Bundle Information Technology and Governance Sub Committee 29 January 2019

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10	Work Programme (Exception areas for assurance on progress and mitigations)
10.1	WCCIS - Assurance on progress
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10.3 Additional Capital allocation (WG) - planned programme

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11 Items to be recorded as received and noted for information by the Committee

11.1 Capital Management Group Minutes - Dec 2019

11.1 Capital Management Group - Minutes of the Meeting held 17th December 2018 FINAL.docx

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12 Any Other Business

13 Items to bring to the attention of the Board/Committee

14 Review of the Meeting

15 Date of the next meeting:28 May 2019 at 9am, Corporate Meeting Rm, HQ

INFORMATION, TECHNOLOGY AND GOVERNANCE SUB-COMMITTEE MEETING

On 29th January 2019 at 09.00 am

AGENDA

1	**Welcome & Introductions** – Note: Mr David Thomas, Director of Digital and Health Intelligence	Eileen Brandreth
2	**Apologies for Absence**	Eileen Brandreth
3	**Declarations of Interest**	Eileen Brandreth
4	**Minutes 31st October 2018**	Eileen Brandreth
5	**Action Log 31 October 2018**	Eileen Brandreth
6	**Chairs Action taken since last meeting**	Eileen Brandreth
7 **7.1**	**Risk Assurance Framework:** (Receive and note and comment on areas of exception) Joint IM&T Risk Register	Nigel Lewis
8 **8.1** **8.2** **8.3** **8.4** **8.5** **8.6**	**Assurance Reports and Action Plans** IMT Audit Assurance report – action plan progress Combined ICO/GDPR Action Plan – assurance on progress Integrated Governance Report / Report of SIRO Controlled Documents Framework / Updated IG Policy Internal Audit Report: Information Governance Report of the Caldicott Guardian	Sharon Hopkins
9 **9.1** **9.1.1** **9.1.2** **9.2** 9.3 9.3.1 9.3.2 9.3.3	**Strategic Issues** Transformation Board Progress and discuss direction Digitally enabled workforce and organisation Accessible information for clinicians Strategic Engagement Alignment of national and local digital developments and direction – note and discuss Update on Welsh Government Review of Governance of: NHS Informatics in NHS Wales Architecture of NHS informatics in Wales PAC report on Informatics in Wales	Sharon Hopkins Verbal Verbal

9.3.4	PAC report Appendix 1	
10 **10.1** **10.2** **10.3**	**Work Programme** (Exception areas for assurance on progress and mitigations) WCCIS – assurance on progress wLIMS Additional Capital allocation (WG) – planned programme	Sharon Hopkins
11 **11.1** **11.2**	**Items to be recorded as received and noted for information by the Committee** Capital Management Group minutes – Dec 2019 NIMB minutes	Eileen Brandreth
12	**Any Other Business**	Eileen Brandreth
13	**Items to bring to the attention of the Board/Committee**	Eileen Brandreth
14	**Review of the Meeting**	Eileen Brandreth
15	**Date of next meeting:** 28 May 2019 9am Corporate Meeting Room HQ, UHW	Eileen Brandreth

Minutes of the Information Technology and Governance Sub Committee Meeting
Held on 31st October 2018 at 1.00 p.m.
Headquarters Meeting Room, UHW

Present:

Eileen Brandreth	EB	Chair
Dr Sharon Hopkins	SH	Deputy Chief Executive /Director of Transformation, Improvement, Informatics and Commissioning (TIIC)
Dr Fiona Jenkins	FJ	Executive Director of Therapies and Health Science
Nicola Foreman	NF	Director of Corporate Governance
Andrew Nelson	AN	Assistant Director of Information and Performance
Christopher Lewis	CL	Deputy Director of Finance

In attendance:

Nigel Lewis	NL	Assistant Director of IT and Strategy
Phil Clee	PC	IT Programme Manager
James Webb	JW	Information Governance Manager
Julie Cassley	JC	Assistant Director of Workforce
Andrew Strong	AS	Wales Audit Office

Apologies:

Andrew Crook	AC	Head of Human Resources Policy and Compliance
Paul Rothwell	PR	Senior Manager Performance and Compliance
Michael Imperato	MI	Independent Member
Dr. Graham Shortland	GS	Medical Director (Caldicott Guardian)
Joanne Brandon	JB	Director of Communications

Minute Ref		Action
ITGSC18/048	**Welcome and Introductions** The Chair of the Committee welcomed Members to the meeting and stated that she had been working with the Deputy Chief Executive and Executive Director of Therapies and Health Science to ensure that the agenda addressed strategic issues and provided assurance.	
ITGSC18/049	**Apologies for Absence** Apologies for absence were noted.	
ITGSC18/050	**Quorum** The meeting was quorate.	
ITGSC18/051	**Declarations of Interest** There were no Declarations of Interest.	
ITGSC18/052	**Minutes of the meeting held on 13th June 2018** The Committee reviewed the minutes of the meeting held on 13th June 2018. **Resolved – that**	

The minutes of the meeting held on the 13th June were approved as an accurate record.

ITGSC18/053 **Action Log 13th June 2018**

Resolved – that

(a) The action log was noted.

ITGSC18/054 **Review of Information Governance Arrangements and Support Report**

The TIIC Director/Dep CEO advised that James Webb had been appointed as the new Information Governance Manager. The committee thanked the previous Manager, Paul Rothwell for his excellent work and heard that he would continue to provide advice to the new manager about how to reframe the Department's workload. Mr Rothwell would also continue to act as the Data Protection Officer until March 2019. The team would be strengthened by two appointments that had been made for posts starting in November.

Resolved – that:

(a) The Sub Committee noted the update report on Information Governance arrangements that were currently in place.

ITGSC18/055 **IG Mandatory Training Report**

This item was referred from the main Health Board, who had queried the efficacy of Information Governance training as there had been ongoing issues where personally identifiable data had been left in unsecure conditions across the UHB.

The Director TIIC/Dep CEO commented that the Information Governance module was part of the Health Boards mandatory training schedule and that the Communications team were raising awareness of the importance in engaging with this training. She also noted that NHS Wales had procured around 200 e-licenses for mandatory training online which was being rolled out by NWIS and that GDPR had helped raise the profile of this issue.

The Assistant Director of Workforce, Julie Cassley mentioned that the current level of IG training compliance is 82.6% which is the second highest mandatory module. The target is 85%, allowing for 15% staff leave or absence, across nearly 15,000 staff across all disciplines.

Resolved – that:

(a) The Sub Committee noted the IG Mandatory Training report on Information Governance arrangements that were currently in place.

ITGSC18/056 **Chair's Actions taken since the last meeting**

It was confirmed that no Chair's actions had been taken since the last meeting of ITGSC.

ITGSC18/057 **IT/IG Risk Assurance Framework Report**

The Chair noted that the IG and IT risk registers had now been combined.

The Director of Therapies and Health Sciences introduced the paper and drew the Sub-Committee's attention to the IT risks rated red and need to prioritize action against available resource. She highlighted the following:

Virtual server farm infrastructure – an updated plan had been taken to the capital management group in Spring. Previous updates to the sub-committee had noted success over the last four years in achieving the investment levels needed to mitigate risks arising from legacy infrastructure however, this year the required level of discretionary capital could not be made available. A risk based approach had been taken to prioritise allocation available. The Chief Executive Officer had written to Welsh Government raising concerns about the capital position. It was noted that failure of the virtual server farm would be of high impact across the Health Board (currently Red scoring 20 with IM&T joint risk register).

Cyber Security – the business continuity risk relating to Cyber was accepted and strengthening cyber security was agreed as critical issue to be addressed Funding to support current plans is not yet secured. Funding opportunities to mitigate this continued to be explored.

WLIMS – will be addressed in Work Programme agenda item 10.2

The Chair asked for comment at the next meeting about how the Risk register was used to support operational running of IM&T. She also noted the issues previously reported in relation to national service outages and whether these were appropriate reflected in the risk register. A brief was requested for the next meeting about which service outages were required to be reported to Welsh Government and whether this was working.

Resolved – that:

(a) The Sub Committee reviewed and noted the report and the concerns expressed within it.

(b) The TIIC to provide assurance on use of risk log in the operational management of IM&T **SH**

(c) A brief be provided about which service outages were required to be reported to Welsh Government and whether this was working. **NL**

ITGSC18/058

Transformation Board Progress Report

The sub-committee discussed which components of the Transformation programme should be part of its assurance role whilst avoiding duplication with the main Board. It was acknowledged that the sub-committee was well placed to champion and challenge elements that relate to digitization and the information access agenda. The Chair and TIIC Director/ Deputy Chief Executive would meet to agree this prior to the next meeting in order to inform the agenda.

Resolved – that:

(a) The Sub Committee noted the report given on Transformation

	(b) The Chair & Director TIIC/ Deputy Chief Executive to meet to discuss which components of the Transformation Programme would be included in the Sub Committee agenda going forward.	**SH/EB/FJ**
ITGSC18/059	**Failure of Services at National Data Centres Report** The Executive Director of Therapies updated the sub-committee that the report submitted should give assurance to the Health Board that there has been local engagement about the impact arising from the previous service failures in the National Data Centre and that concerns had been appropriately raised about this as clearly, the platform needed to be resilient and stable to minimize risk to the services and impact on patients. It was noted that a further breech was managed in accordance with NWIS and the Welsh Government appropriately and communication had improved. There was some discussion ongoing about increasing resilience of locally national provided systems through the provision of a local data mirror copy for use should further instances of main Data Centre access occur. **Resolved – that:** **(a) The Sub Committee noted the report**	
ITGSC18/060	**Work Progress Highlight Reports** **Welsh Clinical Portal Report** The Chair commented favorably about the visual representations of progress with the WCP component roll-out across the UHB, asking that it be simplified to fit onto one page. WCP was developed via a process where additional functionalities (as and when these become available) are distributed for use on a ward by ward basis. National funding available to support this distribution would come to an end in March 2019 and a study on this would be undertaken to consider how the remaining components would be delivered. **Resolved - that:** **(a) The Sub Committee noted the report.**	
ITGSC18/061	**Digitisation of Medical Records Report** Whilst the Health Board had made significant progress in the delivery of digitized records through the use of portal technology, there remained a reliance on paper for recording clinical information. A new module on the PMS system had been built which incorporated all clinical workflow with the new standards needed to support making the data available. This would also allow all outcomes to be captured digitally. **Resolved - that:** **(a) The Sub Committee noted the report.**	

ITGSC18/062 **Welsh Community Clinical Information System Report**

The Executive Director of Therapies presented the report, mentioning that a meeting with colleagues from Cardiff and Vale team and Cardiff Local Authority had taken place to discuss their respective positions in relation to WCCIS. Whilst committed to supporting development of the WCCIS solution, C&VUHB is cognizant that the deployment of the new system must bring benefit over and above that of it's community system (PARIS). The heath component of WCCIS was currently not functional.

Resolved - that:

(a) The Sub Committee noted the report.

ITGSC18/063 **WLIMS Report**

Concerns over the stability of the national architecture and the appropriateness of the WLIMS blood component had been expressed. C&VUH were in discussion with other health boards about how to maintain service through the existing Telepath solution and a paper would be presented to Management Executive within a few weeks for a decision to be made. **FJ**

Resolved - that:

(a) The Sub Committee noted the report.

(b) The Sub Committee noted the conclusion of the Extraordinary National Pathology IT Programme Board held on 5th October 2018.

(c) The Sub Committee noted that a report would be presented to the Management Executive on the WLIMS

ITGSC18/064 **Audits**

IMT Audit Assurance / Action Plan

The Chair noted good progress with the suppliers of the maternity / Theatreman and Specialist Services patient IT systems. Concerns about the virtual server farm had been previously discussed.

Resolved - that:

(a) The Sub Committee noted the report.

