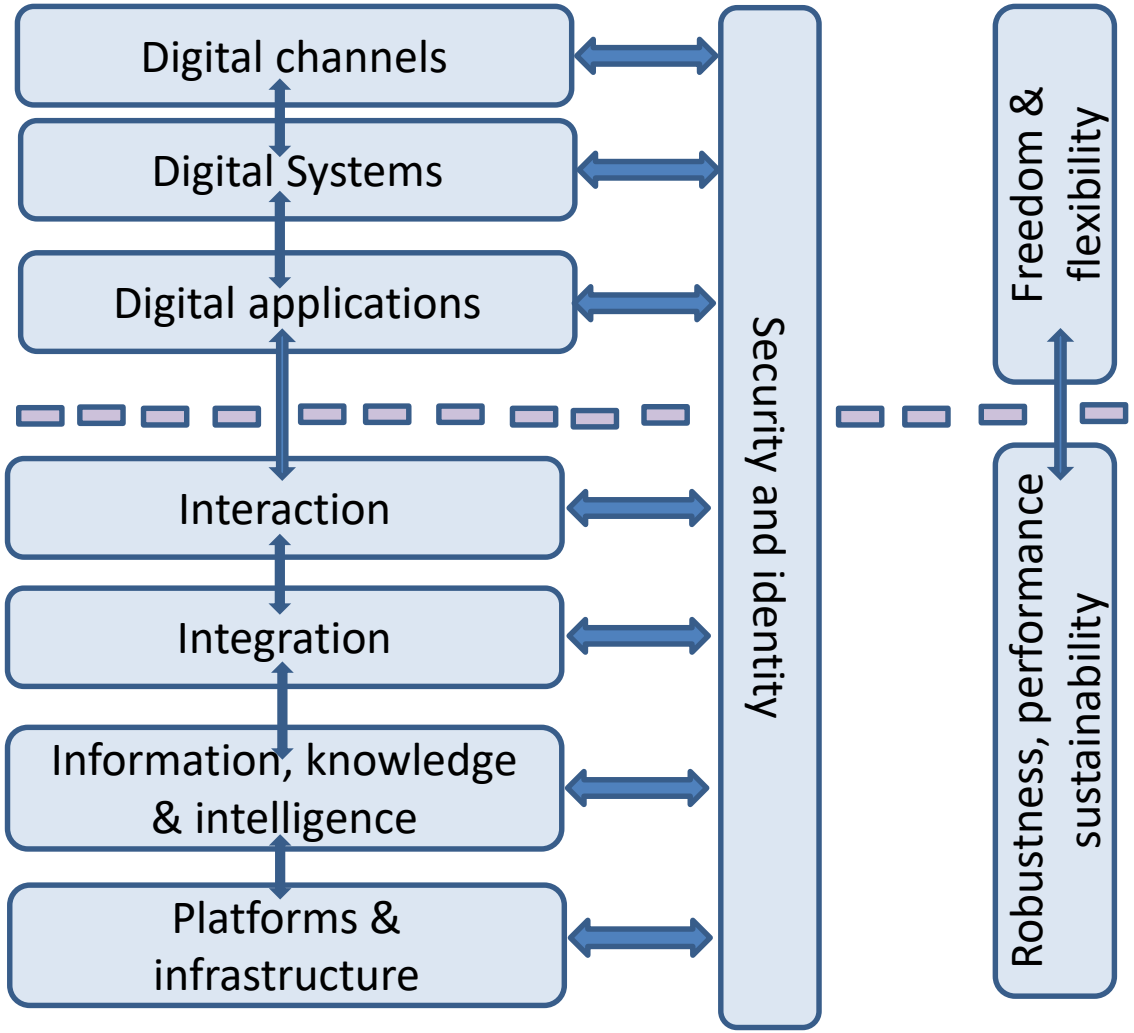
3. Approach - digital transformed NHS in Wales is achievable, but requires a fundamental change of approach and focus

Recommended Architectural Steps

The prize of a digitally enable health and social care system in Wales is within reach, but it cannot be achieved without a change in approach, focus and energy



Future State – with the right focus a target digital architecture that supports the ambition for A Healthier Wales could be achieved:



Why we need a Digital Strategy ….

- Application of digital technology to healthcare is relatively new
- More collaboration, research, development & integration are needed
- Need to influence, drive and benefit from a digitally- enabled heath and care system and future digital technologies
- The current approach is programme and project based …not holistic or strategic
- The strategy must be executed as part of an organisation change programme
- Digital access

Why we need a Digital Strategy ….

- Participation levels are varied
- There are many ‘pockets of enthusiasm’ for digital in the Health Board
- There is little visibility and therefore understanding of what becoming a digitally enabled organisation entails
- To what extent digital technology can address the challenges the organisation faces
- Public sector budget constraints and the current financial position of the UHB impedes cross sector digital initiatives

Digital Strategy – Things to Consider

- Digital exclusion (mitigating or resolving)
- Digitising and sharing Health Records
- Digital Maturity
- Pace & Scalability
- Communication

Digital Services Environment

- **C&V UHB Transformation programme**:
- *Information accessibility*: Information/record richness leading to increased information driven change
- *Digitally enabled workforce*: Re-use of common records, alignment with services, CB co-ordinator roles.
- **The UK and Welsh digital landscape**:
- *LCHRE*: Supporting direct patient care, then extend to integrating health and care, improving care co-ordination, providing a foundation for future health analytics and population health management and also enabling patient engagement and activation. *3 years of £50m digital investment in Wales*: Welsh Government seeks to fund a digital paradigm shift, through 3 years of £50m investment (2019-2022).
- *PAC review and future model/role of National services (NWIS reviewed).*
- *Digital Ecosystem Wales*: Opening up of the National architecture in Wales (internally & externally)

Digital Services Environment

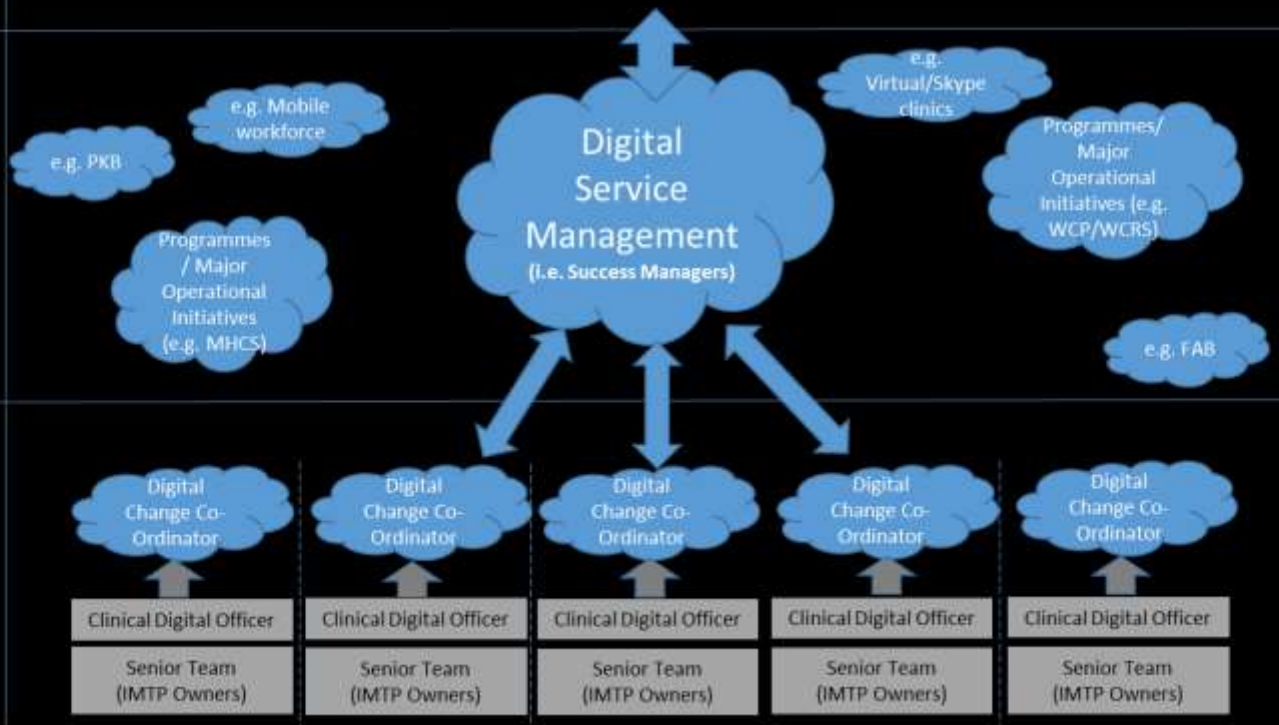
- **A changed Cardiff and Vale landscape**:

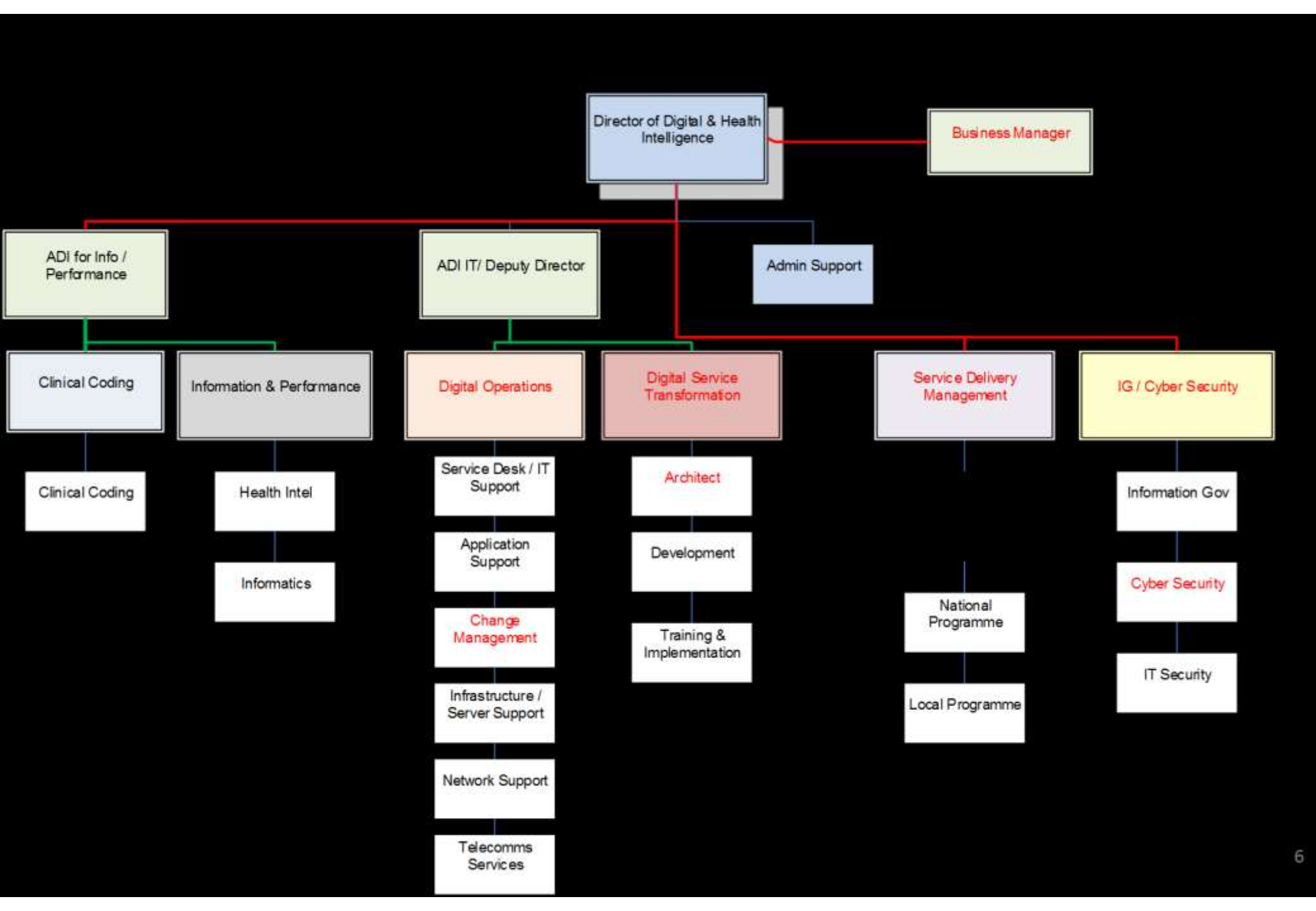
- Year 9 of UHB clinical boards delivering as businesses, not divisions.
- Some clinical boards are new since the current departmental design was established, and hold huge remit (e.g. PCIC) bringing challenge to digital services.
- User expectation is hugely increased (example: the positivity to 74% *mobile* coverage in community in 2011, today we are at c94%, yet expectation outstrips this, leading to WiFi request and cyber challenge).

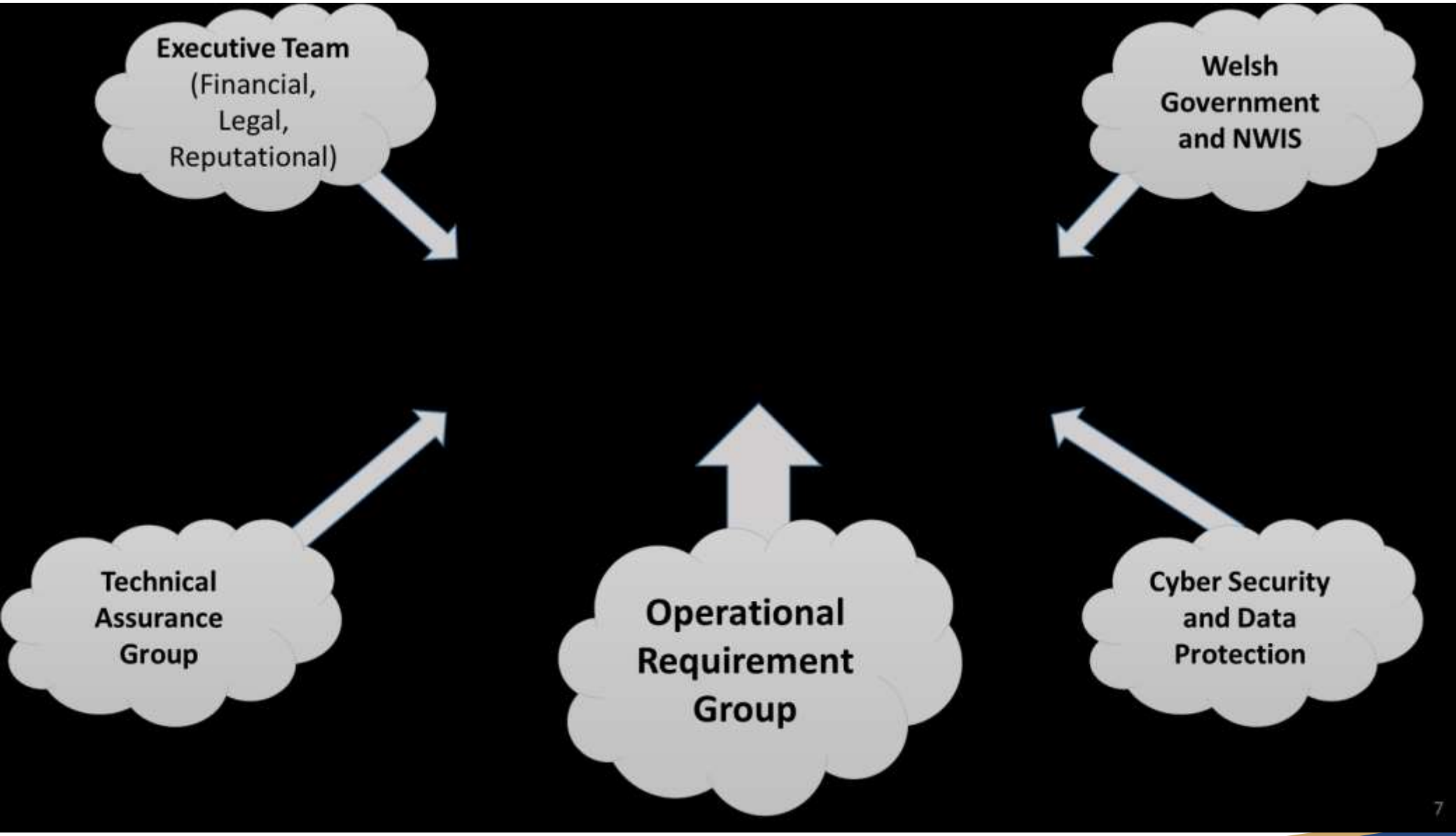
So we need …….**A Refreshed Vision**

Refreshed Digital Vision

- **Greater engagement, alignment and transparency to our businesses:**
- Prioritisation group with clinical board representation.
- Digital service management function – similar to the HR and finance model, having a business lead working across 2 or 3 clinical boards.
- Spreading the role of the digital change co-ordinator role within (and funded by) each clinical board.
- Become less software/system silo-d and ever more business requirement organised.
- Flexible digital change teams, implementing change across products and providers (NWIS, CIVICA)
- Using investment to increase our pace of innovation (gaining value from NDR/CDR, primary care transformation, mobilising the workforce).
- Driving a culture of joint ownership of change with our clinical board customers.


Digital Service Management
(I.e. Success Managers)
e.g. Mobile workforce
e.g. PKB
Programmes / Major Operational Initiatives (e.g. MHCS)
e.g. Virtual/Skype clinics
Programmes/ Major Operational Initiatives (e.g. WCP/WCRS)
e.g. FAB
Digital Change Co-Ordinator
Digital Change Co-Ordinator
Digital Change Co-Ordinator
Digital Change Co-Ordinator
Digital Change Co-Ordinator
Clinical Digital Officer
Clinical Digital Officer
Clinical Digital Officer
Clinical Digital Officer
Clinical Digital Officer
Senior Team (IMTP Owners)
Senior Team (IMTP Owners)
Senior Team (IMTP Owners)
Senior Team (IMTP Owners)
Senior Team (IMTP Owners)


Director of Digital & Health Intelligence
Business Manager
ADi for Info / Performance
ADI IT/ Deputy Director
Admin Support
Clinical Coding
Information & Performance
Digital Operations
Digital Service Transformation
Service Delivery Management
IG / Cyber Security
Clinical Coding
Health Intel
Informatics
Service Desk / IT Support
Application Support
Change Management
Infrastructure / Server Support
Network Support
Telecomms Services
Architect
Development
Training & Implementation
National Programme
Local Programme
Information Gov
Cyber Security
IT Security


Executive Team (Financial, Legal, Reputational)
Welsh Government and NWIS
Technical Assurance Group
Operational Requirement Group
Cyber Security and Data Protection

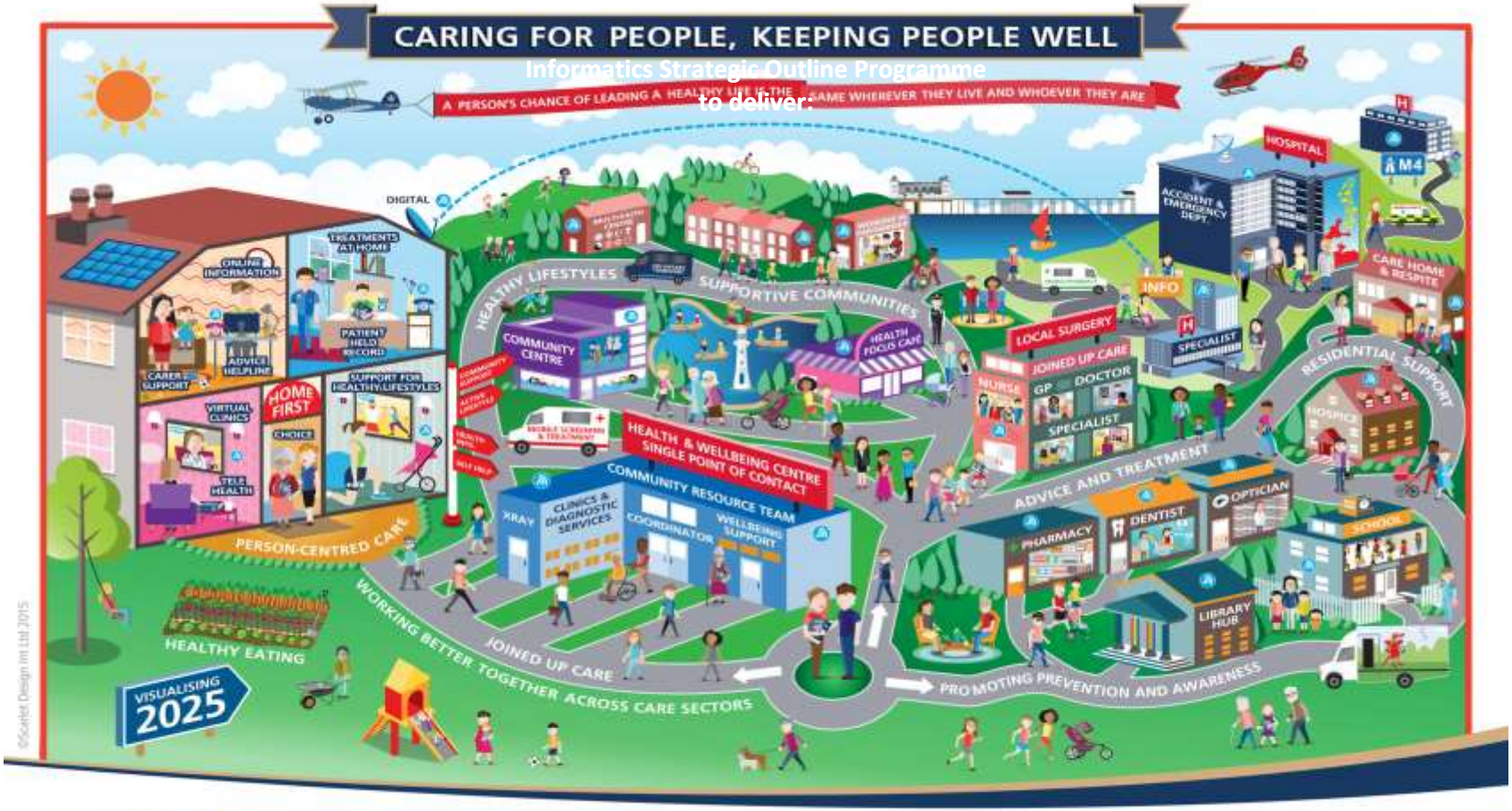
£50M Digital Investment

- 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….)