ITGSC18/065 **Information Commissioners Office Visit – Action Plan**

The Sub-Committee considered action relating to outstanding audit points raised by the Information Commissioner Office in relation to UHB compliance with the Data Protection Act 1998 carried out in May 2016.

The sub-committee was asked to note that significant progress had been made in delivering actions under the original action plan agreed with ICO and that whilst this work was continuing it over-lapped with the new action plan designed to ensure compliance with GDPR. The sub-committee were asked to agree that, going forward, it would receive a combined GDPR/ICO action plan.

Resolved - that:

(a) The Committee noted the update in relation to action following the audit by the ICO of UHBs compliance against the Data Protection Act 1998 which was undertaken in May 2018.

(b) The Committee noted the significant progress which had been made in delivering actions under the original action plan agreed with the ICO.

(c) The Committee agreed that going forward the ITGS Committee would receive a combined GDPR/ICO action plan.

ITGSC18/066 **Combined ICO/GDPR Action Plan**

The observer from the Welsh Audit Office queried whether, given the amount of amber actions outstanding, "significant progress" was the correct term for the sub-committee to accept. The Director TIIC/Dep CEO responded that consistent attention has been paid to this work and progress made. It was accepted that the pace must continue to address outstanding points in full and that whilst so many were in amber it is not where the UHB would wish to be. However as a highly complex organization operating within financial and organizational constraints, progress has been quite significant.

It was noted that progress had been re-baselined for the action plan and this was a realistic representation of action needed to fully comply with the regulations. It was noted that the RAG ratings used should allow for a mechanism to show whether the situation was improving, not changed or deteriorating for each outstanding risk through the use of an arrow, as this would improve understanding of progress against some very broad and longer term actions.

Resolved - that:

(a) The Committee noted the significant progress which had been made in remedying the shortcomings identified by the ICO in their audits of compliance against the Data Protection Act.

(b) The Committee received and commented upon the action plan and the areas of progress which had been made.

(c) The Committee noted that actions which had been taken to strengthen governance arrangements

ITGSC18/067 **Periodic Items for Assurance**

Caldicott Guardian Report

The Medical Director, although not in attendance had sent comments to the sub-committee:

Cardiff and Vale University Health Board (the UHB) is required to complete a Caldicott Principles in Practice (CPiP), Self-Assessment exercise each year to provide assurance that continuous improvement is made. Because of IG staffing problems it had not been possible to complete the 2017/8 CPIP

assessment.

CPIP scores could not be readily reconciled with the ICO's assessment, undertaken in May 2016, that UHB could only be given a "limited assurance" rating in terms of its compliance with the Data Protection Act (DPA) 1998.

Resolved - that:

(a) The ITGSC noted the updates in relation to :

- **Digitisation**
- **Records destruction**
- **Restricted access to central medical records libraries**
- **Medical Records Library**
- **Decommissioning of Whitchurch Hospital**
- **2017/18 Caldicott Principles in Practice Assessment**.

ITGSC18/068 **Integrated Governance Report**

The Chair noted concern with Freedom of Information compliance and was assured by the appointment of two new staff members into the team dealing with this business and that the Committee should see improvement in the level of compliance with FOI requests by the next meeting.

Resolved - that:

(a) The Sub Committee received and noted the report on Integrated Governance.

ITGSC18/069 **Controlled Documents Framework**

The Chair noted the intent to adopt the Welsh version of the IG policy although noted her concern that neither the Controlled Documents Framework nor the updated IG Policy had been brought to the sub-committee.

The Director TIIC / Deputy Chief Executive acknowledged the concern, referencing the difficult staffing circumstances that were impacting on progress in this area and assured the Chair that this would be addressed in the next meeting of the sub-committee. **SH**

The sub-committee were advised that that UHB Controlled Document Framework was being strengthened and rationalized via the updating of the UHB Information Governance (IG) policy. The new policy would amalgamate four separate policies covering IG policy, internet and e-mail use and IT security into one document. These policies had been developed nationally by the Information Governance Managers Advisory Group (IGMAG).

Resolved - that:

(a) The Sub Committee noted that an updated Subject Access

Request Procedure had been submitted to lawyers for review.

(b) The Sub Committee noted that Version 5 of the Wales Accord on the Sharing of Personal Information had been issued.

(c) Deputy Chief Executive to bring the Controlled Documents Framework and the draft updated IG policy to the next meeting.

ITGSC18/070 **Items to be recorded as received and noted**

Resolved - that:

(a) The Sub Committee received and noted the following:

- **NIMB Minutes - 16th August 2018**
- **Capital Management Group Minutes – 20th August 2018**

ITGSC18/071 **Any Other Business**

There was no other business reported.

ITGSC18/072 **Review of the Meeting and Items to bring to the attention of the Board/ Other Committees**

There were no items to bring to the attention of the Board of other Committees

ITGSC18/073

Date of Next Meeting

The date of the next meeting was confirmed as 29th January 2019 commencing at 9.00 a.m. within the Meeting Room at Headquarters.

Signed:

Date:

ACTION LOG
FOLLOWING INFORMATION TECHNOLOGY AND GOVERNANCE SUB COMMITTEE
31 OCTOBER 2018 MEETING

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS
Actions Completed					
Actions In Progress					
ITGSC 18/059, 18/029 and IGSC 17/028	CPiP report	Submit final 2017/8 compliance report to ITGSC	October 2018 January 2019	Paul Rothwell/	17/18 compliance report regarded as complete as exercise essentially regarded as closed by NWIS. Report on 18/19 compliance status to be given to Jan 19 meeting
ITGSC 18/028 and IGSC 17/031	GP Pilot	Three month pilot report to be submitted to the next meeting	TBC	Paul Rothwell	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	January 2019	Graham Shortland	Update noted at October 18 meeting. Further update to be given at Jan 19 meeting
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	January 2019	Sharon Hopkins	Updated noted at October 18 meeting. Review of Info Governance function noted by Executive and actions to rebuild team supported. To be monitored through the governance report.
ITGSC 18/057	IT/IG Risk Assurance Framework	Clarity on which service outages were required to be reported to Welsh Government to be sought	January 2019	Nigel Lewis	Completed
ITGSC 18/063	WLIMS Report	Report to be presented to the Management Executive on how the	December 2018	Fiona Jenkins	Completed

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS
		service could be maintained through the existing Telepath Solution			
ITGSC 18/069	Controlled Documents Framework	The Deputy Chief Executive to present the Controlled Documents Framework and draft IG Policy to the next meeting	January 2019	Sharon Hopkins	On agenda for January
Actions referred to committees of the Board					

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)	12/13/2013	1/18/2019	Capital / HR / Service Interruptions	DOI	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	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 is required in 2018/19, but to-date only £500k has been allocated. However WG funding of £1.786M has now been agreed of which £770K will go towards modernisation of digital infrastructure. This will improve the situation whilst the UHB continues to engaged with WG on the prioritisation of potential future additional IM&T capital.	IM&T implementation programme IT&G Sub Committee established to oversee progress Standards for Health Services: Information management and communications technology	S&D
6.8.2 A3/0104	End of Life Infrastructure	Each year a number of departmental servers fall in to the category of being end of life and without hardware maintenance contract.	12/13/2013	1/18/2019	Service Interruptions	DOI	4	4	16	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 is required in 2018/19, but to-date only £500k has been allocated. However WG funding of £1.786M has now been agreed of which £770K will go towards modernisation of digital infrastructure. This will improve the situation whilst the UHB continues to engaged with WG on the prioritisation of potential future additional IM&T capital.	IM&T implementation programme IT&G Sub Committee established to oversee progress Standards for Health Services: Information management and communications technology	S&D
6.8.3 A3/0105	End of Life Infrastructure	The Health Board's clinical and business needs requires continued and expanding use of server (and PC) based infrastructure. This infrastructure has a maximum lifespan of typically 5 years and then requires replacement.	12/13/2013	1/18/2019	Service Interruptions	DOI	5	3	15	10	MODERATE	The IM&T department identifies and informs the Health Board on a regular basis regarding end of life infrastructure. However whilst there is an infrastructure requirements investment strategy there is no recurring agreed investment programme to meet increased back up needs in the future. IT Infrastructure investment competes for Discretionary, Welsh Government and Year end capital on an ongoing basis.	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 is required in 2018/19, but to-date only £500k has been allocated. However WG funding of £1.786M has now been agreed of which £770K will go towards modernisation of digital infrastructure. This will improve the situation whilst the UHB continues to engaged with WG on the prioritisation of potential future additional IM&T capital.	IM&T implementation programme IT&G Sub Committee established to oversee progress Standards for Health Services: Information management and communications technology	S&D
6.8.4 A3/0108	Backup Demand	Backup demand: The demand by clinical and administrative services for data to aid clinical and admin requirements increased exponentially over time. There is an increasing demand therefore for backup infrastructure to enable effective backup's to be completed within available windows.	12/13/2013	1/18/2019	Service Interruptions	DOI	5	2	10	4	Low	The backup infrastructure in place is sufficient to effectively backup all appropriate data at the moment. However whilst there is an infrastructure requirements investment strategy there is no recurring agreed investment programme to address the increasing demands for the future. IT Infrastructure investment competes for Discretionary, Welsh Government and Year end capital on an ongoing basis.	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 is required in 2018/19, but to-date only £500k has been allocated. However WG funding of £1.786M has now been agreed of which £770K will go towards modernisation of digital infrastructure. This will improve the situation whilst the UHB continues to engaged with WG on the prioritisation of potential future additional IM&T capital.	IM&T implementation programme IT&G Sub Committee established to oversee progress Standards for Health Services: Information management and communications technology	S&D
6.8.5 A3/0109	Back up Media	Clinical Systems require increasing quantities of backup media to maintain effective backups. Revenue stream required from these departments.	12/13/2013	1/18/2019	Service Interruptions	DOI	5	2	10	4	Low	Whilst the core backup infrastructure in place is sufficient to effectively backup all appropriate data at the moment, these backups require copying to tape. There is no revenue stream identified to address this need, a requirement which is continually expanding and will continue to do so. The UHB must institute a policy of departments paying for their backup media or create a central revenue stream to cover these costs. Failure to do so will result in loss of backup capability.	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 is required in 2018/19, but to-date only £500k has been allocated. However WG funding of £1.786M has now been agreed of which £770K will go towards modernisation of digital infrastructure. This will improve the situation whilst the UHB continues to engaged with WG on the prioritisation of potential future additional IM&T capital.	IM&T implementation programme IT&G Sub Committee established to oversee progress Standards for Health Services: Information management and communications technology	S&D
6.8.6 A3/0110	Virtualisation	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 infrastructure to maintain.	12/13/2013	1/18/2019	Service Interruptions	DOI	5	4	20	10	MODERATE	Whilst the processes in place provide adequate protection of server infrastructure in line with the availability of existing resources, the UHB must 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 is required in 2018/19, but to-date only £500k has been allocated. However WG funding of £1.786M has now been agreed of which £770K will go towards modernisation of digital infrastructure. This will improve the situation whilst the UHB continues to engaged with WG on the prioritisation of potential future additional IM&T capital.	IM&T implementation programme IT&G Sub Committee established to oversee progress Standards for Health Services: Information management and communications technology	S&D
6.8.8 A4/0004	Network End of Life	A third of the outer tier of the UHB Cisco Network Infrastructure still remains end of life and has no warranty. It requires a £0.15m replacement programme	12/13/2013	1/18/2019	Service Interruptions	DOI	5	2	10	4	Low	The UHB has replaced all main core switches in the UHW and 2/3 of outer tier switches to help mitigate this risk.	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 is required in 2018/19, but to-date only £500k has been allocated. However WG funding of £1.786M has now been agreed of which £770K will go towards modernisation of digital infrastructure. This will improve the situation whilst the UHB continues to engaged with WG on the prioritisation of potential future additional IM&T capital.	IM&T implementation programme IT&G Sub Committee established to oversee progress Standards for Health Services: Information management and communications technology	**S&D**
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. Current estimates would indicate a need to replace 4500 PC's in order to meet this deadline. There are potentially significant issues with compatibility with applications systems in use both Nationally and within the HB specifically.	12/13/2013	1/18/2019	Cyber /Service Interruptions	DOI	**3**	**5**	15	10	MODERATE	The UHB has less than 60 x XP PC's remaining on the Domain a number of which are due to application software not being able to "run" on Windows 7 and Windows 10 Operating Systems.	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 paper to be prepared outlining the actions plan in relation to Windows 10 migration.	IM&T implementation programme IT&G Sub Committee established to oversee progress Standards for Health Services: Information management and communications technology	**S&D**
6.8.10 A4/0022	Asbestos	The UHB has 6 data cabinets located in the Attic at the University Hospital of Llandough which are now locked due to Asbestos, and now no longer accessible to IT	12/13/2013	1/18/2019	Health & Safety	DOI	4	3	12	4	Low	Three of the Data cabinet areas have had Asbestos removed and the Data Switches have not been contaminated, however the flooring and ladders have not yet been reinstated. Five staff have been counselled for possible access to Asbestos having worked in these areas and Employment Records endorsed a further six staff are yet to be counselled	The UHB Estates Department have commissioned the cleaning of the other attic areas. The Network Team Staff if required to access the area will have "full face masks" and protective clothing and will also be escorted by a colleague	IM&T implementation programme IT&G Sub Committee established to oversee progress Standards for Health Services: Information management and communications technology	**S&D**
6.8.11 A4/0023	Cyber Security	The Cyber Security threats to service continuity	12/13/2013	1/18/2019	Cyber /Service Interruptions	DOI	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 the level of device patching. However further work required is not achievable within the current level of staffing within the department.	Business case for initial staff resource funding has been submitted to relevant levels of HB Boards and accepted as appropriate to the need but funding not currently available. Business case further notes that allocation of funding will not provide an immediate solution, merely for resources to work towards a solution over a relevant time period (12 -18 months).	IM&T implementation programme IT&G Sub Committee established to oversee progress Standards for Health Services: Information management and communications technology	S&D