QUESTIONS ?

Informatics Strategic Outline Programme

to deliver:



Cardiff and Vale University Health Board

Shaping Our Future Wellbeing Strategy

2015 - 2025

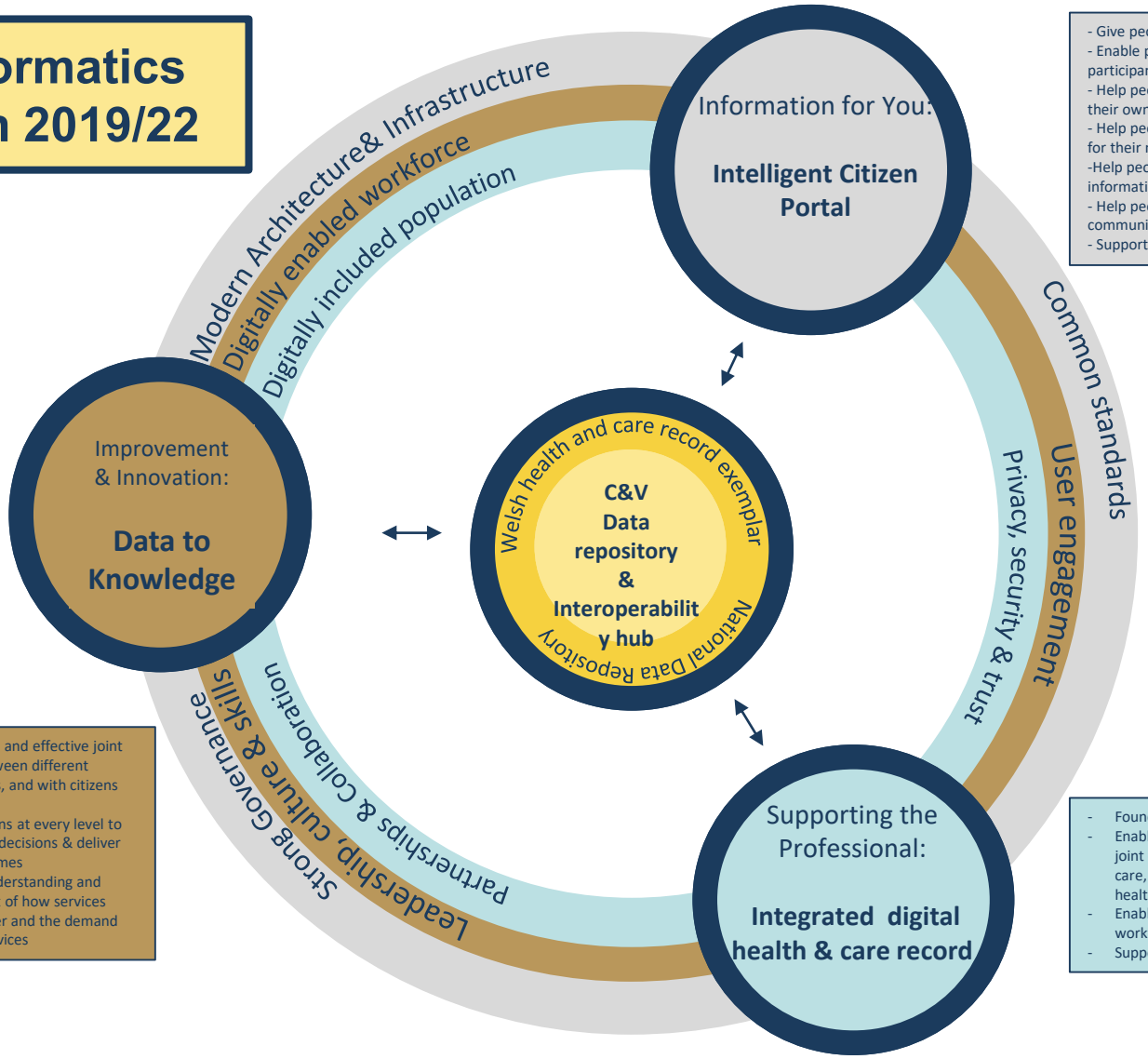
GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro

Cardiff and Vale University Health Board

Strong Governance - Ensuring Privacy, Security & Trust

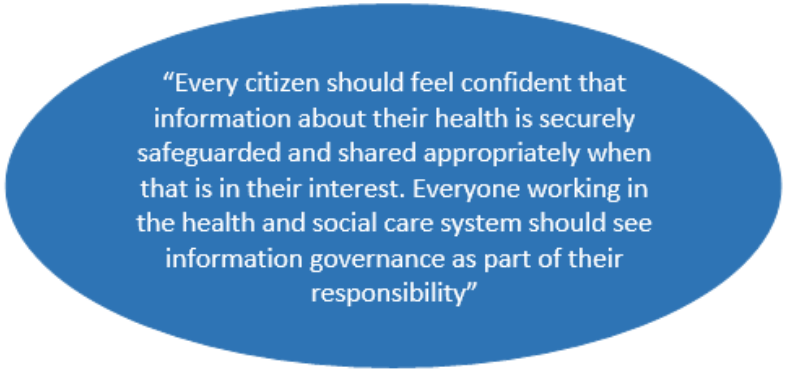
Informatics plan 2019/22



- Give people greater control
- Enable people to become more active participants in their own health and well-being
- Help people to make informed choices about their own treatment, care and support
- Help people find the most appropriate service for their needs
- Help people contribute to and share information about their health and care
- Help people manage their appointments and communications with professionals
- Support the co-ordination of care

- Provides safe and effective joint working between different organisations, and with citizens directly
- Helps clinicians at every level to make better decisions & deliver better outcomes
- Improves understanding and management of how services work together and the demand for those services

- Foundation for safe, high quality care
- Enable health and social care to undertake joint decision making and provide joined-up care, benefiting everyone who receives health services, care and support
- Enable and accelerate multidisciplinary workforce under new models of care
- Support the co-ordination of care



Dame Fiona Caldicott
Information: To share or not to share? The Information Governance Review
March 2013

UHB's Objectives for Information Governance

- To protect the legal rights of all patients and staff in respect of confidentiality and privacy.
- To ensure that personal data is processed in compliance with the GDPR principles.
- To safeguard our information and systems and those of our partners (e.g. GPs, other HBs).
- To ensure we make appropriate use of ICT services, such as email and the internet.
- To provide our staff & care partners with access to the relevant and appropriate information they require at the point that it is required.
- To ensure that the value of the information that the UHB manages is increasingly realised.
- To transition services towards the appropriate adoption of the UHB's technical and data standards and achieve these by 2023.
- Opportunities to achieve improvements in the clinical and cost effective care provided by digital technologies are realised.
- To improve the ability of our population, patients, and staff to make timely, evidence based, decision making.
- To ensure our staff are valued, trusted and enabled.
- To ensure our staff are supported to better manage and balance work and 'out of work' commitments.
- To ensure we comply and act in the intended spirit of the Welsh Government's policy and notably the 'Once for Wales' design principles.

Scope

- IG 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
- Covers personal and business sensitive data.

Accountability and Governance

- Accountability is one of the data protection principles - it makes the UHB responsible for complying with the GDPR and to be able to demonstrate compliance.

- Requires appropriate technical and organisational measures to meet the requirements of accountability.

- We have adopted all of the measures we are required or recommended to take by legislation including:
  - adopting and implementing data protection policies;
  - taking a ‘data protection by design and default’ approach;
  - putting written contracts in place with organisations that process personal data on our behalf;
  - maintaining documentation of our processing activities;
  - implementing appropriate security measures;
  - recording and, where necessary, reporting personal data breaches;
  - carrying out data protection impact assessments for uses of personal data that are likely to result in high risk to individuals’ interests;
  - appointing a data protection officer; and
  - adhering to relevant codes of conduct and signing up to certification schemes.

- Working nationally we are contributing to and supporting the development of a new IG policy for health and care in Wales and the development of tools and frameworks to aid compliance and mitigate risks in an enabling manner.

UHB's accountability and governance structure for Information Governance

- Chief Executive is responsible for ensuring the highest level of organisational commitment to legislative and cultural requirements
- The Data Protection Officer (DPO), is responsible for 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.

UHB's accountability and governance structure for Information Governance

- 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 demonstrating compliance with legislation in respect of the data held, acquired, and stored within their assets and transferred from and to their assets.
- Managers are responsible for the implementation and compliance with the IG policy, the IT security policy and the IG training policy within their department/directorate. This includes ensuring that their users and staff are aware of these policies, understand their responsibilities and are up to date with mandatory information governance training.
- The Corporate IG team provides expert advice and is responsible for developing the strategy, delivery and contractual frameworks to mitigate the risk of non compliance. This includes co-ordination of activities across the UHB which would be beneficial to achieving compliance with legislation and supporting the SIRO in discharging their duties.
- Scrutiny and assurance is formally via the Informatics committee of the boards and discharged through the clinical board performance reviews and quality and safety committees.
- The approach of the UHB is to support and enable our staff to deliver health and care. In the domain of IG this relies heavily on 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.

Data Protection and Compliance

- Key aspects:
  - Fair and Lawful Processing
  - Information Asset Management
  - Individual’s Rights & Consent
  - Accuracy of Personal Data
  - Establishing new data processing activities
  - Records Management
  - Confidentiality
  - Sharing Personal Data
  - Data Quality
  - Data and Technical Standards

Information Security Scope

- User Access Controls
- Portable Devices and Removable Media
- Passwords
- Remote working
- Staff leavers list
- Storage of Information
- Internet and Email Use
- Transportation of data
- Secure disposal
  - Paper
  - Electronic

Progress to date

- Compliance with FOIs turned around with performance fluctuating around 90% in Q1, with sizeable backlog addressed. Although June-19 compliance was only 79%.
- Processes for dealing with non clinical record SARs are good with compliance at 94%. Timely response to requests for the clinical record continue to be challenging and the UHB is working with other NHS organisations, law firms and the ICO to minimise the size of the data requests.
- Establishing data protection as a standing item on all clinical board quarterly Q&S meetings – with corporate IG presence.
- E-learning compliance increased to 73%.
- Recognised Information Governance breach reporting process which allows quick analysis for incident management and consideration for the need to report to ICO.
- Established data protection contracts, joint controller agreement with GPs and risk based approach to indemnity requirements.
- 2 of the IG leadership team achieved post graduate qualifications in data protection and are progressing CPD.

Material Risks

- Cyber security attacks including unlawful user actions resulting in significant data breaches of sensitive personal information – Impact = 5 , Likelihood = 4
- Resource availability and competing priorities within clinical boards and corporate departments to mitigate risks of non compliance by operationalising IG and IT security policy – Impact = 4 , Likelihood = 4
- Disinvestment in departments increases stress and consequently raises absence levels, resulting in vicious cycle, adding to inability to deliver – Impact = 4 , Likelihood = 4
- The size of the fines levied by the ICO and the damages awarded by courts in 2 recent judgements (BA & Morrisons) are significant and handed down for non sensitive data. Thus our assessment of the impact of non compliance is under review and the willingness of smaller data controllers to share data at their own risk has reduced.
- Recording information inaccurately and unreliably, increases the potential for: poorer patient outcomes& experience; flawed analysis & benchmarking resulting in poor decision making; the under recovery of income & an inability to maximise potential of R&D – Impact = 4 , Likelihood = 4
- Using information in-effectively and unethically with DPIAs and DPCs not being completed prior to the contracts for services being signed increases the exposure of risk faced by the UHB and presents difficulties applying remedies against a third party (e.g. data processor, joint data controller) if data is not handled appropriately– Impact = 4 , Likelihood = 4
- UHB's IG policies and procedures are not up to date and/ or do not cover all relevant areas, increases both the likelihood of non compliance and the severity of any action taken against the UHB – with financial and reputational consequences that may materialist in patients and partners being wary of sharing data with us. – Impact = 4 , Likelihood = 4

Mitigation

National work programmes and standards for :

- Patient authentication, IT security, modern infrastructure and architecture, data standards, interoperability

Organisational plans:

- Cyber security action plan
- GDPR action plan.
- Infrastructure and Software refresh
- Internal audit action plan
- National Data Resource
- Quarterly Q&S and Digital Design Board to tactically manage difficult and cross-organisation issues

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	13/12/2013	15/08/2019	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.	IM&T implementation programme IT&G Sub 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.	01/06/2019	15/08/2019	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 and now needs consideration by Management Executive. However the recently agreed 0365 Licence agreement provides and extension of Windows 7 support beyond 2020.	IM&T implementation programme IT&G Sub 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,	2018	18/01/2019	Business and Organisational Strategy	DOI	4	4	16	10	MODERATE	Update 30/7/2019: 2 Business Analyst posts are now funded from regional ICF monies along with regional technical , programme and project lead resources. Timing of implementation will be based on objective functional assessment and tangible, delivered benefits from implementation of the system in a Health Board of similar size and service-scope. WCCIS is 'live' in 12 Local Authorities but only partially in 1 Health Board. WCCIS has been rejected by one Local Authority (Carmarthenshire, which is one of the OLM consortia).	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.	IM&T implementation programme IT&G Sub 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.		15/08/2019	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 currently underway pending planning for go live	IM&T implementation programme IM&T Sub 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.	13/12/2013	15/08/2019	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.	IM&T implementation programme IT&G Sub 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	28/09/2015	15/08/2019	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 training 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	IM&T implementation programme IT&G Sub 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	19/02/2018	15/08/2019	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 refocussed. It is currently not meeting due to IG staffing pressures	IM&T implementation programme IT&G Sub 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	16/02/2018	15/08/2019	Governance	SIRO/DD&HI	4	4	16	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 are greatly assisting process by referring all issues involving data sharing to the corporate IG department. Working with ICO on specific issues relating to the patient portal	IM&T implementation programme IT&G Sub 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.	16/02/2018	15/08/2019	Governance	SIRO/DD&HI	4	4	16	6	MODERAT	Update: Controlled document framework requirements delayed due to resource constraints - 3 key policies to go through the adoption process	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.	IM&T implementation programme IT&G Sub 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
6.8.1 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)	13/12/2013	15/08/2019	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.	IM&T implementation programme IT&G Sub 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"	02/02/2018	15/08/2019	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.	Further detailed discussions with NWIS needed	IM&T implementation programme IT&G Sub 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	28/09/2015	15/08/2019	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	IM&T implementation programme IT&G Sub Committee established to oversee progress Standards for Health Services: Information management and communications technology	D&HI
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.	13/12/2013	15/08/2019	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	IM&T implementation programme IT&G Sub 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	28/09/2015	15/08/2019	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.	National prioritisation for NWIS to open up the national data repositories	IM&T implementation programme IT&G Sub 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.	28/09/2015	15/08/2019	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	IM&T implementation programme IT&G Sub 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.	01/10/2018	15/08/2019	Governance	DD&HI	3	4	12	**4**	MODERAT	Establishment of a formalised corporate prioritisation mechanism based on benefits and corporate drivers for change.	New digitial 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.	IM&T implementation programme IT&G Sub Committee established to oversee progress Standards for Health Services: Information management and communications technology	D&HI

Cardiff and Vale University Health

Addendum 1

Information Governance Improvement Plan

Incorporating

- Information Commissioner's Office Data Protection Audit May 2016

Appendix A

Detailed findings and action plan

Action plan and progress

Recommendation	**Agreed action, date and owner**		**Progress at July 2019** Describe the status and action taken.
A4. Progress work to embed the Deputy SIRO, IAO and IAA structure within the Health Board throughout 2016 ensuring there are IAOs and IAAs in place for each information asset.	**Management Response:** Recommendation accepted. The UHB will ensure that: 1 -All IAOs and IAAs are in place 2- All have clear job descriptions 3 - All have received training - The IG training rate needs to be 76 – 100% 4 - All are actively performing their roles		**Partially Complete** **Evidence:** Asset registers continue to mature, with a flow mapping exercise for pan NHS flows near to completion. The IG policy has reviewed roles and responsibilities across the organisation and seeks to clarify expectations around information asset management and training. The present IG training rate is 73% **Following trials in two of the Clinical boards, all clinical boards will now have a section on their**

	Responsibility: Deputy SIROs/SIRO **Date for implementation:** Immediate – completion March 2017		**quality and safety committee agendas for clinical governance with corporate IG department presence.** From these meetings the UHB has started to develop a community of practice to provide mutual support to asset owners and administrators & share knowledge and lessons. The success of this approach can be seen by the following • The number of area specific Information Asset Registers (IARs) in place (see A37) • Take up of the role of system managers as set out in the Information Asset Register for corporate/large scale IT systems (see A37) The UHB has also made progress by tying in business continuity and the information asset register together in an aligned process.
A5. Ensure role specific training is completed by all current IAOs and IAAs and that a process is in place to ensure this training is completed by staff who are appointed to be a deputy SIRO, IAO or IAA in future within reasonable timescales.	**Management Response:** Recommendation accepted The UHB will ensure that: 1 - All IAOs and IAAs complete training by March 2017. 2 - All IAOs will be trained 4th November 2016 3 - All IAAs will be trained by March 2017		**Partially Complete** **Evidence** The Information Governance training policy describes the requirements on IAOs and IAAs and sets out a tactical approach to delivering this. The roles are also referenced in the all Wales IG training module which has been adopted by the UHB

	Responsibility: Deputy SIROs/SIRO/ **Date for implementation:** Immediate – completion March 2017		
A7. Ensure up to date information is available to staff through relevant policies and the intranet relating to the IG committee structure and specific roles within the IG Team including contact details.	**Management Response:** Recommendation accepted The UHB will ensure that the Information Governance Policy and supporting procedures will be updated at the end of its first full year to reflect the: 1 - evolving nature of the IG management framework 2 - high level controlled documents framework. **Responsibility:** SIRO **Date for implementation:** Immediate – completion March 2017		**Partially Complete** **Evidence** Policies have been reviewed & updated, re: - Information Governance which incorporates the IT security policy - Information Governance Corporate Training Policy Once approved by committee they will be updated on the intranet As at 1st July 2019 the IG website was up to date Please see also: A16 – 19 – updating of Information Governance policy.
A10. Document a clear process for Clinical Boards and Corporate areas to provide assurance to the DHIC.	**Management Response:** Recommendation accepted. The UHB will review the current arrangements to ensure that the CBs and corporate areas provide regular reports to the SIRO and DHIC		**Complete** **Evidence** See A14 for summary details of governance arrangements Assurance to the Information Technology and Governance Sub-Committee (DHIC – successor to IG

	Responsibility: Deputy SIROs/SIRO **Date for implementation:** Immediate – completion March 2017		and IT committees) is also provided via the following reports to which Clinical Boards/Corporate Depts contribute via their designated leads as per A4: • Risk register • Report of Caldicott Guardian • Integrated Governance Report/SIRO Report • Sensitive data issues report On a corporate level this is supplemented by the following audit work: • External – WAO e.g. Annual structured assessment, NHS digital risk assessment on IT and IG risks • Internal – regular covering in annual audit plan
A12. Create a role description for IG Leads and ensure this role is included within the wider IG structure to help raise staff awareness.	**Management Response:** Recommendation approved The UHB will ensure that a job description is provided for all IG leads. **Responsibility:** Head of IG **Date for implementation:** December 2016		**Partially Complete** **Evidence** See A4 – Covered by IG Policy – this needs to be formally agreed and actions implemented
A14. Develop an IG Strategy that sets out the Health Board's long-term IG vision and targets.	**Management Response:** Recommendation approved The UHB will ensure that there is an overarching plan that sets out		**Complete** **Evidence** Modern Architecture, Strong Governance is an established workstream in the UHB's 2019-22 IMTP. It

	the long term IG vision and targets. **Responsibility:** SIRO/ **Date for implementation:** December 2016		seeks to ensure that the accessibility and availability of data, whenever and wherever it is required, is central to the realisation of the UHB's 10 year strategic plan "Shaping our Future Wellbeing" (SOFW). An example of this is sharing of UHB and GP data to support the development of integrated care models. The UHB's IG strategy is therefore predicated on the premise that data must be handled at all times in an exemplary manner, demonstrating to our population and numerous partners who we would wish to share data with that we are trustworthy and using the data for improving health and wellbeing. The UHB's tactical approach to this has been to adopt the principles of Data Protection by Design, and is taking actions to embed IG good data protection practice into our routine procurement and operational practices in a way that is pragmatic and sensitive to the operational environment in which our staff operate. The focus is very much on attempting to make life easier for departments by providing the toolkits to ease the requirements (e.g. standard data protection impact assessments and contracts, information sharing protocols and disclosure agreements) & issuing 12 clear 'commandments' of steps staff can take to minimise the risk of non compliance. The UHB regards itself as leading the way in NHS Wales in terms of some areas of the governance arrangements supporting this: • DPO now appointed with dedicated generic e-mail address. Arrangements are being made

			to replace the current DPO who retires end April 2019. • Detailed privacy notices have been produced for both 'patients' and staff members which are widely available. These set out in detail the legal basis for the UHB to process personal data in relation to its core business activities. Legal advice has also been taken in terms of those settings where the Common Law Duty of Confidentiality (CLDC) applies and those where it does not. It is recognised that these are dynamic documents that will need to be kept under regular review. In particular, the patient facing notice will need to support the requirement under GDPR for special protection for children's personal data, particularly in the context of commercial internet services, such as social networking. In line with CPiP question 21, staff need to actively promote understanding of the ways in which patient/service user information is used, including where patient information is used for purposes other than direct care. It will also be important to be aware of emerging case law in relation to CLDC etc.
A 16, A17, A 18, A19, A21, A22 Create or update relevant policies and procedures as soon as practicable ensuring accompanying or	**Management Response:** Recommendation approved The UHB will ensure that the: Information Governance Policy and supporting procedures will be updated at the end of its first full year to reflect the evolving		**Partially Complete** **Evidence** 1 DHIC committee monitors progress through the Controlled Document Framework. Whilst primary focus of the UHB has been on improving compliance with FOI and GDPR legislation, the three main policies (IG, IG training and IT security)

supporting documents are clearly referenced. Introduce an annual review cycle of critical IG related policies and procedures in particular the Information Security Policy to ensure the policies are still relevant, fit for purpose and contain links to supporting documents	nature of the IG management framework and completion of the high level controlled documents framework. The UHB will ensure that the IT Security Policy will be completed by December 2016 **Responsibility:** SIRO **Date for implementation:** Immediate – completion March 2017		have been reviewed, updated and rationalised into one overarching IG policy. 2 Since the last meeting the policy has been updated for IT security and IG corporate training and is now awaiting formal ratification and implementation. 3 The proposed IG policy is based on the exemplar Information Governance policy developed by Welsh Government's Information Governance Management Advisory Group (IGMAG). This is being expanded to make it more relevant to a healthcare provider environment by adding the following sections: • Use of e-mail • Data standards and accessibility • Use of internet • Information security • Data protection by design • Training and awareness The aim of the policy is to give users a "one stop shop" in terms of accessing fundamental information about IG compliance. Further area specific policies/procedures will be developed as they are produced at a national level. E.g. An all Wales exemplar for Minimising non compliance with Freedom of Information requests is presently in development to which the UHB are actively contributing. The UHB Subject Access Procedure was updated to align it to GDPR. Following review by the UHB's lawyers, further work is being undertaken to ensure it is both achievable and comprehensive, recognising the scale of

			the organisation's operations and the complexity of NHS Wales data architecture.
A29. Add a reference relating to Information risk in the Risk Management Policy, Risk Assessment and Risk Register Procedure along with information relating to the role of the SIRO (for example, as they are in the procedures highlighted in A35).	**Management Response:** Recommendation approved The UHB will ensure that all risk management controlled documents are updated with specific reference to the information governance framework. **Responsibility:** SIRO/ **Date for implementation:** March 2017		**Incomplete** **Evidence** This will be effected as the IG policy is formally ratified
A32. Conduct a review to ensure all teams/ departments are maintaining an adequate up to date risk register in line with Health Board Policy and that all risk registers are reviewed on a regular basis.	**Management Response:** Recommendation approved. The UHB will ensure that: 1 - A review of risk registers is undertaken 2 -An annual review is undertaken **Responsibility:** Deputy SIROs/SIRO/ **Date for implementation:** Immediate – completion March 2017		**Partially Complete** **Evidence** In line with the GDPR action plan, significant clinical board risks relating to IG will be covered at the quarterly Q&S meetings. With corporate IG presence at these meetings we anticipate greater likelihood of success in standardisation and understanding "cross cutting" areas of risk and options for their successful mitigation. Where organisation-level responses to mitigating risks are required, these will be considered and prioritised at the digital design board.

			The over arching corporate risk register, which draws together the significant risks carried by the UHB is received as a standing item by the DHI committee. Risk issues are also covered in Information Asset Registers (A37).
A34. Report all IG related risks through the board committee on a regular basis.	**Management Response:** Recommendation approved The UHB will ensure that the DHIC will review all IG risks periodically. **Responsibility:** Deputy SIROs/SIRO **Date for implementation:** Immediate – completion March 2017		**Partially Complete** **Evidence** 1 - The IG Dept produces a risk register setting out all "cross cutting" areas of risk. This is received as a standing item by the DHIC 2 - The DHIC will also receive a schedule of "extreme" i.e. score 20+ IG tasks from the UHB CRAF twice a year, in July and December nb the format for the CRAF is under review.
A35. Review all policies and procedures outlining the information risk structure within the Health Board ensuring each role is clearly outlined and has a role description. Communicate the structure to staff throughout 2016 to ensure awareness is raised to facilitate full implementation.	**Management Response:** Recommendation approved The UHB will ensure that the Information Governance Policy and supporting procedures will be updated at the end of its first full year to reflect the evolving nature of the IG management framework, the information risk structure and the completion of the high level controlled documents framework. **Responsibility:**		**Complete Evidence** The IG policy has taken evidence and input from all NHS Wales organisations and their risk registers

	SIRO/ **Date for implementation:** Immediate March 2017		
A36. Implement regular risk assessments and reporting of information risks through the information risk structure for all information assets as soon as possible to provide assurance to the SIRO that information risk is being adequately controlled across the Health Board.	**Management Response:** Recommendation approved. See A4. This action will include routine information risk management activities. **Responsibility:** Deputy SIROs/SIRO/ **Date for implementation:** Immediate – completion March 2017		**Partially complete** **Evidence** See item A37 (IARs)
A37. Ensure IARs for each clinical board are completed as soon as possible, reviewed regularly and updated where necessary. Consider if these registers will feed into a Health Board wide IAR or who will have oversight of all Information Assets across the organisation. Review the contents of each IAR to ensure they include all manual records, smaller databases and medical	**Management Response:** Approve recommendation. The UHB will ensure that: 1 - All IARs for clinical boards will be completed as soon as possible and include all information assets. 2 - The corporate risk register arrangements will include a separate register for all information risks. **Responsibility:** Deputy SIROs/SIRO **Date for implementation:** December 2016		**Partially Complete** **Evidence** IARs are in place as follows: Clinical Boards The status of IAR completion is variable. Internal Medicine directorate IAR remains outstanding Corporate Depts An IAR has been produced setting out the following in relation to large scale IT systems: • IAO/IAA • System manager • Description of data processing undertaken

devices that may hold personal data.			• Legal basis • Data retention • Risk e.g. impact of down time • Business continuity plans • Other relevant issues e.g. arrangements for the protection of children's personal data In line with CPiP question 26, IARs need to comprehensively map all information flows, establish and record ownership subject to regular review.
A39. Provide enhanced access to Datix to relevant members of the IG team to ensure they are able to view all IG related incidents reported across the Health Board.	**Management Response:** Recommendation approved. The UHB will ensure that a process is developed to give access to the IG team so that they can view all IG incidents across the UHB **Responsibility:** Head of Information Governance **Date for implementation:** Immediate – completion March 2017		**Complete** **Evidence** Coding and functionality has been developed on DATIX to ensure that all incidents that could potentially relate to IG breaches can be identified from coding or deliberately flagged by reporters or managers. E-mail notifications are automatically sent to managers of the IG Dept and they have access to all such records and a review mechanism. These arrangements will be progressively refined. Reports on incidents that have IG implications are reported to DHIC in open and in committee settings. Incident reporting is covered in the "12 Commandments" podcast referred to in A4.

			The IG dept regularly takes advice via the ICO helpline on whether an incident needs to be reported to them, thus helping the UHB meet the 72 hour reporting deadline for relevant incidents.
A40. Consult external organisations using Datix within Wales to look into the feasibility of making IG a category on Datix. The current situation makes it difficult to conduct swift effective searches for IG related incidents across the organisation. If a category for IG incidents is introduced the Health Board should create alerts for all levels of information incident to be sent to the IG team and relevant directorate managers.	**Management Response:** Recommendation approved The UHB will ensure that a process is developed to create e-datix alerts to the IG team and IAOs. **Responsibility:** Head of Information Governance **Date for implementation:** January 2017		**Complete** **Evidence** Coding and functionality have been developed on DATIX at the UHB to ensure that all incidents that could potentially relate to IG breaches can be identified by coding or deliberately flagged by reporters or managers. E-mail notifications are automatically sent to members of the IG Dept, and they have access to all such records and a review mechanism. These arrangements commenced in January 2017 and are being progressively refined. Introduction of an IG incident category would require the agreement of the supplier to undertake this development. The procurement of a replacement for Datix has commenced and a request for this functionality in the new system has been made. .

A42. Conduct a review of incidents reported across the organisation to ensure directorates do not have backlogs of incidents that have not been adequately investigated or closed when actions have been completed.	**Management Response:** Recommendation approved The UHB will ensure that: 1 - A comprehensive review is undertaken 2 - A report is brought to the DHIC 3 - Actions taken to reduce and eliminate any backlogs 4 - A routine report to the QSCs and DHIC on persistent backlogs **Responsibility:** Deputy SIROs/SIRO/ **Date for implementation:** Programme September 2016 to March 2017		**Complete** **Evidence** All incidents have been reviewed and there is presently no backlog of outstanding issues.
A43. Update the incident reporting policies and procedures to ensure they reflect the current process followed within the Health Board. Information incidents should be defined as a specific type of incident with a specific procedure staff should follow in the event of such an incident occurring.	**Management Response:** Recommendation approved The UHB will ensure that the Incident, Hazard and Near Miss Reporting Policy and Procedure and a Guide to Incident Reporting is updated to include comprehensive reference to information governance. **Responsibility:** Director of Nursing		**Complete** **Evidence** The Incident, Hazard and Near Miss Reporting Policy and Procedure and a Guide to Incident Reporting has been approved. The procedure makes reference in S4.7 to the necessity to report relevant IG incidents to ICO. It is intended to have an IG incident reporting procedure that will be linked to this and will clarify the process to be followed in relation to specific incidents relating to information governance and the sanctions that could be taken in relation to staff who breach UHB policies and procedures in this area.

	Date for implementation: December 2016		The UHB recognises that it is essential for this process to be adopted and "mainstreamed" into operational practice.
A44. Create a PIA Policy Statement and amend and publish the Information Assets Change Procedure to include specific information about completion of PIAs interlinking this into project management procedures and to the PIA template as soon as possible.	**Management Response:** Recommendation approved. The UHB will ensure that: 1 – An Information Assets Change procedure is in place. 2 – A Data Protection Act Policy will be in place 3 - Both the above documents will reference Privacy Impact Assessments **Responsibility:** Head of Information Governance **Date for implementation:** December 2016		**Partially Complete** **Evidence** Included within the proposed but not yet ratified IG policy The UHB is committed to the principles of Data Protection by Design and has adopted the Data Protection Impact Assessment (DPIA) pro forma developed by IGMAG. The IG dept stresses the importance of users completing a DPIA where this is appropriate in the light of the scope of the data processing operating they are intending to undertake and any associated risks to data subjects.
A45. Include a link to the PIA template within the PIA Policy statement and supporting procedures and make completion of this template mandatory as part of the project approval process.	**Management Response:** Recommendation **Responsibility:** Head of Information Governance **Date for implementation:** December 2016		**Partially Complete** **Evidence** See A44

A46. All PIAs should be authorised by a relevant member of the IG team, reported through the DHIC and a log of all PIAs completed should be held by IG.	**Management Response:** Recommendation approved **Responsibility:** Head of Information Governance **Date for implementation:** December 2016		**Complete** **Evidence** A central log of DPIAs has been set up.
A50. Report an overview of all IG related incidents through the DHIC on a regular basis.	**Management Response:** Recommendation approved See B39/B40 The UHB will ensure that: 1 - An overview of all IG related incidents is reviewed periodically 2 - The development and access to the e-datix system will be supported to provide the tools for the IG team. **Responsibility:** Head of Information Governance **Date for implementation:** January 2017		**Complete** **Evidence** Coding and functionality have been developed on Datix to ensure that all incidents that could potentially relate to IG breaches can be identified from coding or deliberately flagged by reporters or managers. E-mail notifications are automatically sent to managers of the IG dept, and they have access to all such records and a review mechanism. These arrangements will be progressively refined. Incidents will continue to be reported to DHIC as per existing arrangements.

A51. Introduce a programme of IG spot checks/ confidentiality audits across the Health Board. Consider utilising the IG Leads, IAOs or IAAs within each CHB or incorporating these checks into a programme of clinical checks or security checks already in operation.	**Management Response:** Recommendation approved The UHB will ensure that: 1 - There is an audit/spot check programme in place. 2 - They are recorded and reported to the SIRO as part of the IG reports. 3 - They are reported to the DHIC **Responsibility:** Deputy SIROs/SIRO **Date for implementation:** March 2017		**Partially Complete** **Evidence** Directors and senior staff are aware that a proactive IG awareness culture is a key enabler supporting realisation of SOFW (the UHB's 10 year strategic plan). They are therefore encouraged to report any incidents, issues etc from which relevant lessons can be learned. These incidents are picked up in reports submitted to DHIC as per item A10. The UHB has a number of tools for user access and security audits, which are used largely on a re-active basis.
A53. Make clear how compliance with each IG related policy will be monitored and put procedures in place to ensure this happens as set out in policy.	**Management Response:** Recommendation approved The UHB will ensure that each policy will set out monitoring arrangements as part of the overall policy review as described in A7. **Responsibility:** Deputy SIROs/SIRO **Date for implementation:** Immediate – completion March 2017		**Complete** **Evidence** All new and updated policies will have a section on compliance and audit. Monitoring arrangements need to be finalised by annual audit plans. Details of future internal audit reviews of IG arrangements will be submitted to DHIC.

B1. Ensure that as the newer management structures mature, the framework is assessed to ensure the original goals are being met and it remains an effective mechanism for managing UHB's records management responsibilities.	**Management Response:** Recommendation approved The UHB will ensure that: Policies and procedures will be: updated to reflect the matured management arrangements. All IG leads have clear job descriptions and training. Arrangements in place to check that Deputy SIROs, IAOs and IAAs are performing to target. **Responsibility:** Deputy SIROs/SIRO **Date for implementation:** Immediate – completion March 2017		**Partially Complete** **Evidence** Updated records management policy agreed. Retention arrangements aligned to Information Governance Alliance guidelines (adopted by Dept of Health). These now need to be reviewed in the light of the requirements of the Infected Blood Enquiry. Older policies to be updated in annual reviews. Task lists circulated (NB see A4) This work overlaps with Health and Care Standard 3.5
B5. Review the mechanisms that are in place to direct changes in records management policy throughout the UHB. Ensure there are mechanisms that cover all the areas of UHB and provide for feedback to give assurance that changes have been	**Management Response:** Recommendation approved The UHB will ensure that: 1 - Records policy and controlled document changes are disseminated through the IG management framework. 2 - This responsibility will be clearly documented in policy.		**Complete** **Evidence** Records Management Procedure approved by former PPP Committee in September 2016. Updated records management policy agreed by Chair of Resources and Delivery Committee (subject to ratification by full Committee on 31 January 2018).. Retention arrangements aligned to Information Governance Alliance guidelines (adopted by Dept of Health)

successfully implemented.	3 - Arrangements are in place to assure the SIRO that any changes are successfully implemented. **Responsibility:** Deputy SIROs/SIRO **Date for implementation:** Immediate – completion March 2017		Current version of policy posted on UHB Policy site. 1 Dissemination of documentation follows the UHB Policy for Management of Policies and other Control Documents
B9. Ensure that ongoing work is monitored and carried on to successful completion.	**Management Response:** Recommendation approved The UHB will ensure that the records audit improvement plan is monitored routinely by the DHIC. **Responsibility:** SIRO **Date for implementation:** Immediate –completion March 2017		**Partially Complete** **Evidence** 2 See B5
B10. Update the posters with the correct web address.	**Management Response:** Recommendation approved The UHB will ensure that the posters are updated. **Responsibility:** Head of Information Governance		**Complete** **Evidence** Poster amended on line and link working. Mechanism needed to ensure that the posters are kept up to date

	Date for implementation: September 2016		
B12. Consider altering the website to increase the keywords that return information on processing personal information, or providing a clear link to the fair processing information in the footer of web pages.	**Management Response:** Recommendation approved The UHB will ensure that the website is altered to include keywords that return information on personal information **Responsibility:** Head of information **Date for implementation:** September 2016		**Complete** **Evidence** Upgraded link to fair processing information
B13. Ensure there is a written requirement that changes to documents that constitute the UHBs fair processing notices to patients are agreed with IG.	**Management Response:** Recommendation approved The UHB will ensure that all documents that constitute the UHBs fair processing notice are approved by the IG team. **Responsibility:** Head of Information Governance **Date for implementation:** September 2016		**Complete** **Evidence** DPA Policy. Clinical Boards/Corporate Depts informed that all fair processing notifications must be approved by the IG team.
B15. See A37	**Management Response:** Recommendation approved The UHB will ensure that:		**Partially Complete** **Evidence** 1. All areas are developing/reviewing their IARs.

	All IARs are completed by July 2017 The area referred to in this finding completed a first draft in June 2016. **Responsibility:** Deputy SIROs/SIRO **Date for implementation:** December 2016		2. They are being developed at varying rates between services and progress is slow generally across the organisation (approximately 15 submitted in total to date) 3 The issue of where responsibility lies in relation to the management of corporate information assets e.g. IT systems that have multiple users such as PMS still needs to be resolved.
B16. Storage areas should be regularly audited to check for any risks that have developed to either the information held or the efficacy of the records management systems.	**Management Response:** Recommendation approved The UHB will ensure that all areas that store records have a rolling programme of audit **Responsibility:** Deputy SIROs/SIRO **Date for implementation:** Immediate – completion March 2017		**Partially Complete** **Evidence** Central Medical Records Dept have developed a robust system underpinned by Standard Operating Procedures (finalised SOPs taken to MRMG for noting). Where not in place these need to be replicated in all other settings where this has not already been done. This process is overseen by the Medical Records Operational Group (MROG) although Clinical Boards and Corporate Depts will need to engage with central management in this process.
B19. Ensure that there are written processes available for staff to follow relating to the processing of medical records. These processes should include what happens if	**Management Response:** Recommendation approved The UHB will ensure that: All areas will have documented procedures related to the records management. All areas will have documented		**Partially Complete** **Evidence** Central Medical Records Dept are developing a robust system underpinned by Standard Operating Procedures When finalised these SOPs need to be taken through MRMG for noting. This needs to be replicated in devolved areas. This process will be overseen by the Medical Records Operational Group (MROG) although

records are not locatable. (See below).	procedures for the tracking and tracing of records. **Responsibility:** Deputy SIROs/SIRO **Date for implementation:** Immediate – March 2017		Clinical Boards/Corporate Depts will need to engage with central management in this process In line with CPiP the following procedures are required: Question 32 - identification and resolution of duplicate or confused paper and electronic records for patients and service users Question 33 – monitoring, measurement and tracing of paper health records
B20. The written processes for the processing of medical records should include a clear workflow for dealing with missing records. They should also include at what points the status of the record should be recorded for monitoring purposes. These figures should then be used to reduce the incidents of lost or missing files. The monitoring of outcomes would also provide useful information to establish patterns that could be addressed.	**Management Response:** Recommendation approved The UHB will ensure that: There is clear guidance on how to manage mislaid, missing and lost records. There are documented procedures that support the guidance. **Responsibility:** Deputy SIROs/SIRO **Date for implementation:** Immediate –completion March 2017		**Partially Complete** **Evidence** Central Medical Records Dept has produced SOP HR011 "Missing Health Records". Relevant elements were to be incorporated in an updated UHB Incident Reporting Procedure, however it has subsequently been decided this detail could be better placed in a dedicated IG/data protection incident procedure. This should include a flow chart showing, on a step by step basis, the action necessary when any Medical Record is not available and mitigation if required information if available via other sources i.e. Clinical Portal (as per notes of Medical Records Management Group on 10 January 2016).
B22. Ensure there are suitable disaster recovery plans in place	**Management Response:** Recommendation approved The UHB will ensure that:		**Partially Complete** **Evidence**

covering all business critical records.	- All areas will have comprehensive disaster recovery plans in place -The plans will be tested routinely **Responsibility:** /SIRO/Deputy SIRO **Date for implementation:** Immediate – completion March 2017		1. Disaster recovery (DR) plans are in place covering corporate and some local IT systems 2. Business continuity (BC) plans need to be developed in all settings 3. DR and BC plans need to be tried, tested and regularly reviewed. 4. The above arrangements need to be covered in Medical Records SOPs.
B23. Prioritise the digitisation of records held by the UHB.	**Management Response:** Recommendation approved The UHB will ensure that: The expansion of digitisation remains high priority. It will make best efforts among competing priorities to fund expansion. **Responsibility:** Deputy SIROs/SIRO/COO **Date for implementation:** 2017/2018		**Partially Complete** **Evidence** 1. The Digital Health Record (DHR) programme has now successfully scanned over a quarter of a million Emergency Unit (A & E) attendances since June 2016. 2. In line with the IM & T Strategic Outline Plan, discussion on the expansion of the wider DHR programme has centred on sustainable expansion and thus the importance of exploring paper light/less options, as well as the ability to retrieve data and ultimately sit well within an EHR platform. The following key points have been agreed: • The adoption of an electronic patient record is an essential platform for the realization of evidence/outcome based, pathway driven care. • Key objectives for delivery are appropriately represented by the Once for Wales design principles: 3. Current strategy is thereby focussed on use of e-forms and specifically e-progress notes, which integrate with the UHB's IT infrastructure and with

			specific regard to future national requirements. Funding has been made available by both WG and the UHB to increase the pace of this work as above.
B24. Ensure that the SOPs in place are as comprehensive as a policy or series of policies, outlining the key requirements for the correct storage, handling and transport of medical records.	**Management Response:** Recommendation approved The UHB will ensure that: All areas will have documented procedures related to all aspects of record management. All procedures will be linked to the Records Management Policy and procedure. **Responsibility:** Deputy SIROs/SIRO/ Heed of Information Governance **Date for implementation:** Immediate – completion March 2017		**Partially Complete** **Evidence** 1. See "Transportation of Case notes and PII procedure". Central Medical Records has produced its own SOP which reflects this. 2. Consideration needs to be given to having equivalent documentation in all settings.
B26. Ensure the Data Protection Policy and Data Security Guidance reference the transport of paper records, and the specific procedures in place.	**Management Response:** Recommendation approved The UHB will ensure that: The updated Data Protection Policy will reference the transportation of papers records procedure. The Data Security Policy and procedures will reference the transportation of papers records procedure		**Complete** **Evidence** Data Protection Policy and Transportation PII procedure covers this item.