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
6.8.12 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.		1/18/2019	Clinical Service Interruptions	DOI	5	4	20	10	MODERATE	The UHB is engaged with NWIS and other Health Boards to evaluate options available to mitigate this risk.	Active options being pursued include: Extend Hard Ware support, Extend Software support, accelerate migration. There was an Extraordinary National Pathology IT Programme held on 5th October 2018 It was agreed at an extraordinary National Pathology IT Programme Board that Health Boards which are currently running 'at risk' legacy versions of the Telepath (TPATH) software should develop plans to upgrade TPATH to a newer version and include a supporting hardware upgrade. This will significantly reduce the risks to these Health Boards associated with existing software and provide a resilient business continuity contingency in the event of further delays to the implementation of the Blood Transfusion module of WLIMS. The affected Health Boards are Cardiff and Vale UHB, Betsi Cadwaladr UHB, Hywel Dda UHB and Cwm Taf UHB. Costs are currently being worked up on behalf NHS Wales. This process is being coordinated by Cardiff and Vale UHB. End of year WG programme 'slippage' monies could be targeted to fund this NHS Wales legacy system upgrade. 18/01/2019 - the risk will be reviewed as part of the implementation of telepath refresh so as such won't be updated until that point	IM&T implementation programme IM&T Sub Committee established to oversee progress Standards for Health Services: Information management and communications technology	S&D
6.8.13 A4/0025	WCCIS National and Local Teams no resourced	WCCIS Risk: The delivery and implementation of a single instance National Mental Health, Community and Therapies System (WCCIS) requires significant resources to co-ordinate work streams and implement key deliverables across all 7 Health Boards and 22 Local Authorities. Consequence: Delayed milestones, poor quality deliverables and ultimately delayed realisation of benefits. Critical deliverables are being held up, including: local business case; delivery of full functionality against the Statement of Requirements; delivery of essential product enhancements; infrastructure, system configuration, service management, ongoing support, integration with other national systems, testing, data migration. Local implementation will require clinical informaticists, business change managers, implementation teams etc.	2018	1/18/2019	Business and Organisational Strategy	DOI	4	5	20	10	MODERATE	Update 6/6/2018: Funding for 2 BA posts lost for 2019/20; Timing of implementation will be based on objective assessment and progression of a suite of c170 changes that require detailed specifications and working through with the vendors. WCCIS is 'live' in 12 Local Authorities and partially in 1 Health Board. WCCIS has been rejected by one Local Authority (Carmarthenshire... one of the OLM consortia).	UHB working with NWIS, WG and Regional IHSCP on review of WCCIS deliverables including Health functionality, information standards, data migration and reviewed commercial arrangements. Funding arrangements are not critical for 2019/20 on this politically WG supported initiative.	IM&T implementation programme IT&G Sub Committee established to oversee progress Standards for Health Services: Information management and communications technology	S&D
Effective governance, leadership and accountability	NWIS Governance	Governance arrangements for overseeing and challenging NWIS are weak. There is insufficient transparency, blurred lines of accountability and they lack a clear set of priorities **Consequences:** The significant resource we provide to NWIS is not optimally used to support the UHB in delivering its statutory obligations nor in supporting us to deliver our strategic objectives as identified in "Shaping Our Future Wellbeing"	2/2/2018	1/18/2019	Governance	DOI/ 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		S & D
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	9/28/2015	1/18/2019	Governance / Clinical	DOI/SIRO	**4**	**4**	16	**9,(3x3)**	MODERAT	DPA action plan being progressed although slow going across a number of directorates. 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.	Ongoing implementation of GDPR/ICO action plan		S & D
Holding information securely and confidentially	Readiness for forthcoming service resilience legislation - NIS	The NIS-Directive (NIS-D) is a directive embedded in UK law that requires the Health Board to ensure continued service where that service is principally provided through ICT based infrastructure. The NIS-D takes no account of type of failure (power, cyber-security, aged infrastructure, mis/lack of investment), just that the failure impacts ICT based services. Failures to deliver healthcare services as a result of ICT systems failure will carry significant fines of up to €20M. Failures as a result of failure to comply with basic resilience recommendations have the potential to be doubled (up to €40M)	1/1/2018	1/18/2019	Clinical / Service / Business Interruption		**5**	**1**	5	**4**	Low	Requires engagement with relevant Competent Authorities – in our case WAG. High level discussions yet to be concluded and the HB is awaiting information from WG.	None at this time		S & D
Recording information accurately and reliably	Data quality	High level risk - core business activities potentially compromised as a result of weaknesses in assurance framework in areas listed below: Absence of Standard Operating Procedures to administer patient activity, Low take up of staff training in Standard Operating Procedures to administer patient activity, Incorrect/incomplete/late recording of activity Absence of ISO 27001 certification. **Consequences:** Potential for poorer patient outcomes and experience, analysis and benchmarking flawed resulting in poor decision making, under recovery of income, inability to maximise potential of R&D	2/19/2018	1/18/2019	Governance	DOI	**4**	**4**	16	**8 (2x4)**	MODERAT	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		S & D
Recording information accurately and reliably	Clinical Records Incomplete	**Risk:** Clinical records are not joined up across disciplines, care settings or geographical boundaries resulting in incomplete and out of date patient information. Summary information is not routinely shared across systems. Differing local service models which are also going through a period of significant change mean access to appropriate data is an increasing need. **Consequence** is unsupported clinical decision-making, introducing patient harm and/or disadvantage and failure to meet NHS Wales digital strategy	9/28/2015	1/18/2019	Clinical	MD	3	4	12	6 C=3, L=2	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		S & D
Using information effectively and ethically	Outcome Measures	**Risk**: Unavailability of full, consistent care delivery information results in an inability to ascertain outcomes of care we provide, and commission, plan and improve services accordingly. **Consequence -** Low assurance on safety, quality and effectiveness of services and satisfaction with services, sub optimal decision making, inability to execute policy and strategy, reputational damage.	9/28/2015	1/18/2019	Business and Organisational Strategy	DOI	3	4	12	4 C=2, L=2,	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		S & D
Using information effectively and ethically	DPA related agreement ts	Risk: obligations and accountabilities relating to the way data is handled are not formalised Consequence: the UHB could suffer detriment and/or have difficulties applying remedies against a third party if data is not handled appropriately	2/16/2018	1/18/2019	Governance	SIRO/DOI	4	4	16	7 (x3)	MODERAT	Library of outline documents for sharing data available with completion supported by corporate information governance department. Requirements to use emphasised in training.			S & D
Using information effectively and ethically	Compliance auditing	Risk Access to sensitive data on relevant IT systems is not routinely audited. '- UHB does not fulfil duty of confidence, - UHB's processes to ensure information is recorded in line with principle of Right patient, right record, right place, right time are compromised, - Consequence: Data may be being accessed in contravention of IG legislation. Potential for significant fines. Reputational damage Suboptimal use of the data available to improve health, healthcare deliver	2/16/2018	1/18/2019	Governance	DOI	3	3	9	8 (x3)	MODERAT	NIIAS, mail Marshall and local solutions in place. Options for fine grain auditing of the warehouse over and above logging SQL code being considered.			S & D
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 (eg WCRS, WRRS) **Consequence** - Inability to deliver strategic UHBs, namely - Supporting people in choosing healthy behaviours, - Encouraging self management of conditions, - Enabling people to maintain or recover their health in or as close to home as possible, - Creating value by enabling the achievement of outcomes and experience that matter to people at appropriate cost, - Enable and accelerate the adoption of evidence based practice, standardising as appropriate	9/28/2015	1/18/2019	Clinical / Service / Business Interruption	DOI	**3**	**5**	15	**1**	Low	Approach identified to work with C&V GPs o 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		S & D
Effective governance, leadership and accountability	Processing of personal data by UHB in research projects	The UHB is not protected in the event that fines are levied if it is held responsible for personal data being compromised in relation to research activity	10/18/2018	1/18/2019	Governance	DOI	3	3	9	8 (x3)	MODERAT	N/a - the UHB cannot insure against this liability and a third party organisation would not give an indemnity because no insurer would cover the errors etc. by another organisation over which it effectively had no control			S & D

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
Effective governance, leadership and accountability	Governance framework (IG policies and procedures)	Risk: IG policies and procedures are not up to date/do not cover all relevant areas. Procedures are not aligned to relevant national policies. Consequence: Lack of clarity in terms of how the UHB expects its staff to work to in order for relevant accountabilities to be discharged.	2/16/2018	1/18/2019	Governance	SIRO/DOI	4	4	16	6 (x3)	MODERAT	Update: Controlled document framework requirements delayed due to resource constraints			S & D
Effective governance, leadership and accountability	Effective resource utilisation	With an increasingly restricted resource, the UHB requires assurance that digital effort is expended in the most benefits laden workload. Benefits based prioritisation requires robust and matured benefits tracking and a matured reprioritisation mechanism. This requires some changes of technique within the Digital department.	10/1/2018	1/18/2019	Governance	DOI	3	4	12		MODERAT	Establishment of a formalised corporate prioritisation mechanism based up benefits and corporate drivers for change.	TBC	IM&T implementation programme IT&G Sub Committee established to oversee progress Standards for Health Services: Information management and communications technology	S & D

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					Director of Therapies	
Renal System			Awaiting completion of audit		Director of Therapies	
E- Advice			Awaiting completion of audit		Director of Therapies	
E – IT Training			Awaiting completion of audit		Director of Therapies	

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
Virtulisation Audit	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
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
Theaterman	1 action still open due to delay in development with supplier due to be complete within the next 6 months Development currently in Test environment and due to switch to live Dec 2019	Complete Continue to monitor progress – **Jan 19** – Testing complete and successful will go into live environment Feb 19
Specialist Service Patient Care IT System	1 action partially complete: The supplier has recently agreed (3rd October 2018) to undertake the testing. Timescale to be agreed within the next month.	**Jan 19** Complete - Supplier and services has confirmed that the integrity of the database dump in a VM has be tested and has worked perfectly.

Virtulisation 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)*
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	New completion date March 2019

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.*			*(See management response update)*
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)*

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.					

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	Partially Complete: Development now agreed with supplier with no cost to the service. Monitor progress of development & implementation. **Jan 2019** Due to be delivered next financial year 2019. Jan 2019 Service awaiting confirmation from EuroKing to find out which upgrade it will be developed in.

Theatreman Audit March 2015

Risk & Recommendation	Priority	Management Response	Responsible Officer	Previously agreed actions	Current Status
R2. Inaccurate data held in system Data entry controls should be established to ensure data has the correct format and is contextually accurate. Constraints should be added at the database level.	MEDIUM	The Directorate accepts that testing is required to locate fields with data controls issues within the whole system. Some initial testing is in the process of being undertaken and this will identify the volume of changes to the system that may be required. Trisoft will be contacted to seek their advice and support to this task. In terms of patient specific test results the directorate will investigate what is in theatreman and what is actually used with a view to disabling these functionalities. Testing completed and sent to Trisoft – currently sat with development. Feb 2017 Data controls addressed by Trisoft, upgrade on hold until CEPOD Whiteboard Project is complete.	Applications Support Manager Theatre IT team Clinical Director/Lead Nurse	**May 2018** The development was due to be complete April 2018 however the vendor has experienced a few issues fixing the bugs and completing our requests which has placed the development six month behind schedule. The issue has been escalated with the vendor – work due to be complete within the next 6 months.	**Complete January 2019** Development has been tested within the test environment. The planned upgrade will now take place on the 20th February 19. *SW to confirm when go live with the upgrade is complete – Feb 2019*

Specialist Services Patientcare IT System Audit 2016/17

R5 Although backups are taken, there has been no test of these to ensure their integrity. **The backups should be tested on a periodic basis.**	Medium	Since the last review the Cardiff & Vale UHB IT Department have confirmed that regular backups are taken. These backups are in line with its veeam based automated integrity checked recovery system. The supplier has confirmed they review the content of these back-ups for omissions and errors. Having migrated the system to a virtual server and upgraded the software, the next steps are for the service, IT department and supplier to agree a timeframe for a backup test.	Sarah Lloyd	Having renegotiated the SLA the service, IT department and supplier to agree a timeframe for a backup test. Aiming for completion in Q2. **October 2018 – update** The supplier has recently agreed (3rd October 2018) to undertake the testing. Timescale to be agreed within the next month.	**Complete Jan 2019** Supplier and services has confirmed that the integrity of the database dump in a VM has be tested and has worked perfectly.

Report Title:	**Combined ICO GDPR Action Plan**								
Meeting:	**Information, Technology and Governance Sub-Committee**						**Meeting Date:**	**29 January 2019**	
Status:	**For Discussion**		**For Assurance**	**X**	**For Approval**		**For Information**		
Lead Executive:	**Deputy Chief Executive / Executive Director of TIIC**								
Report Author (Title):	**Senior Manager Performance and Compliance/Information Governance Manager**								

SITUATION

This report gives ITGSC details of steps being taken to work towards compliance in relation to GDPR/DPA 2018. This process automatically evidences progress in relation to implementing recommendations agreed with ICO following its audits of UHB compliance with DPA 1998 given that this legislation has now been superseded.

BACKGROUND

The information governance (IG) legislative framework has undergone the most profound changes in 20 years with the enactment of DPA 2018/GDPR. This, together the UHB's relatively low baseline in terms of IG legislative compliance as evidenced by the ICO's "limited assurance" audit rating in relation to DPA 1998, means that the UHB faces significant challenges in terms of implementing remedial action.

To streamline assurance arrangements, it was agreed at the October 2018 meeting of ITGSC that a combined ICO/GDPR action plan would be presented going forward. In this way ITGSC is able to track progress via a single reference document.

This approach is now extended to include actions necessary to achieve full compliance with the Caldicott Principles in Practice (CPiP) process (separate agenda item refers).

The above challenges are accentuated by the fact that, across the UHB, very large numbers of people handle personal data in a multiplicity of settings. These arrangements tend to be complex. It is therefore essential that the UHB has governance arrangements that ensure not only that legal requirements are being met but also that the UHB is adequately protected in the event that personal data is compromised for any reason i.e. sanctions pursuant to IG legislation could ensue.

Going forward, the report submitting the ICO/GDPR action plan will therefore give summary details, where applicable, of actions taken at an operational level designed to prevent the UHB being potentially exposed to such risks.

ASSESSMENT

The updated combined ICO/GDPR action plan is attached as **Addendum 1.** ITGSC's attention is drawn to the following significant developments that have occurred since the October meeting

- A joint data controller agreement to support cluster working involving non NHS employees has been developed and is presently going through a scrutiny and approval process.
- A Data Processing Contract (formerly referred to as an Agreement) has been produced by the UHB's lawyers to formalise roles and responsibilities where data is being processed and cover other points as required under GDPR e.g. to protect the rights of data subjects, such as requirements if data is to be transferred outside the EEA. It is standard practice under the DPA to require Data Processors to indemnify the UHB in full in relation to any liability on the part of the UHB if personal data is compromised as a direct consequence of failings by the Data Processor. This indemnity is backed up by a requirement to carry insurance cover of min £5 million per annum. This has now been made available to all other Health Boards via IGMAG. The DPC is also an integral part of procurement arrangements to ensure that the UHB is appropriately indemnified in the event that a data processor is directly responsible for a data breach.
- Management Executive will shortly consider whether it would be appropriate to relax the above indemnity/insurance arrangements in relation to data processing activity by charities and/or small/medium sized organisatons who may be unable to meet these criteria & risk is relatively low.
- Robust documentation is also available to regularise the handling of personal data in other settings. The ISP template developed by WASPI is also adhered to in relation to the sharing of data between the UHB and participating public sector bodies. The same principles essentially also applies to such relationships between the UHB and non public sector bodies.
- The Information Governance Executive Team has given detailed consideration to IG issues in a R & D setting. These have raised numerous challenges which are presently being worked through by interested parties.
- In accordance with WHC (2017) 025 the UHB requires all Data Processors who handle personal data to be certified under Cyber Essentials Plus, as a minimum. Clarification is being sought as to whether equivalent alternative cover would be acceptable.
- Patient Information Sheets have been developed based on the template produced by the Health Research Authority to ensure that research participants are notified of information as required under GDPR.

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ASSURANCE is provided by:

- Reports detailing compliance against legislative requirements.

RECOMMENDATION

The Information Technology and Governance Sub Committee is asked to:

- **NOTE** that significant progress that has been made in remedying shortcomings identified by ICO in its audit of compliance with the Data Protection Act (DPA) 1998.

- **RECEIVE and COMMENT ON** the action plan updated to reflect GDPR/DPA 2018. The action plan gives details of areas where significant progress has been achieved.

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

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

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

Cardiff and Vale University Health

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 January 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. Awareness, Training and development initiatives were ramped up prior to GDPR coming into force in May, with a focus on providing this to asset owners. NHS Wales Legal and Risk solicitors are continuing to contribute to this programme, with previously described initiatives still being used.

	Responsibility: Deputy SIROs/SIRO **Date for implementation:** Immediate – completion March 2017		The Proposed 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 71% The UHB has considered the proposal within the internal audit and will seek to develop a community of practice to provide mutual support to asset owners and administrators. 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	**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		**Partially Complete** **Evidence** As per A4.

within reasonable timescales.	3 - All IAAs will be trained by March 2017 **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** The UHB Information Governance intranet pages have been significantly expanded. This is an ongoing process. The most recent updates were made in line with the Internal Audit on IG carried out at the end of December 2018. Please see also: A16 – 19 – updating of Information Governance policy.
A9. Consider the requirement for a relevant member of each CHB to attend the	**Management Response:** Recommendation accepted The UHB will ensure that consideration is given to:		**Partially Complete** **Evidence** As per A4

IGSC to ensure a speedy and adequate flow of IG related information takes places between the corporate IG team and each CHB and Corporate area. Or formalise the role(s) of the Clinical Director, Clinical Diagnostics and Therapeutics and Assistant Medical Director Information and Technology to act as a conduit for this flow of information regularly monitoring its effectiveness.	1 - The appropriate representation at the IGSC 2 - The role of the AMD for IM&T 3 - The reporting arrangements for deputy SIROs to the SIRO **Responsibility:** SIRO/ IGSC **Date for implementation:** December 2016		
A10. Document a clear process for Clinical Boards and Corporate areas to provide assurance to the IGSC.	**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 IGSC **Responsibility:** Deputy SIROs/SIRO **Date for implementation:** Immediate – completion March 2017		**Partially Complete** **Evidence** See A14 for summary details of governance arrangements Assurance to the Information Technology and Governance Sub-Committee (ITGSC – successor to IG 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
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 the long term IG vision and targets. **Responsibility:** SIRO/ **Date for implementation:** December 2016		**Partially Complete** **Evidence** 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 Create or update relevant policies and procedures as soon as practicable ensuring accompanying or supporting documents are clearly referenced.	**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 and completion of the high level controlled documents framework. **Responsibility:** SIRO **Date for implementation:** Immediate – completion March 2017		**Incomplete** **Evidence** 1 ITGSC monitors progress through the Controlled Document Framework. The current status of this is set out in a separate paper to the current ITGSC meeting. 2 An updated IG policy is submitted to the current IGTSC meeting. . The basis for this is 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 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. Self help guides also being developed. The UHB Subject Access Procedure has been updated to align it to GDPR and, following review by the UHB’s lawyers, is presented for approval to the current ITGSC meeting. .
A21 see A18	**Management Response:** Recommendation approved The UHB will ensure that the IT Security Policy will be completed by December 2016 **Responsibility:** SIRO **Date for implementation:** December 2016		**Partially Complete** **Evidence** See A16 - 19

A22. 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.	**Management Response:** Recommendation approved The UHB will ensure that all policies will be checked annually for the next two years. This will be reviewed thereafter. **Responsibility:** SIRO/ **Date for implementation:** December 2016		**Partially Complete** **Evidence** See A14.
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**
A32. Conduct a review to ensure all teams/ departments are	**Management Response:** Recommendation approved.		**Partially Complete** **Evidence**

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.	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		The IG Dept produces a risk register setting out all "cross cutting" areas of risk. This is received as a standing item by the ITGSC. Risk issues are also covered in Information Asset Registers (A37).
A34. Report all IG related risks through the IGSC on a regular basis.	**Management Response:** Recommendation approved The UHB will ensure that the IGSC 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 ITGSC. 2 - The ITGSC 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	**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.		**Partially Complete** **Evidence** See item A16 - 19

raised to facilitate full implementation.	**Responsibility:** 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	**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		**Partially Complete** **Evidence** IARs are in place as follows: Clinical Boards The status of IAR completion is variable. Corporate Depts An IAR has been produced setting out the following in relation to large scale IT systems: • IAO/IAA • System manager

databases and medical devices that may hold personal data.	**Date for implementation:** December 2016		• Description of data processing undertaken • 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		**Partially 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 ITGSC 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		**Partially 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. This is not considered a viable course of action in the short/medium term. .
A42. Conduct a review of incidents reported	**Management Response:** Recommendation approved		**Partially Complete** **Evidence**

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.	The UHB will ensure that: 1 - A comprehensive review is undertaken 2 - A report is brought to the IGSC 3 - Actions taken to reduce and eliminate any backlogs 4 - A routine report to the QSCs and IGSC on persistent backlogs **Responsibility:** Deputy SIROs/SIRO/ **Date for implementation:** Programme September 2016 to March 2017		Coding and functionality at the UHB have been developed on Datix to ensure 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 members of the IG Dept, and they have access to all such records and a review mechanism. These arrangements commenced in January 2017 and will be progressively refined. A backlog of cases that had been "open" since April 2018 has now been cleared
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 **Date for implementation:** December 2016		**Partially 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. 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 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 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 IGSC and a log of all	**Management Response:** Recommendation approved **Responsibility:** Head of Information Governance		**Complete** **Evidence**

PIAs completed should be held by IG.	**Date for implementation:** December 2016		A central log of DPIAs has been set up.
A50. Report an overview of all IG related incidents through the IGSC 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		**Partially 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 ITGSC 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 IGSC **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 ITGSC as per item A10.
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 ITGSC.