	Responsibility: Head of Information Governance **Date for implementation:** January 2017		
B30. Ensure that there is enough space for records to be stored, either through finalising the commissioning of the new offsite storage, or through weeding and disposing of records that have exceeded their retention date.	**Management Response:** Recommendation approved The UHB will ensure that an integrated plan and costs is considered urgently: All records that have exceeded their retention date and cannot meet the test for continuing retention should be identified and disposed of. Medical record digitisation should be expanded. The remaining requirement for physical storage facilities on site should be defined. It will make best efforts among competing priorities to fund the requirements. **Responsibility:** Deputy SIROs/SIRO **Date for implementation:**		**Partially Complete** **Evidence** 1. The UHB has provided additional off-site storage. Implementation commenced in August 2017. 2. Retention arrangements have been clarified with the approval of the revised Records Management Policy at the meeting of the Resource and Delivery Committee on 30 January 2018. 4. The UHB has discussed a strategy for the expansion of digitisation (B23). The following key points have been agreed: • The adoption of an electronic patient record is an essential platform for the realization of evidence/outcome based, pathway driven care. • Key objectives for delivery are appropriately represented by the Once for Wales design principles:

	Immediate – programme for 2017/18		
B32. Revoke access to areas containing central medical records for all staff not under the direct control of the Outpatients and Health Records (Central) directorate manager. Where push-button code locks are used change the code on a regular basis and keep the combination restricted to records staff.	**Management Response:** Recommendation approved The UHB will ensure that: Pending the closure of the library, entry codes will be changed regularly. Access lists will be reviewed, updated and streamlined. An updated business case for the closure of the central medical records library is completed and considered by the HSMB. It will make best efforts among competing priorities to fund expansion. **Responsibility:** Deputy SIRO CDT/COO **Date for implementation:** September 2016		**Partially Complete** **Evidence** 1. POD for "Restricted Access to Health Records Libraries and Assurance in Locating Health Records" was submitted in November 2016 as part of the 2017/8 planning process but not supported A revised version has been submitted for the 2018/9 cycle 2. The CD&T Clinical Board is again considering the bid amongst its funding allocation in anticipation central resource is unlikely to be allocated/redistributed. 3. However, there has been a successful capital bid for the redesign of the "front of house" section of UHW Health Records. This provides an enabler for a "click and collect" service should the required staffing resource follow. 4. CD & T Clinical Board is embracing a trial of this service in partnership with Surgery Clinical Board to fully assess resource requirements and benefits realisation ahead of any planned expansion. 5. The results of this "restricted" trial and particularly the impact on medical record availability rates, efficiency levels and staff resource, will be shared through MRMG/IT&GSC. 6. In the interim where push button codes are used they are routinely changed, whilst funding is being sought to replace these with electronic access controls (part of this aligned to the capital redesign).
B34. Continue to seek a solution to allow full	**Management Response:** Recommendation approved		**Partially Complete** **Evidence**

audit trails to be logged in case of a query.	The UHB will ensure that discussions with health records, software provider and IM&T move on efficiently. **Responsibility:** Deputy SIRO CD&T **Date for implementation:** December 2016		1. Discussions are on-going 2. The EDRM (Electronic Document and Records Management) does have comprehensive audit functionality and will log users and usage. 3. Reports are in development to more readily monitor and share information as part of the channels of information security management and administration. 4. Aligned to this are plans to mirror the active directory associated with the Clinical Portal for the EDRM, specifically in terms of access restrictions. **5.** However, break glass functionality exists for results. A similar process for an entire record requires whole scale clinical review.
B36. Ensure that there is a procedure that defines the actions to be taken in response to a missing or lost record. Ensure figures are correctly reported so trends can be identified and tackled as part of departmental monitoring.	**Management Response:** Recommendation approved See B20 The UHB will ensure that arrangements are in place. **Responsibility:** Deputy SIRO/SIRO **Date for implementation:** Immediate – completion March 2017		**Partially complete** **Evidence** See B20
B37. Consider adding IG issue as an option on the Datix system for flagging up to the IG team (see also a40).	**Management Response:** Recommendation approved See A39 and A40 The UHB will ensure that a process is developed to give		**Partially Complete** **Evidence** Coding and functionality have been developed on Datix to ensure all incidents that could potentially relate to IG breaches can be identified from coding or deliberately

	access to the IG team so that they can view all IG incidents across the UHB. **Responsibility:** Head of Information Governance **Date for implementation:** January 2017		flagged by reporters or managers. E mail notifications are automatically sent to members of the IG Dept and they have access to all such records and a review mechanism. These arrangements will be progressively refined. See also B20 specifically in relation to missing notes.
B38, 39. Begin the process of confidentially destroying all records that have passed their retention date in line with the UHB retention schedule. Where not already present senior managers should put in place procedures to ensure that staff members reporting to them who have responsibility for the destruction of expired records are carrying out that obligation.	**Management Response:** The UHB will ensure that an integrated plan and costs is considered urgently: All records that have exceeded their retention date and cannot meet the test for continuing retention should be identified and disposed of. Medical record digitisation should be expanded. The remaining requirement for physical storage facilities on site should be defined. It will make best efforts among competing priorities to fund the requirements. **Responsibility:** Deputy SIRO /SIRO		**Partially complete** **Evidence** Retention arrangements have been clarified with the approval of the revised Records Management Policy at the meeting of the Resources and Delivery Committee on 30 January 2018. Services are now embarking on destruction programmes aligned to this, which will include revising or developing local SOPs to bolster governance of the process. Resource for the destruction has not commonly been factored into budgets and as such delivery of plans may be hindered. See also B30.

	Date for implementation: December 2016 for 2017/18		
B41. The ICO recommends that there should wherever possible be only one copy of information to reduce the chance of updates not being reflected across all copies. With multiple copies there is also an increased risk of incorrect handling. Review all records that are held in multiple formats to ensure that there remains a compelling reason to keep all the copies. Where they are to be kept, there should be written procedures to ensure the accuracy of the records is maintained.	**Management Response:** Recommendation approved The UHB will ensure that: Unnecessary printing of paper records is minimised. Digitisation is expanded B23 and B31. Duplicate paper medical records are managed and merged. Disposal schedules are adhered to B3. Spot checks and audits will check record accuracy. **Responsibility:** Deputy SIRO/SIRO **Date for implementation:** Immediate – completion March 2017		**Incomplete** **Evidence** 1. UHB is moving to paper lite organisation. One example of this is avoiding duplication of e-results by eliminating paper copy. 2. Procedure for merging duplicate medical records for patients presenting at OPs to be produced. 3. A plan to implement a medical records destruction programme is agreed. 5. Further discussions have been held regarding a digitisation strategy. The following key points have been agreed: • The adoption of an electronic patient record is an essential platform for the realization of evidence/outcome based, pathway driven care. • Key objectives for delivery are appropriately represented by the Once for Wales design principles:
B43. Ensure there is a mechanism to regularly review the new retention schedule and up-date it as necessary in the future.	**Management Response:** Recommendation approved The UHB will ensure that: The retention and destruction protocol and procedure is aligned		**Partially Complete** **Evidence** Records Management Procedure approved by former PPP Committee in September 2016. Updated records management policy agreed in principle by Chair of

	with the records management policy. Its review date is recorded in the controlled documents framework. It is monitored by the DHIC routinely. **Responsibility:** Head of Information Governance/DHIC **Date for implementation:** September 2016		Resources and Delivery Committee (subject to ratification by full Committee on 31 January 2018).. Retention arrangements aligned to Information Governance Alliance guidelines (adopted by Dept of Health)
B49. Raise staff awareness (for example, through posters near the bins) of who to contact should a bin need emptying.	**Management Response:** Recommendation approved The UHB will ensure that the guidance poster is re-circulated to all areas **Responsibility:** Deputy SIROs **Date for implementation:** September 2016		**Complete** **Evidence** A4 sheet Waste Management Guidance circulated to IG leads August 2016. This needs to be displayed in all areas and on or near bins
B50. Carry out regular inspections of the contractor's facilities to gain assurance that the disposal of confidential waste is being carried out securely and in	**Management Response:** Recommendation approved The UHB will ensure that: An annual visit to the company to check operational and environmental matters is undertaken.		**Partially Complete** **Evidence** 1. Annual visit made in November 2016 with subsequent annual review dates scheduled Clarification needed of any arrangements made by other departments with firms other than Datashred

accordance with the contract provisions.	An annual meeting is held to discuss performance standards. **Responsibility:** Deputy SIRO CD&T/Head of Procurement **Date for implementation:** Immediate – completion March 2017		2. Further discussion needed via MROG to discuss contract and performance measures.
B52. If not already completed, review the mechanisms in place for recording the evidence of destruction. Particular attention should be given to ensuring there a trackable record of the destruction of patient notes.	**Management Response:** Recommendation approved See B50 The UHB will ensure that an urgent review of this matter will be undertaken **Responsibility:** Deputy SIRO CD&T/Head of Procurement **Date for implementation:** Immediate – completion March 2017		**Partially Complete** **Evidence** 1. To be discussed in the meeting with DataShred. 2. This is covered in the SOP for EU cards The UHB Records Management Retention and Destruction Procedure includes a template destruction certificate.
B53. Review the reports submitted for monitoring purposes. Establish if they provide enough information to be used for gaining assurance.	**Management Response:** Recommendation approved See B50 The UHB will ensure that: A range of performance metrics are developed.		**Partially Complete** **Evidence** There is a medical records scorecard (attached) with some KPIs (e.g. use of temporary folders) but arrangements for using this to submit monitoring data to DHIC need to be formalised

	-Routine reports will be developed for operational use and for assurance at the clinical board QSE and DHIC. **Responsibility:** Deputy SIROs/SIRO/COO **Date for implementation:** March 2017		
B54, 55. Complete the establishment of performance measures that can be used to ensure that a clear picture of the state and effectiveness of records management is available to those responsible for it.	**Management Response:** Recommendation approved The UHB will ensure that: A range of performance metrics are developed. Routine reports will be developed for operational use and for assurance at the clinical board QSE and DHIC **Responsibility:** Deputy SIRO/SIRO/COO **Date for implementation:** Immediate – completion March 2017		**Partially Complete** **Evidence** See B53
B56. Regularly review MRMG's progress in relation to meeting its targets to ensure its effectiveness.	**Management Response:** Recommendation approved The MRMG is a working group of the DHIC.		**Partially Complete** **Evidence** 1. Annual work plan in place 2. DHIC monitors performance. Assurance outstanding on some points.

	The DHIC will ensure that the MRMG: Has an appropriate work plan linked to record management audits, and standard requirements. Is discharging its duties and demonstrating progress in the group minutes. Is escalating any risks identified. **Responsibility:** DHIC/MRMG Chair **Date for implementation:** Implemented		3. Minutes received by DHIC. Process is for Chair to raise any items to be escalated.
B57. Regularly (for example, annually) conduct internal records management audits.	**Management Response:** Recommendation approved The UHB will ensure that: A range of performance metrics are developed. Routine reports will be developed for operational use and for assurance at the clinical board QSE and DHIC. **Responsibility:** Deputy SIRO/COO/SIRO		**Complete** **Evidence** 1. Internal audit May 2015 2. ICO audit May 2016 3. Internal Audit March 2017 of MH and CD & T CBs will cover aspects of records management

	Date for implementation: Immediate – completion March 2017		
C1. Complete the draft of IT Security policies (and associated procedures) and implement these. Ensure they are subject to regular review. They should also identify who is responsible for carrying out this review and how often it will be completed.	**Management Response:** Recommendation approved The UHB will ensure that the IT security policy and procedures/guidance will be completed. **Responsibility:** IT Security Manager /DHIC approval **Date for implementation:** December 2016	.	**Complete** **Evidence** 1. IT security policy approved by the PPP 2. Procedures now completed 3. Responsible officer is IT security manager 4. Review annually initially and thereafter three years.
C6. Ensure that users of Good App have to change their passwords regularly.	**Management Response:** Recommendation approved: The UHB will ensure that the Migration by the UHB from Good for Enterprise to GOOD for Works will implement a three month complex password change **Responsibility:** Technical Development Network and Support Manager **Date for implementation:** December 2016		**Complete** **Evidence** All Good Users are being migrated onto the Good for Works platform which requires enforced complex password change. Users now need to change their passwords every 3 months. Linked to this CPIP Question 39 requires that strong passwords need to be used on all systems and changes enforced on a regular basis.
C8. Ensure there are formal requirements in	**Management Response:** Recommendation approved		**Complete** **Evidence**

the revised policies for the use of mobile media to be signed off by managers and staff with their use reviewed at least annually. There should also be consideration for additional training and ensure that staff sign to say they've read and understood the associated policy. Consider building on the process already in place for managers to authorise the payments and ensure these elements are in place for future plans to allow home working for non-NHS owned devices.	The UHB will ensure that the revised Remote Working Procedure includes the above **Responsibility:** Technical Development Network and Support Manager **Date for implementation:** December 2016		Remote working procedure approved in September 2016.
C11. Implement end point security to ensure that only approved devices can be used on UHB systems. Ensure that where information is transferred to removable media that encryption is forced as a default. Also implement and review audit logs of the information that is	**Management Response:** Recommendation approved The UHB will ensure that the solution is planned to be tested in the summer and its implementation is subject to a risk assessment and a funding stream being identified by the UHB. **Responsibility:**		**Complete** **Evidence** BitLocker now being used on all laptops. Migration to Microsoft 7 Enterprise for UHB standard O/S has commenced. This is the most cost effective option. Phil Clee to advice.

copied to removable media.	Technical Development Network and Support Manager **Date for implementation:** March 2017 (subject to funding)		
C22. Review the use of generic accounts to ensure they are still required. Ensure there are compensatory controls in place to mitigate the risks of unauthorised access. For example, restricting which PCs can access generic accounts, ensuring PCs that can access generic accounts are in restricted areas, minimising the records that can be viewed to the those in the particular area, and ensuring that audit trails are in place to monitor access.	**Management Response:** Recommendation approved The UHB will ensure that: The need for generic accounts is reviewed and where they remain mitigation of risks is applied. Access rights will be reviewed **Responsibility:** Deputy SIROs/SIRO **Date for implementation:** To be completed by March 2017		**Incomplete** **Evidence** In the short term the HB recognisies this risk and PC generic accounts are only allocated to users in secure areas. However, it is potentially possible for users knowing generic accounts to log on in other areas. The uHB will address itself to removal of this risk as part of the Office 365 deployment which will require non generic accounts across the organisation.
C24. Implement formal methods to monitor staff access rights and ensure managers are reviewing these. For example, require managers to confirm on a regular basis that	**Management Response:** Recommendation approved The UHB will ensure that: All access rights are reviewed and updated regularly.		**Partially Complete** **Evidence** 1. Managers determine the need for access levels for all staff on recruitment or transfer to another role within the UHB or when leaving the organisation. Formal documentation is completed and shared with IT security team.

current access levels are still required. Consider auditing a sample of these to ensure what is being reported is accurate.	Correct procedures are completed when staff transfer within the UHB or leave the UHB. This forms part of the clinical boards IG annual programme. This forms part of the IG annual report that goes to the SIRO/DHIC for assurance. **Responsibility:** Deputy SIROs/SIRO **Date for implementation:** March 2017		2. Managers will spot check this as part of their responsibilities as IAOs
C29. Review current arrangements and confirm that measures to prevent this type of access are not available. If it cannot be prevented, ensure that its mitigation is considered during hardware/ software refreshes. Establish whether current audit trails record users logging to their PARIS or PMS accounts through another user's Nadex. Include these parameters in any	**Management Response:** Recommendation not approved **Responsibility:** **Date for implementation:**		This recommendation was not agreed by the UHB and remains under discussion.

automated auditing tools that are implemented.			
C38. Implement proactive monitoring of audit log data to help ensure that access is appropriate.	**Management Response:** Recommendation approved The UHB will ensure that: the need to expand NIIAS monitoring will be brought to the attention of the Board. Business case to be provided to inform to best way forward **Responsibility:** SIRO/Caldicott Guardian **Date for implementation:** March 2017		**Partially complete** **Evidence** 1. The function for monitoring system access is subject to review given the current and future requirements and the need for adequate number and expertise to deliver the service. 2. Consideration is being given to making available resource to undertake a nominal amount of compliance auditing both in relation to Welsh Clinical Portal (via NIIAS) and UHB systems.
C57. Update older software to ensure that both the server and the system are supported. Where the use of server 2003 has to be continued, ensure that it is captured within an information security risk register until such time as Windows server 2003 can be updated.	**Management Response:** Recommendation approved The UHB will ensure that: All systems capable of being upgraded within the current deployment have been upgraded. All systems not upgraded are subject to continuing review and will be upgraded when situation change enables this upgrade to take place. A risk register will be created to		**Partially Complete** **Evidence** The process of migrating users applications onto Microsoft supported software continues. Completion date to be confirmed. Latest figures are the uHB has reduced this figure by 75%

	identify and support management of non upgraded systems. **Responsibility:** Owning Service Department/Development Manager **Date for implementation:** The process has started		
C59. Ensure that PCs using Windows XP are updated.	**Management Response:** Recommendation approved The UHB continues to upgrade its XP device infrastructure to Windows 7 and above with a planned completion by the end of the year, subject to suitable funding by the UHB. The UHB has increased its virus scanning and is reviewing options for firewall “packet” scanning for malware, which is dependent on identifying a suitable product and a funding stream the UHB. **Responsibility:** Technical Development Network and Support Manager **Date for implementation:** March 2017		**Complete** **Evidence** The UHB has 68 Windows XP PCs which cannot be upgraded. The IT dept is working with clinical boards to ensure that as many possible of these PCs are removed from the network as functions undertaken by these PC's are replaced.

C66. Ensure that removal of old exceptions for the firewall is formalised and carried out regularly.	**Management Response:** Recommendation approved The Firewall Rules will be updated when the new hardware is installed later this year. **Responsibility:** Network manager **Date for implementation:** Immediate – completion March 2017		**Complete** **Evidence** • Old firewalls are reviewed on a regular basis • New firewall rules have a 12 month allocation
C67. Implement appropriate time constraints to network access through the firewall.	**Management Response:** Recommendation approved The UHB will: Implement a rule for N3 firewall access where access will be added for a set period of time. To remain in the firewall, additional access will be required, this will be the same form submitted with an extension of time. Failure to complete the form adequately will mean a removal of the firewall rule. At present calendar reminders will be used to do this. Long term the UHB will need to assess if it can get this added as a flow management in service point.		**Complete** **Evidence** Time rules are allocated to those applications that are only supported during operational hours. Applications that have remote management Out of Hours cannot have this function enabled.