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.		**Partially 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 IGSC. **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 **Date for implementation:** September 2016		**Complete** **Evidence** Poster amended on line and link working. Mechanism needed to ensure that the posters are kept up to date

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: All IARs are completed by July 2017		**Partially Complete** **Evidence** 1. All areas are developing/reviewing their IARs. 2. They are being developed at varying rates between services and progress is slow generally across the

	The area referred to in this finding completed a first draft in June 2016. **Responsibility:** Deputy SIROs/SIRO **Date for implementation:** December 2016		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 records are not locatable. (See below).	**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 procedures for the tracking and tracing of records.		**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 Clinical Boards/Corporate Depts will need to engage with central management in this process In line with CPiP the following procedures are required:

	Responsibility: Deputy SIROs/SIRO **Date for implementation:** Immediate – March 2017		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 covering all business critical records.	**Management Response:** Recommendation approved The UHB will ensure that: - All areas will have comprehensive disaster recovery plans in place		**Partially Complete** **Evidence** 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

	-The plans will be tested routinely **Responsibility:** /SIRO/Deputy SIRO **Date for implementation:** Immediate – completion March 2017		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 **Responsibility:** Head of Information Governance		**Complete** **Evidence** 3 Data Protection Policy and Transportation PII procedure covers this item.

	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:** Immediate – programme for 2017/18		**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:

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 audit trails to be logged in case of a query.	**Management Response:** Recommendation approved The UHB will ensure that		**Partially Complete** **Evidence** 1. Discussions are on-going

	discussions with health records, software provider and IM&T move on efficiently. **Responsibility:** Deputy SIRO CD&T **Date for implementation:** December 2016		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 access to the IG team so that they can view all IG incidents across		**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 flagged by reporters or managers. E mail notifications are automatically sent to members of the IG Dept and

	the UHB. **Responsibility:** Head of Information Governance **Date for implementation:** January 2017		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 **Date for implementation:** December 2016 for 2017/18		**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.

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 with the records management policy.		**Incomplete** **Evidence** Records Management Procedure approved by former PPP Committee in September 2016. Updated records management policy agreed in principle by Chair of Resources and Delivery Committee (subject to ratification by full Committee on 31 January 2018).. Retention

	Its review date is recorded in the controlled documents framework. It is monitored by the IGSC routinely. **Responsibility:** Head of Information Governance/IGSC **Date for implementation:** September 2016		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 accordance with the contract provisions.	**Management Response:** Recommendation approved The UHB will ensure that: An annual visit to the company to check operational and environmental matters is undertaken. An annual meeting is held to		**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

	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		**Incomplete** **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. -Routine reports will be developed for operational use and for		**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 ITGSC need to be formalised

	assurance at the clinical board QSE and IGSC. **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 IGSC **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 IGSC. The IGSC will ensure that the MRMG:		**Partially Complete** **Evidence** 1. Annual work plan in place 2. ITGSC monitors performance. Assurance outstanding on some points. 3. Minutes received by ITGSC. Process is for Chair to raise any items to be escalated.

	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:** IGSC/MRMG Chair **Date for implementation:** Implemented		
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 IGSC. **Responsibility:** Deputy SIRO/COO/SIRO **Date for implementation:** Immediate – completion March 2017		**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

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 /IGSC 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 the revised policies for the use of mobile media to be signed off by managers and staff with	**Management Response:** Recommendation approved The UHB will ensure that the revised Remote Working Procedure includes the above		**Complete** **Evidence** Remote working procedure approved in September 2016.

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.	**Responsibility:** Technical Development Network and Support Manager **Date for implementation:** December 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 copied to removable media.	**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:** Technical Development Network and Support Manager **Date for implementation:** March 2017 (subject to funding)		**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.

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** 1. Discussions have started around the necessity for generic accounts 2. The next stage is to assess and mitigate risks where the function is necessary and 3. Review access rights 4. The project timeline is to be agreed.
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 current access levels are still required. Consider auditing a sample of these to ensure what is	**Management Response:** Recommendation approved The UHB will ensure that: All access rights are reviewed and updated regularly. Correct procedures are completed when staff transfer within the UHB or leave the UHB. This forms part of the clinical boards IG annual programme.		**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. 2. Managers will spot check this as part of their responsibilities as IAOs

being reported is accurate.	This forms part of the IG annual report that goes to the SIRO/IGSC for assurance. **Responsibility:** Deputy SIROs/SIRO **Date for implementation:** March 2017		
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 automated auditing tools that are implemented.	**Management Response:** Recommendation not approved **Responsibility:** **Date for implementation:**		This recommendation was not agreed by the UHB and remains under discussion.
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		**Partially complete** **Evidence** 1. The function for monitoring system access is subject to review given the current and future requirements

	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		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 identify and support management of non upgraded systems. **Responsibility:** Owning Service Department/Development Manager		**Partially Complete** **Evidence** The process of migrating users applications onto Microsoft supported software continues. Completion date to be confirmed.

	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		**GreenComplete** **Evidence** The UHB has no less than 300 Windows XP PCs many of 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 by 31 July 2018.
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.		**Complete** **Evidence** • Old firewalls are reviewed on a regular basis • New firewall rules have a 12 month allocation

	Responsibility: Network manager **Date for implementation:** Immediate – completion March 2017		
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. **Responsibility:** Network Manager **Date for implementation:** September 2016		**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.
C68. Implement methods to automate the	**Management Response:** Recommendation approved		**Complete** **Evidence**

process of monitoring firewall activity. Ensure that reports generated about inappropriate firewall activity are considered for reporting through the incident management process.	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		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:	**Report of SIRO/Integrated Governance Report**								
Meeting:	**Information, Technology and Governance Sub-Committee**						**Meeting Date:**	**29 January 2019**	
Status:	**For Discussion**		**For Assurance**	**x**	**For Approval**		**For Information**		
Lead Executive:	**Deputy Chief Executive / Executive Director of TIIC**								
Report Author (Title):	**Senior Manager Performance and Compliance / 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 Controlled documents framework and on the DPA 2018 / ICO action plan is 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 ITGSC to receive assurance that the UHB continues to monitor and action breaches of the Data Protection Act (DPA) and that FOI requests and DPA 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 Intelligence took up post on 2 January 2019.
- Arrangements are being made to transfer the Senior Information Risk Owner (SIRO) portfolio to him.
- Paul Rothwell will continue to provide the role of interim Data Protection Officer as part of his wider governance role for the Department of Performance and Information. This will be reviewed in March 2019, at the latest. Paul retires on 30 April 2019.
- The information governance department, following the take up of two posts following an internal skill mix review, has now increased to 5.3WTE, although operates below this level due to long term sickness of one staff member.

2. Data Protection Act – Serious Incident Report

Date reported: 1 October to 31 December 2018

During this period 281 incidents were reviewed of which 128 were identified as relating to an IG issue. These were assessed using a risk rating scale.

0 were considered serious incidents.
2 incidents were raised with ICO but none were considered reportable.

As per ICO Information Governance action plan, e-Datix functionality continues to be refined to allow the department to efficiently and thoroughly evaluate potential IG incidents. As a result there are 0 incidents from 2018/2019 awaiting IG review. As part of the GDPR rollout program, staff should be aware of importance of reporting incidents on e-Datix within 24 hours and the significance of completing the mandatory IG e-learning module.

3. Freedom of Information Act

The 20 day compliance rate for 2018 can be broken down as follows:

	Total requests	Compliant requests	Compliance %
Jan-18	64	58	91%
Feb-18	36	24	67%
Mar-18	42	17	40%
Apr-18	68	4	6%
May-18	49	22	45%
Jun-18	47	25	53%
Jul-18	58	32	55%
Aug-18	49	27	55%
Sep-18	47	19	40%
Oct-18	45	20	44%
Nov-18	54	44	81%
Dec-18	38	31	82%

51 requests remain outstanding for 2018.

FOI compliance figures are an ongoing concern for the department however as demonstrated by the above figures, compliance has significantly improved since November 2018 when the department received an additional 1.8 WTE. The department is still performing without the substantive FOI lead.

The ICO has expressed concern that the UHB has in some instances failed to respond within 20 working days to requests by data subjects for UHB responses to FOI requests to be reviewed. This matter is being addressed by the Director of Corporate Governance/Board Secretary.

4. Subject Access Requests Processed

4.1 Health Records requests October to December 2018

	Oct	Nov	Dec
Requests	492	311	229
Compliant responses	299	173	58 (up to 14th Jan 2019
% of Requests Closed within a month	61%	56%	42%

The volume and compliance of medical records subject access requests continues to be a significant risk to the organisation. Despite utlisation of internal electronic transfer of notes, the department continues to struggle with staffing levels. This is clearly impacting the ability to respond within the legislated timeframe.

4 .2 Non Health Records

There were a total of 7 subject access request submitted for non-health records between October 2018 and December 2018. 7 responses were issued within the statutory one month day time limit.

5. Compliance Monitoring/NIIAS

The UHB continues to audit the appropriate use of systems, adopting both routine monitoring reporting and targeted review. Functionality mirroring but more “intelligent” than that available via the NIIAS system (national IT systems) is under consideration for a possible UHB counterpart.

Work is progressing to monitor all incidents at all levels using e-Datix incident reporting system.

6 Other Key IG Issues

The following other issues are considered in separate reports to the current meeting:

Subject	Paper
Information Asset Registers	IG Improvement plan
Data Flows	IG Improvement Plan
IG policy	IG Improvement Plan
IG in R & D	Separate paper
Indemnity / insurance	Separate paper

ASSURANCE is provided by:

- Reports detailing compliance against legislative requirements.

RECOMMENDATION

The Information Technology and Governance Sub Committee is asked to:

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

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

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

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

Report Title:	**Controlled Documents Framework**								
Meeting:	**Information, Technology and Governance Sub Committee**						**Meeting Date:**	**29 January 2019**	
Status:	**For Discussion**		**For Assurance**	**x**	**For Approval**		**For Information**		
Lead Executive:	**Deputy Chief Executive / Executive Director of TIIC**								
Report Author (Title):	**Senior Manager Performance and Compliance / Information Governance Manager**								

SITUATION

The Controlled Document Framework (CDF) lists key documents that the UHB needs to have in place to evidence that it complies with the information governance accountabilities placed upon it and that these are being adequately discharged.

Cardiff and Vale University Health Board (the UHB) needs to receive assurance that it can satisfy all the requirements that are placed upon it by the Caldicott Principles in Practice (CPiP) framework (separate paper refers) and any other governance requirements.

BACKGROUND

The Information Governance Sub Committee (IGSC) previously received regular reports on the CDF and to ensure the work progresses, reports will continue to be submitted to the ITGSC.

Previous reports were produced from the recommendations of the IG Toolkit which is mandated within NHS England. Whilst not mandated in Wales this has become the accepted measure that the UHB will continue to work towards. Broadly, CPiP mirrors this.

ASSESSMENT

An updated CDF is attached as **Addendum 1**. In line with the rest of Wales GDPR and its implementation together with the new Healthier Wales policy for integrated care services have had a considerable impact on the relevance and appropriateness of many of the UHB's data policies. The national response has been to take forward national initiatives to produce outline policy proposals, via the Information Governance Management Advisory Group, which individual organisations can adapt and adopt to meet their local requirements.

As reported to the October 2018 ITGSC meeting, an updated Information Governance policy has now been written and is attached as **Addendum 2.** Its content is drawn from the following policies developed at national level by the IGMAG:

- Information Governance
- Internet
- E-mail
- Information Security

A specific aim of the document was to reflect the UHB operational environment. This provides an opportunity to cover a range of scenarios that were hitherto covered in a separate

procedures e.g. transport of documentation. For this reason these procedures have been recorded on the CDF as redundant.

Subject to endorsement by ITGSC the policy is now ready to undergo due process i.e.

- Checking by the UHB's lawyers
- Updating of the relevant Equality Impact Assessment
- Consultation with stakeholders

It is recommended that, going forward, exemplar documents developed by IGMAG are adapted for adoption by the UHB in due course subject to updating to reflect the UHB operating environment.

The UHB's Subject Access Request Procedure, attached as **Addendum 3**, has been updated to reflect the requirements of current IG legislation, such as the shortened response period and withdrawal (in most cases) of the facility to levy charges. The procedure has been reviewed by the UHB's lawyers. Further work needs to be undertaken to develop supporting pro formas.

ASSURANCE is provided by:

- The maintenance of a Controlled Documents Framework which outlines the position of policy and control documentation development in accordance with Information Governance requirements.

RECOMMENDATION

The Information Technology and Governance Sub Committee is asked to:

- **NOTE** that it has not been possible to complete updating the UHB Controlled Document Framework since the last meeting because of staffing pressures and the need to prioritise work to lay the foundations for GDPR compliance. Progress has, however, been made.
- **ENDORSE** the updated UHB Information Governance policy, subject to due process as above, for submission to the Resource and Delivery Committee for formal approval.
- **AGREE** the updated UHB SAR Procedure.
- **AGREE** that, in the interests of efficiency, future policies and procedures will be based on equivalent documents and procedures developed by the Information Governance Managers Advisory Group (IGMAG) Wales as exemplars where such documentation is considered appropriate to the UHB operating environment.

Shaping our Future Wellbeing Strategic Objectives

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

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

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

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

APPENDIX 1

Title of Document	Document Type	Document Status	Last review date	New Review Date	Comments
UHB Documents					
Data Protection Policy			11/8/2016	11/8/2019	
Disclosure of Personal Information to the Police	Guidelines	**Review overdue**	4/26/2011	4/1/2014	Incorporated in 290 Personal Information Use and Discloure of and duty to Share Guidelines - Suggest stand alone document to be revised
BreakGlass Incident Procedure	Procedure	Approved	9/20/2016	9/20/2019	Reviewed and Rollover agreed 20/9/16 - IGSC 16/052
Records Management Policy	Policy	Approved	1/30/2018	1/30/2021	30/1/18 R&D minute 17/042
Electronic and paper clinical results review and retention protocol	Protocol	**Review Overdue**	12/10/2012	12/10/2015	National retention period of 100 years for e-records proposed - requires incorporating into UHB policy
Records Management Retention and Destruction Protocol	Protocol	Approved	8/8/2017	8/8/2020	Reviewed 8/8/17 approved 8/8/17 IGSC
Information Governance Policy	Policy	Submitted for endorsement	1/29/2019	1/29/2022	Submitted for endorsement
IT Security Procedure	Policy	Approved	3/31/2015	3/31/2018	Included in IG policy
Freedom of Information Act Procedure	Procedure	Approved	3/31/2015	3/31/2018	
Freedom of Information Act Policy	Policy	Approved	3/31/2015	3/31/2018	

Information Risk Management Procedure	Procedure	Review Overdue	18/09/2015	9/18/2018	
Data Quality Management Procedure	Procedure	Review Overdue	15/09/2015	9/15/2018	
Personal Information Use and Discloure of and duty to Share Guidelines	Guidelines	Review Overdue	22/06/2015	22/06/2018	In final stages of discussions with GPs. Awaiting outcome of National data promise policy proposal

Dealing with Subject Access Requests under DPA	Procedure	Submitted for approval	29/01/2019	29/01/2022	
Data Quality Policy	Policy	Approved	9/15/2015	9/15/2018	
IG Operational Management Responsibilities Procedure	Procedure	Review overdue	1/19/2016	1/19/2019	
IT Security Access Control Guidance	Guidance	Approved	6/10/2016	6/10/2019	
IT Security Authorised Users Guidance	Guidance	Approved	6/10/2016	6/10/2019	
IT Security Network Connection Guidance	Guidance	Approved	6/10/2016	6/10/2019	
Records Management Procedure	Procedure	Approved	6/10/2016	6/10/2019	Reviewed 8/8/17
Data Protection Act Procedure	Procedure	Approved 20/9/16	New Doc	9/20/2019	
Anti-Virus Guidance	Guidance	Approved	9/20/2016	9/20/2019	
Offsite Mobile Computing Guidance	Guidance	Approved	9/20/2016	9/20/2019	
Software Licensing Guidance	Guidance	Approved	9/20/2016	9/20/2019	
IT Security Procedure	Procedure	Approved	9/20/2016	9/20/2019	Incorporates previous Appendix 1 & 14
IM&T Incident Guidance	Guidance	Approved	9/20/2016	9/20/2019	
IM&T Equipment Procurement Guidance	Guidance	Approved	9/20/2016	9/20/2019	
IT Security Internet use local procedures	Procedure	Approved	8/8/2017	8/8/2020	From IT Security Policy
IT Security E-mail local use procedure	Procedure	Approved	8/8/2017	8/8/2020	From IT Security Policy
Security of Assets	Guidance	Approved	8/8/2017	8/8/2020	From IT Security Policy
IM&T Disposal of Equipment	Guidance	Approved	8/8/2017	8/8/2020	From IT Security Policy
IM&T Business Continuity	Guidance	Approved	8/8/2017	8/8/2020	From IT Security Policy
Code of Connection Summary	Guidance	Approved	8/8/2017	8/8/2020	From IT Security Policy
Bring Your Own Device (BYOD)	Guidance	Approved	8/8/2017	8/8/2020	From IT Security Policy - Submitted for approval 8/8/17
IG Mangement Framework	Framework	New Document in draft	8/8/2017	8/8/2018	New Document produced for approval to meet the requirement of IG Toolkit
Clauses within Employment Contracts Procedure	Procedure	Review overdue	6/22/2015	6/22/2018	

Contractual Clauses and Arrangements Procedure	Procedure	Review overdue	6/22/2015	6/22/2018	
Requests to restrict disclosure of personal information guidelines	Guidance	To be developed			**From CDF** Current document references existing document ref 290 Personal Information Use and Discloure of and duty to Share Guidelines S7 references but process needs to be strengthened
Confidentiality Audit Procedures	Procedure	To be developed linked into NIIAS			**From CDF**
IG Incident Reporting Procedure	Procedure	Overdue			Curently have SI reporting procedure in place until Sept 2017. Development of new procedure for IG incidents to be completed
Business Continuity Arrangements	Procedure	Overdue			**From CDF** see (48) above due December 2016
Audit of Clinical Records across all specialties Procedure	Procedure	Overdue			**From CDF** To be developed to supplement the records management Policy and procedures
Auditing of Corporate Records	Procedure	Overdue			**From CDF** Under development by Non-Health Records Group. Originally due December 2016
Redundant Documents					
Privacy Impact Accessment Procedure	Procedure				Section 5.2.5.1 of IG policy
IG Corporate training Policy	Policy				Section 9 of IG policy
Information Asset Procedure	Procedure				Section 5.2.2 of IG policy
Transportation of PII Procedure	Procedure				Section 6.5 of IG policy
Confidentiality Code of Conduct					Section 5.5.1 of IG policy
Local SOP's					
Identification and resolution of duplicate Patient records.	SOP (MROG)				To be reviewed 2019
Monitoring and trace of paper health records	SOP (MROG)				To be reviewed 2019

Actions	Ratification Details (1)	Ratification Details (2)

RD: 17/042

IGSC 17/035 8/8/17

IGSC 17/035

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IGSC 17/035

Cardiff and Vale UHB
Information Governance Policy
DRAFT

Author: Information Governance Department
NOT YET Approved by: Information Governance Executive Team
NOT YET Approved by: Information, Governance and Technology Sub-Committee
Version: DRAFT 0.2
Date: xv/viii/MMXViii
Review date: xv/viii/MMXX

Contents

1. Introduction

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

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

2. Purpose

It is the policy of the UHB to ensure that:

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

3. Scope

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

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

The policy covers the following areas: <<Hyperlink to relevant section>>

- Roles and Responsibilities
- Use and protection of Data

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

4. Roles and responsibilities

This policy is intended to be enabling and relies 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. It is also essential that breaches of this policy and related legislation are reported by the individual via Datix or agreed local reporting mechanisms and to the Data Protection Officer at the earliest opportunity. <<email address>>

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

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

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

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

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

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

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

Information Asset Owners are responsible for the implementation of this policy in respect of the data held acquired, stored within their assets and transferred from their assets (e.g. IT systems, databases, video

stores, clinical record libraries). Specifically Information Asset Owners should have undertaken a self assessment of their directorate's compliance with data protection regulation, using the ICO's tools (link: *https://ico.org.uk/for-organisations/resources-and-support/data-protection-self-assessment/*), once every 24 months and have logged completion with the IG department. Information Asset Administrators will support the Information Asset Owners in fulfilling these obligations.

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

5. Data Protection and Compliance

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

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

5.1.1 Definition of Personal Data

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

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

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

5.1.2 Special Categories of Personal Data

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

5.2 Using data

5.2.1 Fair and Lawful Processing

The UHB will process personal, special category and sensitive data fairly and lawfully, in line with data protection legislation and in accordance with the UHB's patient and staff privacy notices. Processing

broadly means collecting, using, disclosing, sharing, retaining or disposing of personal data or information.

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

Link: http://www.cardiffandvaleuhb.wales.nhs.uk/sitesplus/documents/1143/CVUHB%20privacy%20notice.pdf
http://www.cardiffandvaleuhb.wales.nhs.uk/sitesplus/documents/1143/UHB%20GDPR%20Privacy%20Notice%20%28all%20workers%20and%20employees%29%20revised%2018%20June%202018.pdf

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

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

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

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

5.2.2 Information Asset Management

5.2.1.1 Information Asset Registers

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

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

- the type of information held
- where it came from,
- who it is shared with
- how this information is used

- the legal basis for holding this date – as per the UHB's policy on data control and processing (Privacy Notice) - If in doubt consult the UHB's web page or ask the IG department
- When it should be destroyed (if not in the medical record or essential for business use – e.g. a contract, then the longest retention period including email should be 6 months)
- Who this data is shared with – e.g. Royal Colleges, WG, other NHS organisations, Local Authorities
- Where data is shared, the legal basis for sharing the data (as above, public duty should be used where the basis is patient care)
- Confirmation that no data is stored / transferred outside the European Economic Area including for Artificial Intelligence processing within the cloud.

5.2.1.2 Registering Security, Hosting and Back up arrangements

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

5.2.1.3 Managing paper care records

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

The individual is required to maintain the complete paper care record together where pragmatically possible. Where it is not pragmatically possible, the individual must ensure the record is complete at the end of the activity for which it has been separated or at the earliest possible opportunity thereafter. The record must be restored before the individual leaves the department.