	Responsibility: Network Manager **Date for implementation:** September 2016		
C68. Implement methods to automate the process of monitoring firewall activity. Ensure that reports generated about inappropriate firewall activity are considered for reporting through the incident management process.	**Management Response:** Recommendation approved The UHB will ensure that: The Cisco firewall manager's latest version that is currently being installed is completed The UHB has syslog/traps enabled at a high rate but activity is exceptionally high. Further investigations dependent upon risk assessment and identification of funding streams required. **Responsibility:** The network manager **Date for implementation:** March 2017		**Complete** **Evidence** The UHB firewalls have the latest version operational The UHB has procured CISCO fire-power to its internet Facing PBSA Link. These are fully operational at the 2 boundary entrances to the UHB.

I can confirm that this management response is a true representation of the current situation regarding progress made against our Action Plan outlined in the ICO Data Protection Audit Report dated July 2016.
Signature……
Position……
Organisation……

Report Title:	**IT Delivery Programme – Exception & Issues Report**								
Meeting:	Digital and Health Intelligence Committee					**Meeting Date:**	15th August 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 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:**

- Intelligent Citizen Portal
- Integrated digital health and care record
- Data to knowledge programme

Being built on **3 enabling programmes:**

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

Designed around the **federated national data repository and interoperability hub,** which, once in place, will enable us to progress at greater pace and scale.

ASSESSMENT

The UHB has made good progress in delivering the following IT Delivery Programme priorities since the last Committee:

Local / National Projects

- Upgrade Universal Viewer and Enterprise Archive complete (Cardiology Systems)
- Upgrade to MUSE ECG system complete – this enables ECGs to be shown within the clinical portal
- Implementation of the new BrainLab system (neurology theatres) will be complete W/C 5th August 2019
- Implementation of the new EEG system into neurology due to go live 23rd September – all preparation work complete
- Pharmacy system replacement programme – due to go live April 2020 – IT preparation work with the service commenced

- National Critical Care system – procurement underway – award of contract expected October 2019
- E-Nursing pilot due to commence September 2019 – IT requirements complete and ready to support pilot
- IT requirements to support the ChatHealth Web application – complete

Welsh Clinical Portal and GP Test Requesting

- WCP v3.10 successfully went live in CAV on 31st July which allows CAV to commence a pilot of Hospital to Hospital e-Referral functionality with Cardiology and Cardiac Surgery. CTM Health Board will also be part of the pilot.
- NWIS have reconvened the Electronic Test Requesting National Project Board to take forward improvements to the ETR software which is expected to encourage take up.
- Supportive letter sent out to Health Board clinicians from Chief Operating Officer and Medical Director regarding rollout of Pathology Electronic Test Requesting into Cardiff and Vale's Outpatients Dept
- WCP Results and Notifications pilot in Gastroenterology commenced in June (Dr Jeff Turner's team) and is going well. This enhancement alerts clinicians to test results in WCP for their patients.
- Dr Steven Short has commenced a GP Test Requesting Pilot at the Saltmead Medical Practice. Blood Sciences test requests only in the first instance.

PARIS

- GPs involved in cluster working have been provided access to Paris from their existing desktop PCs, with a view to rolling this model out to the wider GP community in the region.
- CAMHS services repatriated from Cwm Taf went live on Paris in April; phase two, now underway, will support the implementation of a full clinical recording tool-set for the service, reducing reliance on paper records.

e-Optometry Project

- The e-Optometry (Referral) system developed by the UHB to become the national solution enabling "safe and secure" connectivity by every Optometric Practice in Wales into web applications "hosted in NHS Wales. The UHB has been award 7 years funding to support the application nationally
- In parallel a procurement for a National Eye Care Digitisation solution is underway, the solution will be hosted within three regions for NHS Wales. Tenders have been received and the projected go live is for Glaucoma services in all three regions to be available by 31st March 2020.
- The UHB have received £1.2m from the Welsh Government to support the "shared care" of 9,000 patients into primary care and the projected start date is September 2019

Items completed:

- Completion of Stage 1 of the restructuring and Backup Infrastructure deployment required to address evolving requirements
- Implementation of numerous Server Instances supplying Service Departments – eg Genetics, Dental
- Blackberry (GOOD) Server Services Migration
- RDS rollout and increased services
- Completion of the Migration of the corporate PMS suite of modules from end of life infrastructure to new performant infrastructure.
- Migration of the Data Warehouse and associated functions from end of life infrastructure to new more performant infrastructure
- Upgrade of all corporate .NET applications onto latest versions of .NET Framework
- Upgrade of all corporate SQL Server databases migrated onto SQL Server 2012 / Windows 2012;
- PMS Postcoder replacement

Good Progress / ongoing work:

- Replacement of End of Life (EOL) storage arrays
- 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 – 90% complete;

Applications

Items completed:

- Phase 1 COM II development and implementation completed – agile developments and continuing deployments within phase 2
- DIABETES MODULE – including integration in to COM II
- COM II Letters module integration complete.
- 3 new functional services implemented up on D&T (New and migrated from PMS)
- Development of fully functional Virtual Fracture Clinic system integrated into EU Workstation and COM II.
- Mobile PROMS development – additionally integrated in to COM II
- Integration of X-Forms technology with existing Action Requesting as future enabler for 'Electronic Request Form' for Histopathology
- Development of web application for requesting BIS dashboards/services.
- Trauma Clinical Research Register functionality
- Pharmacy Clinical Research Register functionality
- Pre-Op Cardiac Functions and processes
- RTT Target Date functionality added to various modules including Generic Letters
- ERAS report module in Clinical Workstation
- Development of Major Trauma proof-of-concept application
- Integration of our Patient Call system, and Salud, for use in the Dental hospital;
- Development of Neurosurgery "on-call database" within e-Advice

- "Frequent Attenders" functionality within PMS Web Service Interface;
- BIS interface with Secure File Share Portal;
- 3 new services built in to D&T (New and migrated from PMS)
- Partial Booking functionality built into FAB for Physiotherapy Service
- TTH flow in WCWS
- Health Risk Factors for Eye Care Measures (PMS and CoM)

Good Progress / ongoing work:

- COM II – Customised and implemented to 25 Consultants Clinics. Introduction to additional 11 arranged for w/c 05/08/19
- MTC – Full suite application – good progress
- Hospital-to-Hospital (H2H) functionality developed in WPRS;

Completed about to go live:

- Outpatient Follow-up Cycle Functionality
- Patient Knows Best (PKB) integration

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. Frequent communications calls were held involving NWIS and Health Board leads. The main role of local IT leads was communication of progress and impact, as resolution of issues was a national issue. Local systems were not affected.
  A national major incident review is being prepared for August's NIMB with a follow up independent review commissioned for September.
- **WCCIS** continues to fall functionally short of the procurement SoR, as well as UHB requirements. National interfaces are yet to be delivered and the supplier has been issued with two non-conformance notices. The underlying Microsoft Dynamics 2013 platform exited mainstream support in January 2019 and the supplier is committed to development of its next-generation product on Microsoft .NET, without a direct upgrade path.
- **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 PCs that are not currently Windows 10 to avoid Cyber Security risks. An options paper outlining significant requirements has been submitted to the Capital Management Group and will also be submitted to Management Executive group. As part of the agreement for the new Office 365 enterprise Contract, agreement has been reached to provide an extension to Windows 7 support beyond Jan 2020 and potentially through the 3 year life of the new deal.

ASSURANCE is provided by:

Major Incident –In relation to the outage of the NWIS Data Centre and its impacts, 2 reviews are currently underway, one for presenting to NIMB in August and an independent review commissioned for September.
WCCIS assurance is provided through ongoing local and regional involvement in national programme groups, including the new Service Management Board. A meeting with the national programme SROs is scheduled for October 2019.
Windows 10 Upgrade: Options have been developed for Windows 10 upgrades, mitigated by the extension of windows 7 support beyond Jan 2020 for up to 3 years.

RECOMMENDATION

The Board is asked to:

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

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:	**IT Delivery Programme – LIMS Exception & Issues Report**						
Meeting:	Digital and Health Intelligence Committee				**Meeting Date:**	15th August 2019	
Status:	**For Discussion**		**For Assurance**	**Y**	**For Approval**		**For Information**
Lead Executive:	**Director of Digital and Health Intelligence**						
Report Author (Title):	**Assistant Director of IT**						

SITUATION

NHS Wales procured and implemented the National Laboratory Information Management System (LIMS) some years ago. This system was intended to be the Laboratory System for Wales covering all modules in the previous Telepath System. There have however been significant delays in developing the required functionality to an acceptable level such that a number of modules still remain on the Legacy Telepath System.

BACKGROUND

It has been necessary to maintain the legacy Telepath System to run a number of key modules including Blood Transfusion throughout the time of the implementation of the new LIMS system. The LIMS system has now reached the end of its contract as is currently in contractual extension phases pending the re-procurement of a new National Lab System solution as part of the LINC project.

ASSESSMENT

A number of parallel strands of activity are currently underway in this area to take forward the re-procurement of a new LIMS system and to mitigate risk in reliance on the legacy telepath system.

The attached appendix outlines the plans for the **new National LINC project** which will replace the current LIMS system.

Key highlights are as follows:

- Pre Procurement – April 2018 to September 2019
- Procurement – October 2019 to Dec 2020
- Development – Jan 2021 to June 2022
- Deployment – July 2022 to Dec 2023 (Cav first July 2022 to Dec 2022)
- Benefits realisation and handover to operations – Jan 2024 to Mar 2024

In order to mitigate the risk of the **current legacy telepath platform** which still runs key systems such as Blood transfusion, as the current LIMS functionality proved incapable of running the module, the following actions have been agreed:

- National and Local agreement has been reached to upgrade the Telepath Software and Hardware platform
- New hardware has been commissioned and installed
- Software upgrade has been commissioned and installed
- Supplier configuration has been undertaken
- Testing and acceptance plan is currently being finalised in readiness for implementation and go live

ASSURANCE is provided by:

The Health Board is actively involved in the National LINC project to procure and implement a new Laboratory Information System for Wales. The Project will look to standardise procedures in Wales rather than changing with each implementation. The project is also looking to deploy at Cardiff and Vale UHB first, being the most complex tertiary centre.

The UHB is also deploying upgrades to the existing Telepath system to ensure it has stability going forwards in advance of the LINC project.

RECOMMENDATION

The Committee is asked to:

- Note the progress in relation to the new national LINC project
- Note the plans being put in place to mitigate the risks and provide stability within the legacy Telepath system

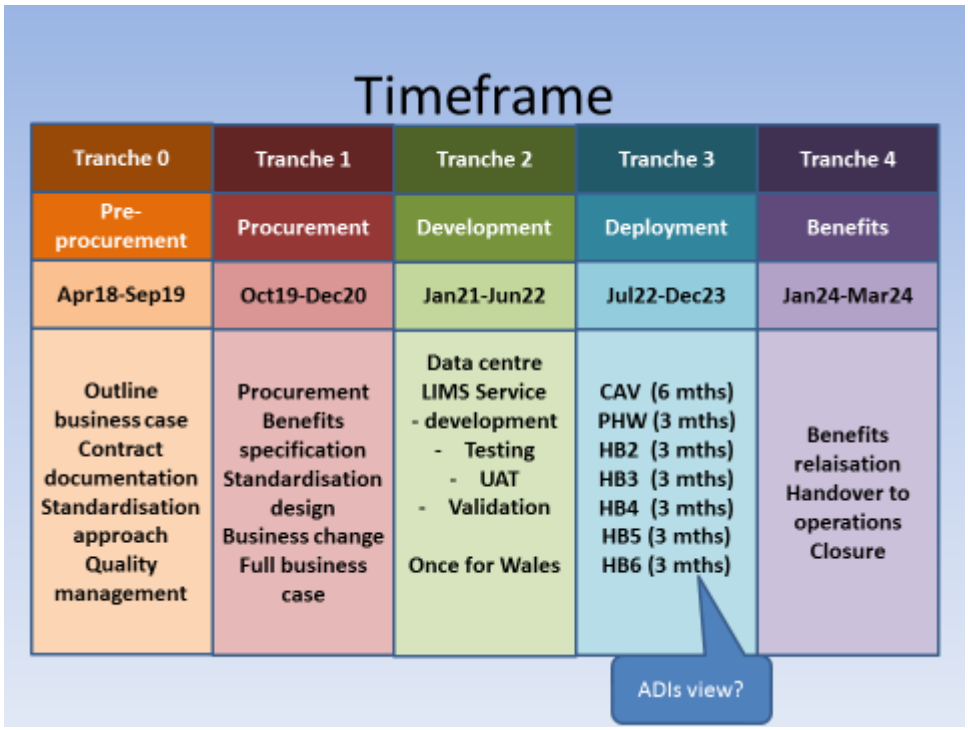
Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver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

Appendix One

LINC SCOPE AND TIMESCALES



Report Title:	**Information Governance Compliance**								
Meeting:	**Digital & Health Intelligence Committee**						**Meeting Date:**	**15th August 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 Information Technology and Governance Sub Committee (ITGSC) on how the UHB has complied with the obligations of each piece of legislation that satisfy the information governance requirements.

Progress on the development of the Integrated IG policy is presented in the DPA 2018 / ICO action plan in a separate report.

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 are being consolidated after a period of acute shortage which has inevitably impacted on the ability of the Dept to discharge its core duties. The new staffing structure is essentially as follows:

- David Thomas, Director of Digital and Health Intelligence is the interim Senior Information Risk Owner
- Dr Stuart Walker, Medical Director, is the Caldicott Guardian
- James Webb is the interim Data Protection Officer
- The information governance department is currently resourced at 5.8 WTE but is functioning below this level due to long term sickness of 1 WTE.

2. Data Protection Act – Serious Incident Report

Date reported: Q1 2019/2020

During Q1 of 2019, the Information Governance Department reviewed 272 IG related incidents via the UHBs e-Datix incident module.

Of these 1 was considered a serious incidents and was subsequently reported to the Welsh Government.
6 incidents were raised with ICO, with 2 of the 6 having been formally reported.

As per the GDPR action plan, through ongoing engagement and uptake of the training module there is growing awareness as to the importance of IG incidents being reported on e-Datix within 24 hours of a staff member being made aware.

3. Freedom of Information Act

The 20 day compliance rate for Q1 2019/2020 can be broken down as follows:

	Total requests	Compliant requests	Compliance %
Apr-19	48	41	85.4%
May-19	35	33	94.3%
Jun-19	38	30	78.9%

Following the appointment and training of 1.8 WTE staff, FOI compliance is no longer a serious concern for the department, despite a drop in June 2019. The situation has improved to the extent that the average compliance for Q1 2019/2020 is 86.0% compared to 31.1% for the same period last year against an overall compliance of 56.8% for 2018/2019. Responses and engagement from services remains the only barrier to 100% completion. This is being addressed via the GDPR engagement sessions. A small number of FOI requests are

outstanding.

In response to a number of complaints, the ICO has reaffirmed its position that FOI internal reviews are to responded to within 20 working days. Internal reviews are processed by Corporate Governance.

4. Subject Access Requests Processed

4.1 Health Records requests Q1 2019/2020

	Total requests	Compliant requests	Compliance %
Apr-19	315	158	50.2%
May-19	351	223	63.5%
Jun-19	350	237	67.7%

The complexity and volume of medical records subject access requests and our ability to respond, continues to pose a significant risk to the UHB. Health data held across numerous sites in paper and electronic format coupled with delays in clinical sign off are reflected in our low compliance rate. The compliance figures whilst poor, demonstrate a month on month increase in Q1 which can be attributed to the continued development and experience of newly appointed staff. It is expected that improvements will continue.

It should noted that despite our poor compliance, the UHB receives very few complaints which would suggest that we are ensuring that requests that are not replied to within the legislated timeframe are being updated and expectations are being well managed.

4 .2 Non Health Records

There were a total of 16 subject access request submitted for non-health records during Q1 2019/2020. All were completed and 15 were compliant within the regulatory timeframe.

5. Compliance Monitoring/NIIAS

Due to challenging resources, NIIAS monitoring has been limited during 2019. The intention is that training will be provided to the Information Governance Department so appropriate compliance can be adhered to.

6. Information Governance - Mandatory Training

Despite a slight increase in mandatory training compliance from 71% to 73%, this is still significantly below the UHBs target and should be a cause of concern. The module has been updated to incorporate the changes implemented by GDPR and is required to be completed every two years. The Information Governance team recognise the challenges that many staff

face regarding limited access to PCs. A classroom IG training module is in development to address this.

ASSURANCE is provided by:

- Reports detailing compliance against legislative requirements.

RECOMMENDATION

The Digital and Health 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	
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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
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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.

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 – To be confirmed or removed pending National audit findings			Audit Complete and attached		Director Digital & Health Intelligence	
Renal System			Awaiting completion of audit		Director Digital & Health Intelligence	
E- Advice			Audit Complete and attached		Director Digital & Health Intelligence	
E – IT Training			Audit Complete and attached		Director Digital & Health Intelligence	

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						
IT Strategy		6.8	Strategic MTED deployment	15 days	Director of Therapies	Complete
Virtulisation			Review the security and resilience of the updated virtualised environment.	15 days	Director of Therapies	Q3
IT Strategy			Welsh Patient Referral Services (WPRS)	TBC	Director of Therapies	Complete

Contents

Audit	Progress	Notes
e- IT training	The audit has provided x 7 findings 2 of which are medium and the rest all low.	To date the following have been completed: /findings 3,4,6 & 7.
e-Advice	Finding 1 – Ongoing. Benefits Analysis is underway. Due to complete by 31st August 2019. Finding 2 – Ongoing 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
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.	
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	July 2019 Actions being addressed by the departmental restructure process which is ongoing and due to be complete September 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

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** As assessment of the impact of these measures should be carried out and	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
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 mitigation measures, how many versions the training system can be	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
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 **Recommendation**	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		**Complete** 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.

Risk & Recommendation	Priority	Management Response	Responsible Officer	Previously agreed actions	Current Status
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 consultative process is in place which	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 and discussed with the WCP trainer on	Jo Brooks/Bill McClernon/Peter Noneley		Ongoing – will be agreed at next user group meeting

Risk & Recommendation	Priority	Management Response	Responsible Officer	Previously agreed actions	Current Status
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		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) Training attendants' feedback is collected at the end of the session.	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 to**

Risk & Recommendation	Priority	Management Response	Responsible Officer	Previously agreed actions	Current Status
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 systems. The feedback emails should be reviewed on a regular basis.		emails will recommence once the trainer has returned to post.			**accommodate this feature**

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

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.

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.

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		Subject to receipt of the digital funding from WG
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, processes and	David Thomas Deadline Sept 2019		Subject to receipt of the digital funding from WG

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.		procedures to reduce the likelihood of a cyber security incident.			
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 difficult	**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		Subject to receipt of the digital funding from WG

Risk & Recommendation	Priority	Management Response	Responsible Officer	Previously agreed actions	Current Status
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		Subject to receipt of the digital funding from WG

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 there is no formal patch plan / process that set this out;	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		Deadline Sept 2019

Risk & Recommendation	Priority	Management Response	Responsible Officer	Previously agreed actions	Current Status
• 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 updates / reminders to staff on good practice related to cyber security.	**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		

Risk & Recommendation	Priority	Management Response	Responsible Officer	Previously agreed actions	Current Status
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.					
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		Deadline Sept 2019

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)*	July 2019 Actions being addressed by the departmental restructure process which is ongoing and due to be complete September 2019
R2 –Patching **Finding** Although the ESXi hosts are currently patched and up to date, there is no	**Medium**	Agreed ***October 2018 – update*** *The demand on existing resources prevents this approach being changed.*	Phil Clee / N Lewis 6months	Due to be complete Sept 2018	July 2019 Actions being addressed by the departmental

Risk & Recommendation	Priority	Management Response	Responsible Officer	Previously agreed actions	Current Status
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.*		*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 due to be complete September 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. **Recommendation**	**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)*	July 2019 Actions being addressed by the departmental restructure process which is ongoing and due to be complete

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

Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Cardiff & Vale University Health Board

Information Governance: General Data Protection Regulation (GDPR)

Draft Internal Audit Report

2018/19

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Service

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Please note:

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Service Strategy and Terms of Reference, approved by the Audit Committee.

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1. Introduction and Background

The review of compliance with the GDPR within the Health Board has been completed in line with the 2018/19 Internal Audit Plan for Cardiff and Vale University Hospital Board ('the Health Board').

The General Data Protection Regulation (GDPR) was adopted on 27 April 2016. It took effect from 25 May 2018 and is immediately enforceable as law in all member states of the European Union (EU).

The primary objectives of the new legal framework are to institute citizens' rights in controlling their personal data and to simplify the regulatory environment through a unified regulation within the EU. Many principles of the GDPR are broadly the same as the existing Data Protection Act (DPA). One of the most significant changes is the increased penalties. Under the new regulations, penalties will reach an upper limit of €20m or 4% of annual turnover, whichever is higher.

The relevant lead Executive Director for this review is the Deputy Chief Executive.

2. Scope and Objectives

The overall objective of the audit was to provide assurance to the Health Board that arrangements are in place and managed appropriately within its wards, departments and directorates to ensure compliance with the requirements of the GDPR.

The areas that the review sought to provide assurance on are:

- appropriate action is being taken to ensure that management and staff are aware of the GDPR and the impact it is likely to have;
- local governance controls and measures have been implemented; and
- a register of information assets is maintained and identifies the source, responsibility and sharing arrangements for each asset.

3. Associated Risks

The potential risks that were considered in this review are as follows:

I. insufficient preparation for the new GDPR resulting in non-compliance with the requirements of the regulation;

II. controls not operating resulting in non-compliance; and

III. reputational damage and/or financial loss.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with GDPR is **Limited assurance**.

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

RATING	INDICATOR	DEFINITION
Limited assurance		The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

The UHB started making preparations for GDPR in advance of its implementation, with training provided to the staff group deemed to be Information Asset Owners (IAO). However the loss of staff within the Information Governance (IG) team and the absence of the IG Manager meant that this work did not continue smoothly. Guidance for staff on the website has not been updated and contains incorrect information and procedures have not been updated to reflect GDPR requirements. Within Clinical Boards there has not been a consistent mechanism for ensuring appropriate actions are undertaken to enable compliance with GDPR and there is a lack of visibility from the IG team into Clinical Board processes.

In general, staff awareness of IG and GDPR is reasonable, however there are some areas where this awareness is not complete and may lead to non-compliance, this is particularly the case for subject access requests and breach reporting.

The UHB has a Privacy Impact Assessment (PIA) process in place, along with a staff Privacy Notice, and service user Privacy Notice, however service user information regarding GDPR is often not on display.

There is an Information Asset Register (IAR) process in place and the majority of areas have started to develop these, however this is not the case for all departments and there is a degree of inconsistency and incompleteness for those departments who have created an IAR. The processes within the UHB do not fully identify information flows or the basis for processing.

In summary, although there are areas of good practice, the extent to which guidance is outdated, the lack of full awareness and the non-compliance areas means that the UHB has no process to provide assurance over compliance and limited mechanisms to identify non-compliance before a reportable breach occurs.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	Central Actions		✓		
2	Local Governance			✓	
3	Information Asset Registers		✓		

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

Design of Systems/Controls

The findings from the review have highlighted no issues that are classified as weakness in the system control/design for GDPR.

Operation of System/Controls

The findings from the review have highlighted twelve issues that are classified as weakness in the operation of the designed system/control for GDPR.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

Objective 1: Appropriate action is being taken to ensure that management and staff are aware of the GDPR and the impact it is likely to have.

The following areas of good practice were noted:

- an update of actions taken to prepare for GDPR went to the IT Committee group in May18 with detail on further work needed;
- the requirements for GDPR compliance were identified and actions fed into the ICO action plan;
- training sessions were provided for IAOs (Directorate Managers); and
- monitoring of the GDPR is undertaken by the Information Technology and Governance Sub Committee.

The following significant findings were identified:

- There was no GDPR action group or task and finish group or similar set up to drive and ensure Clinical Boards undertook the appropriate actions. The IG team went to all Directorates and gave a presentation on GDPR and the requirements etc. However there has been no checking to ensure actions have been taken and that Clinical Boards are ensuring compliance, and there is currently limited visibility from the IG team to Clinical Boards.
- Reviewing the processes within Clinical Boards indicated that most of these do not have a structure to identify the required actions to be undertaken to ensure compliance with GDPR and no process to ensure that compliance is achieved. These processes are of an ad-hoc nature and vary across Directorates and Clinical Boards.
- The staff resource within the IG team has not been sufficient to ensure appropriate preparation for GDPR within the organisation. The lack of continuity at the manager level and the lack of staff resource has meant that issues raised by Clinical Boards have not been dealt with promptly and the training provided across the UHB not been complete.
- The current procedure for subject access requests on the UHB web site is still the old one and contains incorrect information.
- Guidance for staff on the UHB intranet is out of date and incorrect, with the following issues identified:
    - there is a note re GDPR and an associated link stating the GDPR has 6 principles. However the GDPR contains 7 principles.
    - the IG start page has more references to the Data Protection Act (DPA) than GDPR and also has the absent IG Manager mail as the contact. (this mailbox is full)

- The IG page links to a sub page on the data protection act. This page hasn't been updated to reflect GDPR and still refers to 8 DPA principles. In addition the link to the DPA on the ICO site is dead (as it is no longer valid) This is also true of other links to ICO information e.g. the definition of personal data.

Objective 2: local governance controls and measures have been implemented to enable compliance with the GDPR.

The following areas of good practice was noted:

- staff awareness has been raised by emails and reminders sent to staff, and inclusion in some Directorate newsletters;
- some Directorates have undertaken actions to improve the compliance position;
- IG breaches are understood and reported on Datix;
- relevant staff aware of PIAs and these are being completed;
- PCIC have an IG group, this has highlighted areas where work needs to be done to comply with GDPR, and is auctioning these;
- roles and responsibilities for IG / GDPR are well defined in PCIC;
- PCIC have provided training on GDPR to their staff and raised awareness;
- Dental CB provide training on IG on a regular basis;
- Medical records and Dental Clinical Board keep a record of access requests to track compliance; and
- in general awareness of GDPR is indicated by staff raising relevant queries and reporting breaches.

The following significant findings were identified:

- One of the key vehicles for raising awareness of GDPR and enabling compliance is the IG module within mandatory training. However compliance rates for the UHB are not high, with an average of 68.5%. (maximum of 84% for Dental, minimum of 59% for both Capital, Estates and Facilities and Surgical Services).
- Although training was provided to Directorate Managers (as these were the group defined as IAOs), this was prior to GDPR being active and there has been limited follow up training provided and limited detail on specific actions to be undertaken. In addition not all staff in roles dealing with information have had relevant training, in particular

staff within Dermatology have not had training but are currently undertaking the IAO role.

- Although in general staff are aware of what constitutes an IG breach and are aware of the need to report in Datix, the knowledge of the revised timescale under GDPR is not complete and there is a risk that a breach may not be entered on Datix immediately (particularly on Friday / weekends). This potential delay in reporting could lead to a risk that the UHB will not comply with the 72 hour reporting window defined within GDPR.
- There is currently a lack of clarity regarding the conflicting requirements of GDPR, Welsh Government retention guidelines and UHB practice due to instructions following "scandals" such as the infected blood scandal and the abuse scandal. Due to this the UHB is retaining records longer than the period stated within WG guidelines.
- The processes / guidance for staff dealing with transfers of information to non EEA states is not complete. Staff do not always understand the need for gaining explicit consent for this and thus may not do so.

Objective 3: A register of information assets is maintained and identifies the source, responsibility and sharing arrangements for each asset.

The following areas of good practice were noted:

- IARs in place for many areas including: central IT systems; PCIC; Child Health; Health Records; Therapies; Dental.

The following significant findings were identified:

- There is no IAR in place and no work undertake to develop one for Dermatology or Internal Medicine. In addition the IARs for some other areas are incomplete as they do not go into detail regarding what is held at each locality. Furthermore, from reviewing all the IARs there are inconsistencies in the collection and recording of information on them
  - entering of UHB wide systems on some but not others. There is a lack of clarity over who is responsible for recording these;
  - identification of IAO is inconsistent; and
  - differing templates are being used.

- The IAR process does not pick up all items that would allow the full benefits to be gained and ensure full compliance with GDPR:
  - information flows are not being recorded on the IARs; and
  - the basis for processing is not being considered.

7. Summary of Recommendations

The audit findings, recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**3**	**8**	**1**	**12**

Finding 1– GDPR Coordination (Operating effectiveness)	Risk
There was no GDPR action group or task and finish group or similar set up to drive and ensure Clinical Boards undertook the appropriate actions. The IG team went to all Directorates and gave a presentation on GDPR and the requirements etc. However there has been no checking to make sure actions have been taken and that Clinical Boards are ensuring compliance, and there is currently limited visibility from the IG team to Clinical Boards. Reviewing the processes within Clinical Boards indicated that most of these do not have a structure to identify the required actions to be undertaken to ensure compliance with GDPR and no process to ensure that compliance is achieved. These processes are of an ad-hoc nature and vary across Directorates and Clinical Boards. Accordingly the UHB has no process to provide assurance over compliance and limited mechanisms to identify non-compliance before a reportable breach occurs.	Insufficient preparation for the new GDPR resulting in non-compliance with the requirements of the regulation.
Recommendation	**Priority level**
The UHB should consider establishing a GDPR group with representation from all clinical boards. The function of the group should be to ensure appropriate compliance actions are taken and to provide assurance that the UHB has good processes to ensure compliance with the GDPR.	**High**

Management Response	**Responsible Officer/ Deadline**
The UHB has adapted the all Wales IG policy. As part of the process to formal adoption, consultation and impact assessment will be taking place through which we anticipate identification of all clinical board requirements and prioritised action. The UHB sees placing responsibility and accountability as close as possible to the operational front line as the key to having an empowered and engaged workforce. Thus we see that the role of the corporate IG department is to design delivery of compliance and to provide specialist advice, rather than co-ordinate and deliver. The UHB has adopted a process whereby clinical board quarterly quality and safety committees have a standing item to cover their IG risk issues and receive an update from a member of the corporate IG department on material issues. It is accepted that as resources and expertise accumulate in line with expectation, there is more the central team can do on communication and engagement including the creation of a virtual mutually supporting networking of IAOs / IAAs. As recommended this will include setting up a GDPR group for a year.	Head of IG - Improvement approach with engagement around IG policy to take place up to end of Q1 2019/20

Finding 2– IG Team Resource (Operating effectiveness)	**Risk**

The staff resource within the IG team has not been sufficient to ensure appropriate preparation for GDPR within the organisation. The Information Governance Manager has been absent since March, and the post covered by 2 consecutive managers. The team itself consists of only 4 additional staff, 2 of which are recent appointments. The lack of continuity at the manager level and the lack of staff resource has meant that issues raised by Clinical Boards have not been dealt with promptly and the training provided across the UHB not been complete.	Insufficient preparation for the new GDPR resulting in non-compliance with the requirements of the regulation.
Recommendation	**Priority level**
The resource requirement for the Information Governance team should be fully assessed and resource provided appropriately.	**High**
Management Response	**Responsible Officer/ Deadline**
The UHB has, over recent years, had to take business decisions in order to deliver a financially balanced plan. We recognise these have had significant consequences on many of our staff and resulted in high levels of sickness which have compounded the challenges. We fully appreciate that a once in a generational change to IG legislation coincided with difficult financial circumstances has presented us with a challenge, but we would contend that this was a short sharp shock to the system which is now being adopted into routine ways of working as knowledge and awareness builds from experiential learning.	Head of IG – Q1 2019/2020

The UHB has just completed consultation on a revised structure for the digital and intelligence directorate which will result in resources increasing to 5.8 wte, and the department continuing to be complimented by specialist advice from both Welsh Health Legal and Risk and a local legal firm. To confirm the financial resource for this external support is available within the UHB's budget .	

Finding 3– Subject Access Requests (Operating effectiveness)	**Risk**
The current procedure for subject access requests on the UHB web site is still the old one and contains incorrect information as it states both the old 40 day timescale, the fee and that access requests must be made in writing and using the UHB form. However the GDPR and ICO guidance is clear that requests may be verbal and organisations 'may not insist on the use of a particular means of delivery for a SAR'. In addition the GDPR timescale is 30 days and no fee can be charged. This means that the UHB does not have an appropriate procedure in place, the guidance to staff and patients is wrong, and consequently staff are not complying as they are insisting requests go to medical records in writing.	Insufficient preparation for the new GDPR resulting in non-compliance with the requirements of the regulation.
Recommendation	**Priority level**
A revised Subject Access Procedure should be completed, placed on the intranet and flagged to all staff.	**High**

Management Response	**Responsible Officer/ Deadline**
Accepted & completed	Head of IG – March 2019

Finding 4– Guidance for Staff (Operating effectiveness)	**Risk**
Guidance for staff on the UHB intranet is out of date and incorrect, with the following issues identified: - there is a note re GDPR and an associated link stating the GDPR has 6 principles. However the GDPR contains 7 principles. -the IG start page has more references to the DPA than GDPR and also has the absent IG Manager mail as the contact. (this mailbox is full) - The IG page links to a sub page on the data protection act. This page hasn't been updated to reflect GDPR and still refers to 8 DPA principles. In addition the link to the DPA on the ICO site is dead (as it is no longer valid) This is also true of other links to ICO information eg the definition of personal data. One reason for the out of date information is that the only person in the IG team with access to change the information is the absent information governance manager. However this means that there is no accurate information easily available to staff through the IG pages.	Insufficient preparation for the new GDPR resulting in non-compliance with the requirements of the regulation.
Recommendation	**Priority level**

The IG webpages should be updated to ensure they present current, accurate information.	**Medium**
Management Response	**Responsible Officer/ Deadline**
The intranet is up to date	Head of IG – Q2 2019/20

Finding 5– Mandatory Training (Operating effectiveness)	**Risk**
One of the key vehicles for raising awareness of GDPR and enabling compliance is the IG module within mandatory training. However compliance rates for the UHB are not high, with an average of 68.5%. (maximum of 84% for Dental, minimum of 59% for both Capital, Estates and Facilities and Surgical Services)	Controls not operating resulting in non-compliance.
Recommendation	**Priority level**
The UHB should seek to ensure all staff complete the IG training module.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Accept – The UHB has rolled out the new GDPR compliant IG mandatory e-learning module. Completion is being promoted alongside other mandatory training and in particular is being reinforced at the GDPR work groups. In	Head of IG / WOD – National implementation Q3 2019/2020

addition, a GDPR presentation has been developed that can be delivered locally where PC access is a barrier to mandatory training completion and generally where completion is low.	

Finding 6– Training Provision(Operating effectiveness)	**Risk**
Although training was provided to Directorate Managers (as these were the group defined as IAOs), this was prior to GDPR being active and there has been limited follow up training provided and limited detail on specific actions to be undertaken. In addition not all staff in roles dealing with information have had relevant training, in particular staff within Dermatology have not had training but are currently undertaking the IAO role.	Controls not operating resulting in non-compliance.
Recommendation	**Priority level**
Training on GDPR should be enhanced and provided to all staff acting in an IAO or IAA role. Further information should be passed to Directorates on the specific actions to be undertaken following GDPR.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Training is via the mandatory training route described in recommendation 5. The UHB will take actions to ensure we have asset registers and awareness of GDPR across the medicine clinical board as an early priority.	Q3 -2019/20 General Manager Medicine

Within clinical boards there will be further emphasis and engagement on the responsibilities and requirements for IAO/IAA roles, in order to enable appropriate senior staff to be allocated/trained, following implementation of enhanced training programme "Dojo" training which is designed to help staff understand cyber security threats is available on ESR.	

Finding 7–IARs (Operating effectiveness)	**Risk**
There is no IAR in place and no work undertake to develop one for Dermatology or Internal Medicine. In addition the IARs for some other areas are incomplete as they do not go into detail regarding what is held at each locality. furthermore, from reviewing all the IARs there are inconsistencies in the collection and recording of information on them - entering of UHB wide systems on some but not others. There is a lack of clarity over who is responsible for recording these. - identification of IOA is inconsistent - differing templates are being used	insufficient preparation for the new GDPR resulting in non-compliance Controls not operating resulting in non-compliance.
Recommendation	**Priority level**
All areas should be asked to complete an IAR or feed into an IAR.	**Medium**

Further guidance should be issued over what information to collect and how to record it using the standard template.	
Management Response	**Responsible Officer/ Deadline**
All areas have been asked on numerous occasions to complete asset registers and this was being reported into UHB committees. We acknowledge that the readiness is varied across service areas, which is a reflection on the operational challenges and the wider level of performance with other deliverables and risks requiring prioritisation. The UHB will take actions to ensure we have asset registers and awareness of GDPR within dermatology and across the medicine clinical board as an early priority. Update: No IARs yet completed in internal medicine and dermatology – Clinical Board and directorates again reminded of legislative requirement to do so.	Medicine Clinical Directors, Directorate Managers and IAOs Q2 2019/20

Finding 8–Breach Reporting (Operating effectiveness)	**Risk**

Although in general staff are aware of what constitutes an IG breach and are aware of the need to report in Datix, the knowledge of the revised timescale under GDPR is not complete and there is a risk that a breach may not be entered on Datix immediately (particularly on Friday / weekends). This potential delay in reporting could lead to a risk that the UHB will not comply with the 72 hour reporting window defined within GDPR.	Controls not operating resulting in non-compliance.
Recommendation	**Priority level**
A reminder should be sent to all staff to ensure that all IG breaches are entered onto Datix immediately.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Acknowledged – further engagement is planned via the requirement to consult and impact assess the IG policy Update – Requirements to meet 72 hour timescale are being re-iterated via training and through the quarterly quality and safety committee meetings (2 out of the 8 meetings already attended).	Head of IG Q2 2019/20

Finding 9– Retention of Records (Operating effectiveness)	Risk
There is currently a lack of clarity regarding the conflicting requirements of GDPR, Welsh Government retention guidelines and UHB practice due to instructions following "scandals" such as the infected blood scandal and the abuse scandal. Currently the UHB is retaining records longer than the period stated within WG guidelines. As the GDPR states that records should only be kept "as long as necessary" this may mean non-compliance. Guidance for retention of child health records states to keep until the 25th birthday then destroy, however due to recent "scandals" such as infected blood / abuse etc. they have been told not to destroy until the record has been looked at to ensure nothing needs to be kept. Due to the lack of clinical resource these records are not being reviewed, and accordingly not destroyed and so they are retaining records longer than guidance states.	Controls not operating resulting in non-compliance
Recommendation	**Priority level**
This issue should be raised with WG to confirm that the requirement to keep overrides the stated retention guidelines. This issue should be entered onto the UHB risk registers.	**Medium**
Management Response	**Responsible Officer/ Deadline**

National policy is being discussed at IGMAG and Medical Directors (Caldicott Guardians) groups. Given the advent of digital and the opportunities presented by 'big data' analysis the proposal is that digital records containing the core clinical record will be kept for 100 years. The UHB is an advocate of this position The paper record is being retained on instruction of the NHS Wales Chief Executive for the reasons stated in the findings.	No action required

Finding 10– IAR Completeness (Operating effectiveness)	**Risk**
The IAR process does not pick up all items that would allow the full benefits to be gained and ensure full compliance with GDPR: - Information flows are not being recorded on the IARs. - The basis for processing is not being considered.	Controls not operating resulting in non-compliance.
Recommendation	**Priority level**
The IAR process should pick up information flows and also consider the basis for processing.	**Medium**
Management Response	**Responsible Officer/ Deadline**

In line with the approach taken across NHS Wales which has been discussed openly with the ICO's office a phased approach to the development of IARs has been adopted. Presently the UHB is in the process of mapping flows, with the initial focus having been on mapping new flows, those concerning R&D (potentially higher risk) and those into NWIS. The legal basis for processing in the majority of cases is patient care as set out in our privacy notice The UHB is using the requirement to get the documentation right for all new flows as a tool for increasing knowledge of what is required Update: Arrangements covering national data submissions and flows completed.	Operationally: IAOs as laid out in the IG policy Corporately: SIRO & DPO Q2 2019/20

Finding 11–Non EEA Information Transfers (Operating effectiveness)	**Risk**
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.	Insufficient preparation for the new GDPR resulting in non-compliance with the requirements of the regulation.
Recommendation	**Priority level**
The UHB should make clear the requirement to gain explicit consent for these transfers.	**Medium**

Management Response	**Responsible Officer/ Deadline**
As above – there is no requirement for consent where the data processing by a non EEA 3rd party has an EEA 'adequacy notice' or covered by 'appropriate safeguards' as confirmed by expert advice. Information around this is being shared and informed by work reporting into IG MAG and advice on non EEA data processing provided by GDPR work group.	Complete - continuation of existing practice

Finding 12– Service User information (Operating effectiveness)	**Risk**
Although information (posters) for patients were sent out to all Directorates, these have not been put up in all cases.	Controls not operating resulting in non-compliance.
Recommendation	**Priority level**
Directorates should be reminded to display the GDPR information.	**Low**
Management Response	**Responsible Officer/ Deadline**
Accept – SIRO will write to Directorate Managers & CDs to remind them of this requirement	SIRO – end of February 2019

Updated: letter sent and outstanding issues being picked up at clinical board Q&S meetings.	

Audit Assurance Ratings

 **Substantial assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

 **Reasonable assurance** - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

 **Limited assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

 **No Assurance** - The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

Report Title:	Terms of Reference – Digital and Health Intelligence Committee							
Meeting:	Digital and Health Intelligence Committee					**Meeting Date:**	15.08.2019	
Status:	**For Discussion**	x	**For Assurance**		**For Approval**	x	**For Information**	
Lead Executive:	Director of Corporate Governance							
Report Author (Title):	Director of Corporate Governance							

SITUATION

In line with the UHB's Standing Orders, Terms of Reference for Committees of the Board, should be reviewed on an annual basis.

This report provides Members of the Digital and Health Intelligence Committee Committee with the opportunity to review the Terms of Reference prior to submission to the Board for approval.

This Committee is a newly established Committee of the Board.

REPORT

BACKGROUND

This Committee is a newly established Committee of the Board and replaces the Information Governance and Information Technology Committee which previously reported into the Strategy and Development Committee.

ASSESSMENT

The Terms of Reference for the Digital and Health Intelligence Committee were development by the Director of Corporate Governance and have been reviewed by the Chair of the Committee, the Executive Lead and Director of Digital and Health Intelligent.