5.2.1.4 Storing and moving data

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

5.2.3 Individual's Rights & Consent

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

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

- A request to gain consent to use information about the patient should be made prominent and be clearly separated from other requests for consent – such as those in regards to treatment.
- Consent has required a positive opt-in such as unticked opt-in boxes or similar active opt-in methods.
- Consent should be specific and granular. You should allow individuals to consent separately to different purposes and types of processing wherever appropriate.

- Be clear that this consent is for NHS Wales & Cardiff and Vale UHB and name any specific third party organisations who will rely on this consent

5.2.4 Accuracy of Personal Data

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

5.2.5 Establishing new data processing activities

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

5.2.5.1 Data Protection Impact Assessment (DPIA)

All new projects or major new flows of information must consider information governance practices from the outset to ensure that personal data is protected at all times. This also provides assurance that NHS Wales organisations are working to the necessary standards and are complying with data protection legislation. In order to identify information risks a DPIA must be completed. If there is any doubt as to what and whether a DPIA is required, the information governance department should be requested to assist.

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

5.2.5.2 Third Parties and Contractual Arrangements

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

UHB documents & specifications (such as the UHB's Data Processing Contract, Security Arrangements, Contracts, Procurement technical specification, codes of conduct, access and auditing specifications) must be used in formalising the arrangements for the processing and sharing of the personal data the UHB controls or will be controllers of (not process on others behalf). This is to ensure that personal data is processed in a consistent manner and the roles of responsibilities of the parties are clearly understood.

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

5.2.6 Incident Management and Breach Reporting

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

risk registers accordingly. Incidents must be reported immediately following local reporting arrangements.

5.2.7 Information Governance Compliance

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

5.3 Records Management

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

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

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

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

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

To achieve this the UHB and its employees will follow the Lord Chancellor's Code of Practice on the management of records issued under section 46 of the Freedom of Information Act 2000.
Link: http://webarchive.nationalarchives.gov.uk/+/http://www.dca.gov.uk/foi/reference/imprep/codemanrec.htm

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

Records will be managed in accordance with the UHB's Records Management Retention and Destruction Protocol and Schedule
Link : xxxSion O Keefe

5.4 Access to Information

NHS Wales organisations are in some circumstances required by law to disclose information. Examples include information requested under the Freedom of Information Act (hyperlink to FOI policy:
http://www.cardiffandvaleuhb.wales.nhs.uk/sitesplus/documents/1143/v3%20ready%20for%20u

pload.pdf) , the Environmental Information Regulations or requests for personal data.

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

5.5 Confidentiality

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

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

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

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

5.6 Sharing Personal Data

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

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

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

5.6.2 One-off Disclosures of Personal Data

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

Personal data may need to be shared externally on a one-off basis, where an ISP or equivalent sharing document does not exist. It is important that this sharing follows all the principles of good information

governance and that local arrangements are made and followed to ensure suitable processes are followed.

5.7 Welsh Control Standard for Electronic Health and Care Records

5.7.1 The Control Standard

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

5.8 Data Quality

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

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

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

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

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

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

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

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

8. Data quality management: At every level across the Health Board those managing data quality

must have the appropriate skills and knowledge.

5.9 Data and Technical Standards

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

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

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

6. Information Security

6.1 User Access Controls

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

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

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

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

6.1.1 Physical Access Controls

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

Individuals, departments and information asset owners are responsible for determining the relevant security measures required based on local risk assessment.

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

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

6.1.2 Passwords

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

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

6.1.3 Remote Working

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

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

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

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

6.1.4 Staff Leavers and Movers

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

6.1.5 Third Party Access to Systems

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

6.2 Storage of Information

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

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

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

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

6.3 Portable Devices and Removable Media

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

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

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

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

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

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

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

6.4 Secure Disposal

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

6.4.1 Paper

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

6.4.2 Electronic

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

6.4.3 Other Items

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

6.5 Transporting and relocation of information

6.5.1 Transporting Information

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

6.5.2 Relocating information

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

7. Use of the internet

7.1 Position Statement

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

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

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

7.2 Conditions & Restrictions on Internet Use

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

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

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

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

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

7.3 Personal Use of the Internet

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

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

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

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

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

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

8. Email

8.1 Inappropriate emails

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

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

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

8.2 Personal Data and Business Sensitive Information: Filtering and Misdirection

The NHS Wales network is considered to be secure for the transfer of any information including Personal Data and business sensitive information within NHS Wales (email address must end in wales.nhs.uk) and a number of other Welsh Public sector organisations including Welsh Government (email address must end in gov.Wales), the Vale of Glamorgan and Cardiff Local Authorities (email addresses must end in .gov.uk) and South Wales Police (email address must end in .police.uk). A full list is available from the Information Governance department. Whilst it is safe and secure to transfer personal data between these addresses without encryption or passwords, the user must have a lawful basis for doing so.

but not any of the Universities. However, to mitigate against the risk of misdirection users should consider the use of encryption or other security measures when transferring Personal Data or business sensitive information.

Transfer of Personal Data or business sensitive information to any email address not ending in one of the address types provided above, {Which presently includes all of the University and Charities who we work closely with} is not currently considered secure. Where this type of information needs to be sent, appropriate security measures must be implemented, for example, the secure file sharing portal, secure mail systems or encryption.

Users must be vigilant in ensuring that all emails are sent to the correct recipient and to use the NHS address book to check that the correct email address or addresses have been selected. Misdirected emails containing personal or sensitive data should be reported via local incident reporting processes.

8.3 Personal Use of Email

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

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

Staff who use NHS equipment outside NHS Wales premises (for example – in a home environment) are permitted to send personal emails . Use of the email under these circumstances must be through a

secure VPN connection provided by the UHB. Use of the equipment for such purposes is still subject to the same conditions as laid out in this policy.

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

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

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

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

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

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

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

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

9. Training and Awareness

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

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

10. Monitoring and compliance

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

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

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

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

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

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

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

11. Review

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

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

12. Equality Impact Assessment

This policy has been subject to an equality assessment.

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

13. Documents to read alongside this Procedure

- Records Management Procedure
- Records Management Retention and Destruction Protocol and Schedule
- Information Governance Policy and Framework
- Data Protection Act Policy and Procedures
- Freedom of Information Act Policy
- Risk Management Policy
- Information Risk Management Procedure
- Guide to Incident Reporting Incident Management Investigation and Reporting. [Serious incidents]
- Electronic and Paper Clinical Results Review and Retention Protocol
- Records Management Code of Practice for Health and Social Care 2016
- Data Quality Operational Management and Responsibilities
- Records Management Policy
- Records Management Retention and Destruction Protocol
- Validation at Source System (VASS) checks mandated by Welsh Government.
- Data Standard Change Notifications (DSCNs) issued by the National Wales Informatics Service
- Other relevant documents mandated by Welsh Government

Annex: Policy Development - Version Control

Revision History

Date	Version	Author	Revision Summary
1/8/18	-	Andrew Fletcher, NWIS	NWIS policy documents for Information Governance, Information Security, Internet Use and Email Use
15/8/18	V0.1	Andrew Nelson	Amendments to draw documents together and include UHB 12 commandments, local variation and requirements for adoption of technical and data standards

17/8/18	V0.2	PJR, JW & AVN	Inclusion of DQ, data standards and medical records. Clarification of information ownership in respect of data stored on UHB network

Reviewers

This document requires the following reviews:

Date	Version	Name	Position

Approvers

This document requires the following approvals:

Date	Version	Name	Position

Annex 2: Equality Impact Assessment

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

Equality Duties

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

Key	
✓	Yes
x	No
-	Neutral

Human Rights Based Approach – Issues of Dignity & Respect

The Human Rights Act contains 15 rights, all of which NHS organisations have a duty. The 7 rights that are relevant to healthcare are listed below.			
Consider is the policy/service/project or scheme relevant to:	**Yes**	**No**	**N/A**
Article 2: The Right to Life	X		
Article 3: the right not to be tortured or treated in a inhumane or degrading way	X		
Article 5: The right to liberty	X		
Article 6: the right to a fair trial	X		
Article 8: the right to respect for private and family life	X		
Article 9: Freedom of thought, conscience and religion	X		
Article 14: prohibition of discrimination	X		

Measuring the Impact

What operational impact does this **policy, service, scheme or project**, have with regard to the Protected Characteristics. Please cross reference with equality duties	
	Impact – operational & financial
Race	This is a high level framework approach which aims to achieve the values under the policy, it is the protection of everybody's information and gives clear guidelines. The policy details how the organization protects someone's data and security without prohibiting access to services and providing adequate access to data to meet individual needs and the appropriate sharing of data.
Sex/gender	
Disability	
Sexual orientation	
Religion belief and non belief	
Age	
Gender reassignment	
Pregnancy and maternity	
Marriage and civil partnership	

Other areas	
Welsh language	
Carers	

Outcome report

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

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

Risk Assessment based on above recommendations

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

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

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

Risk Grading Descriptors

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

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

Dealing with Subject Access Requests under Data Protection Legislation Procedure

Introduction and Aim

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

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

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

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

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

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

This procedure outlines the standard process to be followed by Cardiff and Vale University

Health Board (the UHB) to ensure that we adhere to the legislation and we have a consistent approach for dealing with requests for personal information. This procedure supports the UHB's overarching Information Governance Framework.

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

Objectives

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

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

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

Scope

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

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

Disclaimer

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

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Summary of reviews/amendments			
Version Number	**Date of Review Approved**	**Date Published**	**Summary of Amendments**
1	18/12/2015	06/04/2016	New Document

2			Updated document

Contents Page

10	Standard Application Form Record of Verbal Request	

1. Compliance with the Data Protection Legislation

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

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

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

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

2. Roles and Responsibilities

2.1 Medical Director

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

2.2 Board Secretary

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

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

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

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

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

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

2.3 Information Governance Department

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

Within the Information Governance Department there will be an Information Governance Co-ordinator with responsibility for receiving and logging requests within a central data base. The co-ordinator will issue acknowledgement letters and will oversee the process of obtaining and collating information throughout the UHB.

2.4 Medical Records (Central)

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

2.5 All Staff

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

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

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

- Applicants who make contact either in person or by telephone should be encouraged to put their request in writing. However, this is not a requirement of the legislation and therefore the UHB must accept requests made verbally. Wherever possible verbal requests should be documented on the relevant pro forma (Contents item 10 refers).
- Standard subject access request form should be issued to the requestor advising the form should be returned to the Information Governance Department or Medical Records Legal Services.

- Requests received by letter, fax or e-mail must be directed immediately to the Information Governance Department or Medical Records Legal Services.
- Applicants will be required to provide appropriate proof of identification before the request can be processed. The identification acceptable would be driving licence, passport or copy of a recent utility bill, no more than three months old.
- Requests from nominated representatives (e.g. solicitor) acting on behalf of an individual must have signed written consent from the individual and this will be retained with the SAR from and proof of identification.
- The UHB is legally obliged to comply with all subject access requests within one month of receipt of request. The one month to commence only after receiving the verified proof of identification and, where applicable, the necessary fee. The UHB may extend the one month period for a further two months where necessary, taking into account the complexity and number of requests.

4. Charging for subject access requests

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

5. Procedures for processing requests

- Requests may be received anywhere within the UHB. Although the UHB encourages individuals to put their requests in writing, this is not a requirement of the legislation and so requests may be made verbally.
- As part of this process each request requires timely and appropriate clinical approval.
- All requests must be transferred immediately to the appropriate department either Medical Records, Information Governance Department (IG) or devolved medical records settings as per item 2.2 Requests for General Practice records should be directed to the relevant practice .
- Requests to be logged in databases and either reference number or hospital number allocated
- Request to be acknowledged (SL1)

- If sufficient information is provided by applicant to continue processing the request this to be forwarded to the appropriate individuals/departments for information to be extracted
- Information to be returned for consideration for release
- Response to be issued including information appropriate for disclose

More detailed area specific procedures are provided in the appendices below

6. Requests from the Police

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

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

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

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

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

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

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

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

7. Reporting Arrangements

Compliance against the one month response limit will be recorded and reported to the Information Technology and Governance Sub Committee (ITGSC), within the integrated Information Governance Report, at every meeting. The reports will identify any areas of weakness for compliance within the UHB and plans to address continued poor performance will be developed and monitored via the ITGSC. If necessary any identified high risk areas will be included within the IG risk register as will the requirement to comply with the one month limit and potential risks of fines or enforcement action from the Information Commissioner.