RECOMMENDATION

The Digital and Health Intelligence Committee is asked to:

APPROVE the Terms of Reference for the newly established Digital and Health Intelligence Committee and
RECOMMEND the changes to the Board for approval.

Shaping our Future Wellbeing Strategic Objectives			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	x
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	
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

Sustainable Development Principles: Five ways of working	Prevention	x	Long term		Integration		Collaboration		Involvement		
Equality and Health Impact Assessment Completed:	Not Applicable										

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Cardiff and Vale University Health Board

Digital and Health Intelligence Committee (DHIC)

Terms of Reference

To be approved by the Board: September 2019

Next Review Due: March 2020

DIGITAL AND HEALTH INTELLIGENCE COMMITTEE

TERMS OF REFERENCE AND OPERATING ARRANGEMENTS

1. INTRODUCTION

1.1 The UHB Standing Orders provide that "*The Board may and, where directed by the Welsh Government must, appoint Committees of the LHB Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees*".

1.2 In line with Standing Orders (3.4.1) and the UHB Scheme of Delegation, the Board shall nominate annually a committee to be known as the **Digital and Health Intelligence Committee**. The detailed terms of reference and operating arrangements set by the Board in respect of this committee are set out below.

1.3 Digital & Health Intelligence (referred to as Digital) comprises Information Technology, Business Intelligence/Analytics, Information Management, Information Governance, Clinical Coding. It includes some specific IT project teams including those managing the PARIS system, use for mental health/Community services and local management of the Welsh Clinical Portal. Its function is to provide enabling services across the UHB to support the effective use of technology and the use of data/intelligence in the delivery of services.

2. PURPOSE

The purpose of the DHIC is to:

2.1 Provide **assurance** to the Board that;

- Appropriate processes and systems are in place for data, information management and governance to allow the UHB to meet its stated objectives, legislative responsibilities and any relevant requirements and standards determined for the NHS in Wales.
- There is continuous improvement in relation to information governance within the UHB and that risks arising from this are being managed appropriately.
- Effective communication, engagement and training is in place across the UHB for Information Governance

2.2 Seek assurance on the development and delivery of a Digital Strategy (which encompasses the areas detailed in paragraph 1.3 above) for the UHB ensuring that:

- It supports Shaping our Future Wellbeing and detail articulated within the IMTP
- Good partnership working is in place
- Attention is paid to the articulation of benefits and an implementation programme of delivery
- Benefits are derived from the Strategy

3. DELEGATED POWERS AND AUTHORITY

In order to achieve its purpose the DHIC must receive assurance that:

- The UHB has an appropriate framework of policies, procedures and controls in place to support consistent standards based processing of data and information to meet legislative responsibilities.
- Recommendations made by internal and external reviewers are considered and acted upon on a timely basis.
- A risk register is in place and that risks are being appropriately identified, assessed and mitigated at all levels in relation to information governance, management and technology.
- Statutory and mandatory requirements are being met such as Caldicott Guardian, FOI, GDPR etc.

In order to do this the Committee will take the following actions:

3.1 Approve policies and procedures in relation to the Strategy

3.2 Receive assurance that all statutory and mandatory requirements are being met such as Caldicott Guardian, FOI, GDPR etc.

3.3 Receive assurance on the delivery and implementation of the strategy and associated work plan

3.4 Receive assurance on clinical and staff engagement of the digital agenda

3.5 Receive, by exception, data breach reports on the following areas:

- Serious reportable data breaches to the Information Commissioner (ICO) and the Welsh Government
- Sensitive information (break glass system)
- E-mail
- National and local auditing such as NIIAS
- freedom of information,
- subject access requests
- Data Quality
- IG risk assessments
- Incidents – lessons learned from all recorded / reported incidents.

3.6 Receive periodic reports on development, procurement and implementation of national and local IM&T systems

3.7 Review risks

- Periodically consider risks escalated to the Committee from Clinical Boards / Corporate Departments in relation to:
  - Information Governance
  - Information Management
  - Information Technology

- Review risks escalated to the Committee that have a risk rating of 12 and above.

4. AUTHORITY

4.1 The Committee is authorised by the Board to investigate or have investigated any activity within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the UHB relevant to the Committee's remit, and ensuring patient/client and staff confidentiality, as appropriate. It may seek relevant information from any:

- employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and
- any other committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.

4.2 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

5.0 ACCESS

5.1 The Chair of Digital & Health Intelligence Committee shall have reasonable access to Executive Directors and other relevant senior staff.

6.0 SUB COMMITTEES

6.1 The Committee may, subject to the approval of the UHB Board, establish sub committees or task and finish groups to carry out on its behalf specific aspects of Committee business.

7. MEMBERSHIP

Members

7.1 A minimum of three (3) members, comprising:

Chair	Independent member of the Board
Vice Chair	Chosen from amongst the Independent members on the Committee
Members	At least one other independent members of the Board

The committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

Attendees

7.2 In attendance:

	Deputy Chief Executive & Director of Transformation

		Director of Digital and Health Intelligence Assistant Medical Director IT Director of Corporate Governance Other Executive Directors will attend as required by the Committee Chair
7.3	By invitation	The Committee Chair may invite: - any other UHB officials; and/or - any others from within or outside the organisation - to attend all or part of a meeting to assist it with its discussions on any particular matter.

Secretariat

7.4	Secretary	- As determined by the Director of Corporate Governance

Member Appointments

7.5 The membership of the Committee shall be determined by the Board, based on the recommendation of the UHB Chair - taking account of the balance of skills and expertise necessary to deliver the committee's remit and subject to any specific requirements or directions made by the Welsh Government.

7.6 Committee members' terms and conditions of appointment, (including any remuneration and reimbursement) are determined by the Board, based upon the recommendation of the UHB Chair {and on the basis of advice from the UHB's Remuneration and Terms of Service Committee}.

Support to Committee Members

7.7 The Director of Corporate Governance , on behalf of the Committee Chair, shall:

- arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and
- ensure the provision of a programme of organisational development for committee members as part of the UHB's overall OD programme developed by the Director of Workforce and Organisational Development.

8. COMMITTEE MEETINGS

Quorum

8.1 At least two members must be present to ensure the quorum of the Committee, one of whom should be the committee Chair or Vice Chair.

Frequency of Meetings

8.2 Meetings shall be held no less than three time per year, and otherwise as the Chair of the Committee deems necessary – consistent with the UHB annual plan of Board Business.

Withdrawal of Individuals in Attendance

8.3 The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

9. RELATIONSHIP AND ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

9.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.

9.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

9.3 The Committee, through its Chair and members, shall work closely with the Board's other committees, including joint (sub) committees and groups to provide advice and assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business; and
- sharing of information

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

9.4 The Committee will consider the assurance provided through the work of the Board's other committees and sub groups to meet its responsibilities for advising the Board on the adequacy of the UHB overall framework of assurance.

9.5 The Committee shall embed the UHB's corporate standards, priorities and requirements, e.g., equality and human rights through the conduct of its business.

10. REPORTING AND ASSURANCE ARRANGEMENTS

10.1 The Committee Chair shall:

- report formally, regularly and on a timely basis to the Board and the Accountable Officer on the Committee's activities. This includes verbal updates on activity and the submission of committee minutes and written reports throughout the year;
- bring to the Board and the Accountable Officer's specific attention any significant matters under consideration by the Committee;

- ensure appropriate escalation arrangements are in place to alert the UHB Chair, Chief Executive (and Accountable Officer) or Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the UHB.

10.2 The Committee shall provide a written, annual report to the board and the Accountable Officer on its work in support of the Annual Governance Statement..

10.3 The Board may also require the Committee Chair to report upon the committee's activities at public meetings or to community partners and other stakeholders, where this is considered appropriate, e.g., where the committee's assurance role relates to a joint or shared responsibility.

10.4 The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of any sub committees established. In doing so, account will be taken of the requirements set out in the NHS Wales Audit Committee Handbook.

11. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

11.1 The requirements for the conduct of business as set out in the UHB Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- quorum (set within individual Terms of Reference)

12. REVIEW

12.1 These terms of reference and operating arrangements shall be reviewed annually by the Committee with reference to the Board.

Report Title:	Work Plan 2019/20 – Digital and Health Intelligency Committee								
Meeting:	Digital and Health Intelligency Committee						**Meeting Date:**	15.08.19	
Status:	**For Discussion**	x	**For Assurance**		**For Approval**	x	**For Information**		
Lead Executive:	Director of Corporate Governance								
Report Author (Title):	Director of Corporate Governance								

SITUATION

The purpose of the report is to provide Members of the Digital and Health Intelligence Committee with the opportunity to review the Committee Work Plan 2019/20 prior to presentation to the Board for approval.

REPORT

BACKGROUND

The work plan for the Committee should be reviewed annually prior to presentation to the Board to ensure that all areas within its Terms of Reference are covered within the plan.

ASSESSMENT

The work plan for the Digital and Health Intelligence Committee 2019/20 has been based on the requirements set out within the Digital and Health Intelligence Committee Terms of Reference which assumes that the Committee meets three times a year.

RECOMMENDATION

The Digital and Health Intelligency Committee is asked to:

REVIEW the Work Plan 2019/20
APPROVE the Work Plan 2019/20
RECOMMEND approval to the Board of Directors

Shaping our Future Wellbeing Strategic Objectives			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	x
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	

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											
Sustainable Development Principles: Five ways of working	Prevention	x	Long term		Integration		Collaboration		Involvement		
Equality and Health Impact Assessment Completed:	Not Applicable										

Digital Health Intelligence Committee Work Plan 2019 - 20				
A -Approval D- discussion I - Information	**Exec Lead**	**15-Aug**	**01-Oct**	**04-Feb**
Agenda Item				
Assurance				
Data, Information management and governance Assurance Review	DT			
Information Governance Assurance Review	DT			
Information Governance Training Update	DT			
Information Governance Communications and Engagement Plans	DT			
Digital Strategy Assurance on development and delivery	DT			
Framework of policies , procedures and controls	DT			
Internal Audit and WAO Reviews	DT			
Other external reviews	DT			
Staff Engagement on Digital Agenda Assurance				
Risk Register	DT	D	D	D
Development, procurement and implementation of national and Local IMT systems	DT			
Statutory and Mandatory Requirements				
Caldicott Guardian	DT			
Freedom of Information	DT			
GDPR Compliance	DT			
Serious Reportable Data Breaches	DT			
Digital and Health Intelligence Committee				
Annual Work Plan	NF	A		A
Self assessment of effectiveness	NF	D		D
Induction Support for Committee Members	NF			
Review Terms of Reference	NF	A		A
Produce Digital and Health Intelligent Committee Annual Report	NF	A		A
Minutes of Digital and Health IntelligentCommittee Meeting	NF	A		A
Action log of Digital and Health Intelligent Committee Meeting	NF	D		D

Report Title:	**Legacy Statement - Information Technology and Governance Committee**								
Meeting:	Digital and Health Intelligence Committee (DHIC)						**Meeting Date:**	15.08.19	
Status:	**For Discussion**	x	**For Assurance**		**For Approval**	x	**For Information**		
Lead Executive:	Director of Corporate Governance								
Report Author (Title):	Director of Corporate Governance								

SITUATION

The purpose of the report is to provide Members of the Digital and Health Intelligence Committee with the opportunity to review of the work its predecessor the Information Technology and Governance Committee.

REPORT

BACKGROUND

The Information Technology and Governance Committee was not a Committee of the Board and it reported into the Strategy and Delivery Committee. It is requirement of the Health Board's Standing Orders that there should be a Committee of the Board which deals with IT. Therefore, when the Committees of the Board were reviewed in March 2019 the Board agreed that there would be a new Committee of the Board which would deal with IT issues.

ASSESSMENT

This document details the work of the Information Technology and Governance Committee over the period ending April 2019. Its purpose is to capture the information so it is not lost and has been completed in the format of an 'Annual Report' which were written for the other Committees of the Board at the end of the Financial Year.

The work of the Information Technology and Governance Committee will now be taken forward by a Committee known as the Digital and Health Intelligence Committee although the new Committee as a Committee of the Board will be more strategic in order to provide assurance to the Board.

RECOMMENDATION

The Digital and Health Intelligence Committee is asked to:

Review the Legacy Statement 2018/19 and note the work undertaken by the Information Technology and Governance Committee.

Shaping our Future Wellbeing Strategic Objectives			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	

2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	x
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	
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

Sustainable Development Principles: Five ways of working	Prevention	x	Long term		Integration		Collaboration		Involvement		
Equality and Health Impact Assessment Completed:	Not Applicable										

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Cardiff and Vale University Health Board

Legacy Statement of the Information Technology and Governance Committee 2018/19

1.0 INTRODUCTION

In accordance with best practice and good governance, when a Committee is closed or replaced, the Committee should produce a legacy statement of its activities of the previous 12 months prior to its ending. The Legacy Statement to the Board sets out how the Committee has met its Terms of Reference during the financial year prior to being replaced by the Digital and Health Intelligence Committee (DHIC).

2.0 MEMBERSHIP

The Committee membership is made up of Two Independent Members, Three Executive Directors, IT Specialists and the Director of Corporate Governance.

3.0 MEETINGS AND ATTENDANCE

The Committee met three times during the period 1 April 2018 to 31 March 2019. This is in line with its Terms of Reference. The Information Technology and Governance Committee achieved an attendance rate of 75% (80% is considered to be an acceptable attendance rate) during the period 1st April 2018 to 31st March 2019 as set out below:

	13/06/2018	**31/10/2018**	**29/01/2019**
Eileen Brandreth (Chair)	✓	✓	**x**
Dr Sharon Hopkins	✓	✓	✓
Dr Graham Shortland	✓	**x**	**x**
Dr Fiona Jenkins	✓	✓	✓
Peter Welsh	✓	-	-
Andrew Nelson	✓	✓	✓
Paul Rothwell	✓	**x**	**x**
Chris Lewis	✓	✓	**x**
Nicola Foreman			✓
Michael Imperato	-	-	✓
Total	**100%**	**71%**	**55%**

4.0 TERMS OF REFERENCE

The Terms of Reference were last reviewed and approved by the Committee in October 2017 and were due for review in October 2018 but by this time the Committee knew that its current arrangements were going to change in the new financial year to make it a Committee of the Board.

5.0 WORK UNDERTAKEN

During the financial year 2018/19 the Information Technology and Governance Committee reviewed the following key items at its meetings:

IG/IT Risk Assurance Framework

- Information Governance and Information Technology Risk Registers at each meeting
- Information Governance arrangements and support
- Information Governance – mandatory training
- Digitally enabled organisation
- Report against national Strategy and Policy and implementation
- Delivery of IMTP

Strategic Issues

- Transformation Board Progress
- Failure of Services at National Data Centres
- Welsh Government – review of Governance of NHS Informatics in Wales
- Digitally enabled workforce and organisation
- Strategic engagement
- NHS Informatics in NHS Wales
- Architecture of NHS Informatics in Wales
- PAC report on Informatics Wales

Specific Programmes:

- Welsh Laboratory Information Management System at each meeting
- Digitisation of Medical Records

Audits

- IMT Audit Assurance Action Plan at each meeting
- ICO Visit and ICO/DPA Action Plan at each meeting
- Information Governance

Items for Assurance

- Caldicott Guardian
- Integrated Governance Report at each meeting
- National Health Care Standards
- Informatics Capital Programme
- SIRO Report

- GDPR Update at each meeting
- IMT Audit Assurance Report
- Controlled Documents Framework at each meeting

6.0 REPORTING RESPONSIBILITIES

The Committee has reported to the Strategy and Delivery Committee after each of the Information Technology and Governance Committee meetings by the minutes being presented to the Committee once approved.

7.0 OPINION

The Committee is of the opinion that the draft Audit Legacy Statement 2018/19 is consistent with its role as set out within the Terms of Reference and that there are no matters that the Committee is aware of at this time that have not been disclosed appropriately.

Eileen Brandreth

Committee Chair

CAPITAL MANAGEMENT GROUP MEETING
MONDAY 20TH MAY 2019
CORPORATE MEETING ROOM, HQ, WOODLAND HOUSE

Present:
Abigail Harris, Executive Director of Strategic Planning (Chair)
Marie Davies, Assistant Director of Strategic Planning
Lee Davies, Director of Operations?
Chris Lewis, Deputy Finance Director
Richard Hurton, Assistant Finance Director
Geoff Walsh, Director of Capital, Estates and Facilities
Nigel Mason, Business Manager
Nigel Lewis, IM&T
Fiona Jenkins,
Mike Bourne, CD&T
Edward Hunt

In Attendance; Zoe Riden-Phillips

		ACTION
1.	**APOLOGIES FOR ABSENCE** Apologies were received from Steve Curry & Clive Morgan	
2.	**NOTES FROM THE PREVIOUS MEETING** RH advised that the note under Rookwood Relocation heading was implied as a statement rather than an action*; 'RH advised GW that WG required details of the projects that were being funded by the Neo Natal gain share.'* The remainder of the minutes were accepted as an accurate record.	
3.	**MATTERS ARISING** **Birthing Pools** GW advised that structural investigation works were ongoing in the Women's unit, as previously recommended, following a request by the Clinical Board for funding to support the procurement of 2 additional birthing pools. **Hoists** FJ advised that at the recent Medical Equipment Group (MEG) meeting, Clinical Engineering had raised concerns with regards the servicing/repair	

	of patient hoists following a report that only 1 hoist was working across the UHL site. Clinical Engineering advised the MEG that they had submitted a proposal to undertake the servicing and repair of the hoists with the budget transferred from Estates and Facilities. GW reminded the group that the proposal submitted by Clinical Engineering had been considered by the CMG and that it was not supported as the costs were significantly more than the allocation available within the Capital & Estates budget. In response to the report that only 1 hoist was working across the UHL site, GW advised that there was no evidence to support this claim. He had sort advice from Tony Ward, Head of Discretionary Capital and Compliance, who confirmed via email, that a significant number of hoists had been serviced by Arjo over the recent weeks. GW also advised the CMG, that Arjo had identified a number of hoists,that were not included on the UHB asset register. TW was in the process of adding these items to the register and obtaining costs to add them to the servicing schedules. NM advised the group that a follow up meeting was scheduled with Arjo to agree a revision to the contract to a upgrade to Gold service contract that would provide 24/7 cover and allow the nursing staff to contact Arjo directly. In addition to the revised contract, the Compliance team were developing a hoist replacement programme, as a number of the hoists inspected by Arjo, had been condemned. FJ agreed to circulate the arrangements for reporting faults, ie. Nursing staff contacting Arjo directly, to the Medical Equipment Group. **Fairwater Road** GW advised the group that the UHB had acquired 200 Fairwater Road at the end of the 2018/19 financial year with funding from WG slippage monies. It was anticipated that the building, adjacent to the GP practice would support the expansion of services in this part of Cardiff, which is subject to significant housing development. During the later stages of the acquisition it was identified that a small parcel of land adjacent to the property had not been identified by Cardiff City Council on the boundary plans, although it was used as a parking area for the building users. Alteration of the documents at such a late stage in the process would have delayed completion of the acquisition of the facility into the 2019/20 financial year which would have proved difficult from a funding perspective. The cost of the additional land is £10k and GW proposed that the group approve the acquisition of the area of land subject to WG approval, as it would provide additional parking for building users. It was agreed that GW progress with the acquisition as proposed.	**FJ** **LD** **GW**

	Colcott to Barry Hospital AH advised the group that the Health Minister had responded to the referral submitted to by the CHC. The Minister advised the CHC that the relocation of services from Colcott clinic to Barry Hospital was not considered a Substantial Service Change and also noted that the UHB were nor required to engage with the public on such a matter. **IM&T** NL advised that IM&T were awaiting confirmation of national funding from WG. **Cystic Fibrosis** LD agreed to liaise with David Allinson in relation to the request from the Clinical Board to retain the existing CF facility at UHL which was raised at the March 2019 CMG.	**LD**
4.	**EXECUTIVE SUMMARY** GW presented the Capital Management Report, referring to the CRL, he advised that the Discretionary Capital funding of £14.28m for the financial year was committed with little room to manage any additional schemes within the year. He advised that the -£2.2m identified in the CRL group 2, related brokerage agreed with WG for the purchase of Woodland House in 2018/19. AH advised the group that the Health Board (HB) was considering an option to defer the £2.2m payment to next financial year, 2020/21, to facilitate the purchase of Barclays House for WEQAS. AH noted that Andrew Goodall, WG, had given approval in principle although the HB would be required submit a formal request to WG. RH raised concerns with this approach as it could have a considerable impact on the 2020/21 Discretionary Capital programme. The discretionary capital programme for the current financial year included a 'pay back' of funding of £1.2m to the Rookwood project, which the UHB received in 2018/19 but in agreement with WG reallocated to support the discretionary capital programme as the underspend was reported late in the process. The delays to the start of the Rookwood scheme due to the need for enabling works has identified that the current CRL allocation may not be met. Although the spend profile in 2019/20 may be reduced the anticipated outturn cost of the Rookwood project indicates a potential overspend of circa £600k, due to unfunded enabling works. Whilst this includes a significant risk allocation that may not be realised if it were to be the case this would put an additional call on the discretionary funding allocation in 2020/21.	

	If the UHB deferred the repayment of the £2.2m until 2020/21 together with the £1.2m payback to the Rookwood Scheme and with the £0.6m potential overspend re the same scheme we could see the discretionary capital funding commencing the year with circa £4m already committed. RH & CL agreed that delaying payback to the next financial year would carry considerable risk and pressure. CL suggested that it would be more appropriate to separate the issues by requesting WG approval for the acquisition of Barclays House, without including the deferral of the payback. In summary, the CMG agreed that it was in the HB interest to payback the £2.2m within the financial year, and to convince WG that the acquisition of Barclays House for WEQAS services is highly beneficial to the UHB and emphasize that the service provides a non-recurrent revenue income of £1.7m per year AH advised that the Discretionary Capital report should be presented at management executives and UHB Board, in May 2019. It was suggested by FJ that if it was too late to submit a Board Paper that perhaps it could be included in the Chairs report. AH and RH agreed that for the purposes of the ME/Board reports, the Discretionary Capital Programme would include include the £1.8m to acquire Barclays House, although it was noted that any changes were to be reported to CMG, followed by Strategy & Delivery Committee. GW agreed to issue full discretionary capital report including the funding and total of property sales for presentation at ME & Board. **WEQAS Business Case** AH advised the group that she had met with the WEQAS lead and that it was agreed that a they needed to submit a paper to describe the basis of their expansion and the benefits of their service. There remained little understanding of the service WEQAS provided and how much of the service was of benefit to the UHB, NHS Wales and what percentage of their income was from outside of Wales. It was broadly agreed that WEQAS would benefit from support from the Strategic planning team to ensure that there was a sound governance structure around their proposal AH enquired if it was only the acquisition costs that were required or would there be further capital funding required for the building fit out. GW confirmed that the £1.8m did not include alterations or fit out, which was not an inconsiderable sum.	**GW** **MB**

	MB explained that WEQAS had not opportunity to convert its revenue income to capital, otherwise it would be able to fund both the acquisition of the building and the fit out from the profits generated. AH proposed that WEQAS be requested to produce a 3 to 5 year plan identifying the increase in capacity and surplus after the expenditure of works in the new property to justify the BC. RH advised that the UHB have a £715k budget for revenue to capital transfer that could be utilised if WEQAS were able to undertake small refurbishments. **2.0 Major Capital Projects** GW provided an update of the two 'All Wales Capital Schemes'; • Neo-Natal phases 2a and 2b had been handed over to the UHB. The completion of the scheme in its entirety was scheduled September 2019. GW noted the delays included within the report, and highlighted the risk in the remaining contingency fund of £175k with £381k of potential risk remaining on the risk register. • Rookwood scheme was progressing well, with CRI internal building work on programme to complete December 2019. GW reported a potential 6 week delay to the external works however the contractor continued to review programme for mitigation. The main works at UHL had been delayed due to the enabling works required to relocate departments that had back filled previously vacated areas. The anticipated completion date for the main Rookwood component of the project was now being reported as end of January 2021. GW had met with the Supply Chain Partner who was reviewing the programme to determine whether there was any opportunity to pull back some of the time delay. **Capital Development Matrix** GW presented the Capital Development Matrix that included all schemes of development managed by Capital, Estates and Facilities and Strategic Planning Services. The schedule identified the status, budget, progress and any issues affecting programme delivery. **1.4 a -** GW advised that a meeting had been scheduled with Adam Wright and Tony Turley, 20.05.19, to review proposed layouts of the UHW Vascular & Hybrid Theatre that had been issued by the architect. The UHB had agreed to progress with OBC/FBC for the scheme, GW emphasized the importance of including the enabling works in the OBC to be able to achieve the end date. **1.3d** - Sketch drawings were in process for the Interim arrangements for the Major Trauma Centre (MTC), a meeting was scheduled with Zoe Roberts 23.05.19 for review and sign off.	

	MB advised that a request for a 2nd CT scanner for the Emergency Unit had been rejected, GW advised that was not the case, during a recent workshop the attendees from CD&T were advised to submit a case for consideration. MB advised that a 2m table would be required in the area and that a test for fit had been carried out. AH suggested that MB reprioritise the diagnostic equipment priority list submitted to WG and requested that MD and MB discuss as a separate meeting. **2.2 -** AH requested an update on Radio Pharmacy; GW advised that a project team meeting was scheduled 21/05/2019 including a conference call with the newly appointed Head of Radiopharmacy. FJ requested that a decision be made by the next CMG meeting, AH advised GW to escalate any issues following the scheduled conference call. **2.8 f & g -** AH requested confirmation that the B4H Ward refurbishment had appropriate funding. GW advised that B4H Ward refurbishment was included in the overall ward refurbishment programme listed within the report. C5 North refurbishment was being absorbed within the contingency fund. GW confirmed that the UHB had not received endorsement of the Sofw in the community Programme Business Case and that until this had been confirmed, funding for the OBC could not be accessed to progress Park View or CRI.	**MB/MD**
5.	**2.5 Letters of Approval** One letter of approval received in month being the approval of funding for the MRI Scanner replacement at UHW. This is yet to be returned to Welsh Government (WG) As a result the funding remained in the unapproved section of the CRL.	
6.	**MEDICAL EQUIPMENT REPORT** FJ presented the Medical Equipment Report and advise the group that CM role had changed and he was now the Managing Director of Genomics Partnership Wales. FJ confirmed that she was looking at how the portfolio held by CM could be supported moving forward including his role in relation to medical equipment. FJ confirmed that the Medical Equipment Group had an re-established and suggested that regular representation from Capital, Estates and Facilities would be useful. GW advised that NM would be the appropriate member to attend the group. FJ reported that £1m had been allocated from Discretionary Capital to the urgent medical equipment replacement budget, against the £4-£5m list of medical equipment replacements and known medical equipment issues.	

	Known issues included; • £2m – 2 additional birthing pools • £2m – replace Philips Perioperative patient monitors • Replacement of automated decontamination re-processors in UHW endoscopy & Urology • Consolidate a Central Sterilisation service. AH noted that the CMG had previously agreed to write out to CB's to identify a lead although unsuccessful, FJ noted that 1 clinical board would be required to lead service from a corporate responsibility for an off-site decontamination unit, and advised the Surgery would be the appropriate CB. FJ had briefly discussed with Adam Wright and Mike Bond. AH requested that LD address at Director of Ops Group to identify scope of a lead or identify how to lead or what would be required to source. FJ raised 2 medical equipment requests for CMG approval; • The replacement of 5 ophthalmology chairs / operating tables at £51k • Replacement detector for the Children's Hospital General Radiology room at £42k The CMG collectively approved the requests to be funded from the £1m allocated funds.	**LD**
7.	**IM&T REPORT** NL reported that WG had planned to invest £25m Capital and £25m revenue across Wales however, no update had been received of the allocated funding for the UHB. NL noted the requirement to upgrade or replace all devices that were not running Windows 10, as Windows 7 becomes End of Life in 2020. NL advised that a paper will be drafted for presentation at the next CMG scheduled June 2019, highlighting the capital and revenue costs. AH advised that the SBAR would require presentation at ME due to the revenue implications.	
8.	**SERVICE PLANNING** AH presented four business cases that were issued for consideration and approval for submission to UHB Board and WG. • Strategic Outline Case (SOC) Academic Avenue, New Block, £93.2m to WG. • Business Justification Case (BJC) Development of Cystic Fibrosis at UHL, to UHB Board • Outline Business Case (OBC) Development of the Wellbeing Hub at Penarth, £14m, to UHB Board • Outline Business Case (OBC) Development of the Wellbeing Hub at Maelfa, £12m, to UHB Board	

	AH noted that information was outstanding in the Outline Business Cases for Maelfa and Penarth although agreed that presentation at UHB board would continue as scheduled with a covering letter. The group noted and approved the Business Cases.	
	ANY OTHER BUSINESS GW advised the group that WG colleagues had enquired as to the position with regard to the return of the offer acceptance letter for the MRI replacements for UHW. Neither GW or RH could advise the Chief Executive in respect of the appropriateness of the funding as they were not party to the submission. MB was asked to confirm the allocation included in the correspondence was correct.	**MB**
11.	**DATE AND TIME OF THE NEXT MEETING** Monday 17th June 2019	

NHS WALES INFORMATICS MANAGEMENT BOARD

Minutes of the meeting
Thursday 11 April 2019 – 14:30-17:00

Attendees:

Andrew Goodall (AGD) (Chair)	Welsh Government
Frances Duffy (FD)	Welsh Government
Caren Fullerton (CF)	Welsh Government
Ifan Evans (IE)	Welsh Government
Albert Heaney (AH)	Welsh Government
Peter Jones (PJ)	Welsh Government
Bradley Kearney (Secretariat)	Welsh Government
Nicola Prygodzicz (NP)	Aneurin Bevan University Health Board
Dylan Williams (DW)	Betsi Cadwaladr University Health Board
Sharon Hopkins (SH)	Cardiff and Vale University Health Board
David Thomas (DT)	Cardiff and Vale University Health Board
John Palmer(JP)	Cwm Taf University Health Board
Anthony Tracey (AT)	Hywel Dda University Health Board
Andrew Griffiths (AG)	NHS Wales Informatics Service
Ruth Chapman (RC)	NHS Wales Informatics Service
Helen Thomas (HT)	NHS Wales Informatics Service
Neil Frow (NF)	NHS Wales Shared Services Partnership
Huw George (HG)	Public Health Wales
Sian Richards (SR)	Swansea Bay University Health Board
Daniel Phillips (DP)	Velindre NHS Trust
Chris Turley (CT)	Welsh Ambulance Service Trust
Claire Bevan (CB)	Welsh Ambulance Service Trust

Presenting:

Glyn Jones (GJ)	Welsh Government
Rhiannon Caunt (RCau)	Welsh Government
Tracey Hill (TH)	Public Health Wales
Rebecca McGrane (RMc)	Public Health Wales

Apologies:

Frank Atherton	Welsh Government
Evan Moore	Betsi Cadwaladr University Health Board
Rhidian Hurle	NHS Wales Informatics Service
Karen Miles	Hywel Dda University Health Board
Steve Ham	Velindre NHS Trust

1. Welcome, introductions and apologies

AGD welcomed members to the meeting, and noted apologies.

2. Chair's opening remarks

AGD said that the outcomes of the governance and architecture reviews meant that 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. AGD said that the meeting could be one of the last in its current format. He said it was important not to abandon some of the progress made in structuring governance, however there were expectations that changes would take place and it was important to move in a different direction.

AGD also said that one critical test for members and their respective organisations was to deliver things quicker at the local and national level, he said that pace and agility was a specific criticism from the Public Accounts Committee.

3. Discussion items

Open data

GJ gave a presentation to members about the use of open data. The key points from the presentation were:

- Open data refers to data that can be freely used, reused and shared with anyone under the Open Government Licence (OGL).
- The OGL had a five-star rating scheme that defines how easy it is for an external organisation to use data shared from another organisation. Organisations may find it easier to iteratively move up the rating system rather than aim for five stars immediately.
- The benefits of open data are that it provides transparency, improves services, helps boost economic growth, drives efficiency in the public sector, allows better decision making and provides better scrutiny.
- The perceived downsides are cost (but these can be relatively low), risks to privacy (but data shared is neither sensitive nor personal), and misuse (but this can be mitigated through good metadata).
- Examples include Transport for London, whose open data approach had allowed apps such as Citymapper to be developed, and the Food Standards Agency who publish information regarding restaurant hygiene ratings for app developers to use.
- Opportunities for health include providing information on the location of services, waiting times, opening hours and workforce data. This could lead to a number of benefits including better information for patients and families, reduced burdens on staff, improved integrated delivery, and increased openness and transparency.

AGD noted that he'd been asked recently about social care data, and said that there was an opportunity to be better in terms of the use of data there. AGD asked members for their thoughts on an "open data by default" approach.

SH said she supported the principle, and that the more open data was, the more it would support getting the public engaged with services. She also said that third

parties may be able to help display information in a better way for the public, and that some applications such as Patients Know Best feel quite controlled in comparison.

JP said there was an opportunity to move quickly on access to data. He said that previously, Welsh Government had tried to produce a picture of public services and publish live data, but the updating and refreshing the data became a burden. He noted however that different technology exists now that could make that possible.

CF said that organisations didn't need to do much to make a start on open data. She said that behind some of the examples in England, the data was the same as that which was available in Wales, the only difference being that we are not getting the benefit from it.

EW said if the ambition was to encourage people to train and work in Wales, the absence of open data might propagate myths and reasons why people would choose not to come to Wales. CB agreed, stating that open data would help educate the public and change behaviours.

There were also discussions regarding the opportunities that the Digital Health Ecosystem Wales provides to companies who wish to use open data, the opportunities that improved signposting of the availability of open data might provide, and the fact that some providers of services such as Dewis Cymru may be reluctant to make their datasets fully open.

AGD said that there was a feeling that Wales was not fully articulating what it was already doing in terms of data in health and social care. He said there was a challenge to members to allow others to use our data, as we may have not be using it well enough. He noted that A Healthier Wales outlines a more individualised approach, and so open data might go some way to validating that offer.

<u>Risks and issues</u>

AG gave further updates against the risks listed as critical on the NIMB risk register.

NP said that things were taking longer than anticipated on the rollout of WEDS, and said that she was not clear on the latest timescales. She said that a short paper to NIMB on the rollout would be useful. AGD agreed, and reiterated that he would like the risk resolved soon given its implications for other areas. He asked members for their views on the risks outlined.

HG said that the risk around patient authentication had not moved in a while, and highlighted that the scale of the piece of work was quite large in comparison to the risk. AGD noted that the risk should be reviewed with a view to potentially elevating it. AG said their outline plan around authentication needed resourcing, and that if they could find that funding soon it would make a big difference to the progress of other initiatives.

FD highlighted the risk around the data promise, stating that whilst there had been some struggles to move it forward, work was taking place including taking legal advice to work through some of the current issues. HT said that the data promise

was the main area of concern in Workstream 3, and they were keen to see it escalated as a risk as it would impact on the workstream's progress as a whole.

NF highlighted cyber security and asked whether others were happy with progress in that area. AGD said that cyber security was a key feature in the architecture review's report, and that it would be picked up positively in the final recommendations.

NP said that generally, it would be helpful if NWIS could provide a summary paper ahead of the risk register that highlights the main risks and provides a short narrative about those. NP raised specific concerns about the progress of WLIMS and WCCIS.

AGD asked NWIS to provide a note after the meeting to confirm timetables for WLIMS. He also said that he wanted the risks around WCCIS to be escalated to him personally, as he was concerned about the potential for delays in Aneurin Bevan, and was also concerned that the rollout would be affected.

EW said that Powys had seen great benefits from WCCIS. NP said that she recognised the huge benefits for staff and the excitement among staff who have used it elsewhere, but one area that was going live first in Aneurin Bevan was mental health, where there was already a system in place. She said there were fundamental issues that needed to be resolved, and that she did not wish to switch a system on and have it not do what it's meant to. AGD accepted the point, but commented on areas with no community information system at all and reiterated that organisations were given the chance to formally be part of discussions regarding the national specifications of WCCIS at the time.

Action: NWIS to submit a paper outlining the latest position and timescales of WEDS to the next NIMB meeting.

Action: NWIS to provide a short paper summarising the most critical risks alongside the full risk register at each NIMB meeting.

Action: NWIS to provide confirmation of WLIMS implementation timescales to members.

Action: Welsh Government and NWIS to escalate issues with rollout of WCCIS to AGD including an assessment of its risk status. NWIS to provide updates to each NIMB on progress, and WCCIS to feature as a standing item on future NIMB agendas.

<u>Architecture review</u>

IE spoke to members about the outcomes from the architecture review. He confirmed that Channel 3 had completed their work on time, and that a review group including some colleagues present, was now considering the recommendations and discussing practical implementation. He said that the review assessed the current state of readiness to deliver A Healthier Wales as amber, and noted that there was certainly potential to get to an effective architecture model due to the investment already made. IE also said that the review group would develop a programme of work to deliver the review's recommendations.

AGD said that the architecture review was perhaps more helpful when read alongside the governance review. He said that the Minister was open to reflect on the recommendations from this external work but it would be up to officials and stakeholders to set out the final recommendations e. He updated members by saying he was due to meet with Carol Shillabeer the day after the meeting to talk through some of the options and what expectations were from the perspective of Chief Executives.

Cardiff and Vale – Electronic referral management

AGD said he was pleased to be discussing the paper submitted from Cardiff and Vale, as it represents a fairly significant achievement. DT confirmed that 100% of referrals across 67 services in the health board were now being done electronically. He said that it had taken the best part of two years, and during that time they had to recognise that the behavioural changes required took the longest and needed to be managed carefully and with resilience. He said the health board was now looking at doing the same for tertiary services, and it set a good standard that he would expect to continue. He also said he was happy to share the learning they'd taken from the exercise with anyone interested. SH agreed that the behavioural changes were one area they learned a lot from, particularly how the organisation consolidated business change alongside organisational development.

Representatives from the other organisations gave updates as to how far they were in providing electronic referrals. AGD said that it could often feel as though there was a lot of scrutiny on organisations, and that it was important to highlight milestones such as this that were good for both Cardiff and Vale, and for Wales as a whole.

4. Decisions

WTSB statement of principles

PJ said that the Welsh Technical Standards Board (WTSB) were established at the request of NIMB, and that they have now produced a set of principles by which they want to work in order to deliver technical standards that allow data to be accessible wherever it was needed.

Members agreed the WTSB statement of principles and the recommendations of the paper.

CaNISC business justification case

HG presented the business justification case for the replacement of CaNISC. He acknowledged one of the main questions in terms of there potentially being alternative products or 'off the shelf' solutions available, and said he hoped the paper would address this question in terms of costings and mitigations. He said the project had reached a stage where the finances are clear in the ongoing discussions he had had with Welsh Government colleagues in the DHC team and the finance team. The paper had also been through the IPAD assurance group, and their comments were picked up in the amended version of the paper.

AGD said he was surprised that there wasn't a similar product already being used elsewhere in the UK or identified within the market. He also noted that clinicians he had spoken to all agreed that a national system was needed confirmed through the network work and development in the specification. HG acknowledged the Somerset system that had been raised in discussions before, and also noted that he thought it was further in development than it actually was.

JP asked what evaluation had been done in terms of what alternative products are available. HG said the evaluation was in two parts; firstly, an evaluation of available products had been done, and secondly an evaluation of whether to ask an external developer to produce what they're asking NWIS to do. HG said that the second point was an ongoing conversation.

SH asked whether the Somerset system had been looked at by clinicians in Wales and had an assessment been taken as to whether that system could be built upon to take things further than they currently were. HG said that the Somerset system only offers ten tumour sites currently in England, only provides two updates a year and was linked to the English patient record.

AG said that if cancer records were to be made part of a wider EPR, then it would become a larger business case. He said there was still the option to bring in developer teams to do development if needed. He said that the solution was aligned to what the architecture review said in terms of interoperability.

AGD said that there was a need to move this forward, and that at this stage he was looking for general support. He also noted that every cancer clinician he had spoken to said that a national solution was essential. He said he would like to all the costs to progress to the next stage and noted that there was the potential for flexibility further down the line. It was important that any progress was in line with open architecture principles from the recent review.

5. Papers to note

JP said that Cwm Taf had signed off on their WEDS business case, and that should be noted in the strategy highlight report. He said he would follow this up with NWIS after the meeting.

There was a discussion about the highlight reports in general, in which AGD said that there was a clear need to revisit the national digital strategy after the governance and architecture reviews.

AGD also raised My Health Online as an area that he would like to see more detail on implementation. He said that he would like to discuss this at a future meeting.

AGD also noted the number of positives that were highlighted in the workstream reports as having been delivered by the strategy, including WCP going live in primary care and WAST, the 100% rollout of GP2GP and the successful implementation of Choose Pharmacy.

From the CCIO report, AGD welcomed the news that PACS had now gone live in Cardiff and Vale.

Action: NWIS to update strategy highlight reports to confirm Cwm Taf's signing off of WEDS business case.

Action: MHOL to be discussed at a future meeting, with a paper being provided by NWIS with detailed delivery, implementation and usage figures.

6. Minutes and actions of previous meeting

The minutes of the February meeting were approved by members.

7. Any other business

AGD said that the WAST strategic outline case was an item to note as it was not listed as a priority deliverable as agreed at the previous NIMB, and that it would be best managed as a direct conversation between WAST and Welsh Government. CT said he was having a number of conversations already about the project, including with the DHC team in Welsh Government.

AGD also noted the paper on Welsh language, and RC explained the issue and recommendations. PJ said that if members agree to move forward on the basis set out in the paper, there was the possibility of deferment of enforcement. He also said that his team were working with the Welsh language unit on a number of issues around Welsh language, particularly patient safety.AGD said that he wanted all organisations to work on a coordinated approach to this, noting that digital is an enabler to properly support Welsh language use and standrads.

AGD reminded members that whilst this might be the last meeting of NIMB in its current form, he asked members to keep the meeting scheduled for 10 June in their diaries.

AGD asked for an update on WPAS in Betsi Cadwaladr UHB, having raised this with the BCU Executive Team. AGD confirmed that the team there were working flat out on the next stage implementation.

Action: All organisations to work with NWIS to work on a coordinated approach to the implementation of Welsh language standards.

NIMB will provisionally meet next on 10 June 2019.