8. Complaints and feedback

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

APPENDIX 1

STANDARD OPERATING PROCEDURES FOR DEALING WITH NON MEDICAL RECORDS

1. Receipt of Request

- Requests can be received anywhere within the UHB and do not need to be made in writing. All requests must be sent immediately to the Information Governance Department (IG).
- On receipt of request the IG Co-ordinator will log the request on the database allocating a unique identifying reference number.

- Create a new electronic file within the Information Governance s:/drive using the unique reference number and this file will be used to save all correspondence relating to the request and its processing this will include copies of information issued/redacted.
- If the request contains sufficient information to process the IG co-ordinator will issue a standard acknowledgement letter stating the request will be processed within one month.
- If identification has not been included this will be requested by the IG co-ordinator using standard letter
- If insufficient information provided to process the request a standard letter will be issued along with an accompanying subject access request form
- If request is from a representative of an individual a letter of consent must be obtained.

2. Processing of Request

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

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

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

3. Reviewing information

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

- All information collated will be reviewed by a member of the Information Governance Team
- If any third party individual, not including a health professional, is named or has provided information about the applicant the following must be considered by the IG team prior to releasing information:- ○ Can the request be complied with without revealing information which relates to and identifies any third party individuals? If so the third party information must either be removed prior to releasing or alternatively the consent of the third party individuals must be obtained
  - ○ Careful consideration must be given prior to disclosure to ensure that the applicant would not suffer harm or distress on receipt of the information. This will be the subject of discussion with the relevant departmental manager

4. Releasing / Refusing Information

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

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

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

APPENDIX 2

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

Relevant legislation

Access to Health Records Act 1990

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

General Data Protection Regulation and Data Protection Act 2018

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

Applications

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

Processing and Responding

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

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

Fees

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

Information and Advice to Patients

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

Procedures for Dealing with Requests from Benefit Agency Benefits Claims

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

Procedures for Dealing with Insurance Claims Insurance Claims

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

5. Enter details in book.

Litigation

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

APPENDIX 3

REQUESTS TO ACCESS DENTAL RECORDS

Relevant legislation

Access to Health Records Act 1990

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

General Data Protection Regulation and Data Protection Act 2018

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

Applications

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

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

Processing and Responding

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

Requests from Dentists / GP's

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

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

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

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

APPENDIX 4

REQUESTS TO ACCESS OCCUPATIONAL HEALTH RECORDS

Applications

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

Processing and Responding

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

Fees

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

APPENDIX 5

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

Relevant legislation

Access to Health Records Act 1990

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

General Data Protection Regulation and Data Protection Act 2018

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

APPENDIX 6

REQUESTS TO ACCESS MENTAL HEALTH AND ROOKWOOD HOSPITAL RECORDS

Relevant legislation

Access to Health Records Act 1990

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

General Data Protection Regulation and Data Protection Act 2018

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

Applications

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

Charging

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

Processing and Responding

1. The relevant medical records will be obtained, including obtaining information from the Paris system, OT records, physiotherapy records and copies of all information will be made.
2. The completed file will be passed to the consultant (healthcare professional) who had the last contact with the patient for them to review the file. He/she should consult with other health professionals who have had a significant input to the patient's care.
3. The health care professional should see the record itself or an extract.

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

APPENDIX 7

STANDARD OPERATING PROCEDURES FOR DEALING WITH REQUESTS TO ACCESS PHYSIOTHERAPY RECORDS

Relevant legislation

Access to Health Records Act 1990

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

General Data Protection Regulation and Data Protection Act 2018

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

APPENDIX 8

STANDARD OPERATING PROCEDURES FOR DEALING WITH REQUESTS TO ACCESS PODIATRY RECORDS

Relevant legislation

Access to Health Records Act 1990

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

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

General Data Protection Regulation and Data Protection Act 2018

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

Applications

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

Podiatry Records are held in the following areas:

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

1. The applicant will be asked to complete an application form in order to assist with verification to ensure the correct case records are actioned.

2. Once completed application form received this should be acknowledged either in writing or verbally.
3. Proof of identification must be sought and provided before work to retrieve records commences.
4. All applications will be notified to the IG Dept for logging on the database

Charges

No charge is payable

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

Processing and Responding

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

Further detailed information is available in the following document

“Guidance on the Management of the Request for Copies of Patient's Podiatry Records”

APPENDIX 9

STANDARD OPERATING PROCEDURES FOR DEALING WITH REQUESTS TO ACCESS DIETETIC RECORDS

Relevant legislation

Access to Health Records Act 1990

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

General Data Protection Regulation and Data Protection Act 2018

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

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

APPENDIX 10

STANDARD OPERATING PROCEDURES FOR DEALING WITH REQUESTS TO ACCESS RADIOLOGY IMAGES

Relevant legislation

Access to Health Records Act 1990

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

General Data Protection Regulation and Data Protection Act 2018

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

APPENDIX 11

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

Relevant legislation

Access to Health Records Act 1990

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

General Data Protection Regulation and Data Protection Act 2018

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

APPENDIX 12

PRIMARY CARE MEDICAL RECORDS

Relevant legislation

Access to Health Records Act 1990

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

General Data Protection Regulation and Data Protection Act 2018

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

APPENDIX 13

EMERGENCY UNIT

Relevant legislation

Access to Health Records Act 1990

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

General Data Protection Regulation and Data Protection Act 2018

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

APPENDIX 14

IVF To follow

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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Auditors:	Martyn Lewis

Executive sign off:	Chief Operating Officer
Distribution:	S
Committee:	Audit Committee

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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.

Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the C&V University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

1. Introduction and Background

The 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

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**

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**

Finding 4– Guidance for Staff (Operating effectiveness)	Risk
Guidance for staff on the UHB intranet is out of date and incorrect, with the	Insufficient preparation for the new

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.	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**

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**

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	**Medium**

or IAA role. Further information should be passed to Directorates on the specific actions to be undertaken following GDPR.	
Management Response	**Responsible Officer/ Deadline**

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**

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**

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**

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**

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. Staff 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**

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**

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:	**Report of Caldicott Guardian**								
Meeting:	**Information, Technology and Governance Sub-Committee**						**Meeting Date:**	**29 January 2019**	
Status:	**For Discussion**		**For Assurance**	**x**	**For Approval**		**For Information**		
Lead Executive:	**Medical Director / Caldicott Guardian**								
Report Author (Title):	**Senior Manager Performance and Compliance / Information Governance Manager**								

SITUATION

As with previous reports the bulk of the matters presented below have been drawn from meetings at the Medical Records Management Group (MRMG) supplemented by related discussions as appropriate.

BACKGROUND

The Information Governance Sub Committee previously received information on matters that come under the remit of the Caldicott Guardian. This report continues this process.

ASSESSMENT

i) Digitisation of the health record

As reflected in the Outpatient Digitisation paper received at the previous ITGSC, the focus at an operational level is to support paperless or paper-light solutions which complement the organisation's digital strategy. Whilst a long standing item for MRMG it is clear the UHB now has specific programmes of work that place more focus and direction on this matter. As such updates regarding the digitisation of the medical record are seemingly better delivered through the governance arrangements accompanying these programmes. The Medical Director and Director of Digital & Health Intelligence are set to discuss this further. Consequently, this report is likely to no longer contain an item specifically related to digitization.

ii) Records Destruction

The suspension of the destruction of medical records, as per direction from the Infected Blood Enquiry, remains in place. Exploration into the bulk scanning of records (with a view to post destruction as appropriate), is proving to be cost prohibitive externally or constrained by a lack of suitable capacity internally; the UHB has just one industrial scanner. Discussions have taken place with Aneurin Bevan Health Board, given the use of the same software and their superior scanning resource. Whilst these have been positive in principle, there is currently a lack of capacity to support. A review will take place in six months to determine whether the position has

changed. In the meantime, the most viable option remaining is to use third party deep storage. A procurement process is required to enable a cost analysis. It is understood the SIRO will discuss with the Management Executive and possible direct approach to the Enquiry for clarity on destruction if alternative options prove to be impractical.

iii) Restricted Access to Central Medical Records Libraries

The trail of restricted access to library 3 has proved extremely successful, resulting in around 8% of acute records held at UHW being provided through a 'Click and Collect' service rather than self-serve. It has been combined with location based filing (LBF), which in turn has delivered better stock management and improved record availability rates related to the area.

To expand the roll-out of restricted access across all filing libraries requires a full switch to 'Click and Collect' and with this, to LBF. The request data collected as part of the trial indicates this requires a minimum of 3 WTE filing library staff (Band 2). This is not additional resource as the equivalent time required to retrieve records is currently undertaken by staff within Clinical Boards. Reallocation of this existing resource would enable Health Records to implement full restriction (within a relatively short timeframe) and help to satisfy ICO Action Plan recommendation B32. An agreeable redistribution mechanism continues to be explored with Clinical Boards, however, the challenge of disaggregating existing staff resource remains and is likely to require organisational support to remedy.

iv) Medical Records Library

The stock reduction exercise (via significant use of deep storage facilities), continues to result in significant improvements in UHW and UHL filing libraries. This is evidenced in the most recent workplace inspection (08.01.19). In noting item ii) above, alternative plans to destruction are required imminently to avoid a return of issues associated with over capacity.

The inspection report does raise a recurring issue related to antiquated storage equipment, of which some is static shelving, but most relate to moveable bays (now in operation for more than two decades). Replacement parts are no longer manufactured and resultantly repair and maintenance is constrained. Operator incidents have occurred. Short term mitigation is taken wherever possible, however, part and possibly full replacement is the recommended remedial action. No applicable budget exists to take this forward and associated costs are prohibitive set against prevailing cost-pressures (mostly related to recent and past stock reduction exercises).

v) Decommissioning of Whitchurch Hospital

A recent visit to Whitchurch Hospital by the Caldicott Guardian, Information Governance Manager and Heath Records Directorate Manger, has concluded that the site has now been cleared to a suitable standard.

The review included inspection of a number of areas previously known to have held a considerable amount of personal identifiable information (PII). Those areas have been cleared

to a high standard and no significant PII was found.

As previously outlined there are significant lessons to be learnt with regards the decommissioning of other sites which have the potential to contain such material. The Capital & Estates team will kindly lead arrangements as they have with Whitchurch, however, Clinical Boards are ultimately responsible for areas due to be vacated and as such must ensure robust arrangements are undertaken to prevent any PII being retained inappropriately.

The Caldicott Guardian has communicated these the details of these notes and recent outcomes of the inspection to the Execuitve Director of Planning

vi) **2018/9 Caldicott Principles in Practice (CPiP) Assessment**

Cardiff and Vale University Health Board (the UHB) is required to complete a Caldicott Principles in Practice (CPiP) self assessment exercise each year to provide assurance that continuous improvement is made.

A self- assessment as at December 2018 has now been undertaken. This indicates a score of 78% i.e a rating of "4*" – this is defined as follows:

****	76-90%	Your responses to the assessment demonstrate a good level of assurance of information governance risks; but there is still work to be done.

For ease of reference areas that need addressing i.e. because the full score was not achieved for the relevant questions have been highlighted on the GDPR/ICO action plan (separate paper refers) where these come under the scope of that piece of work.

ASSURANCE is provided by:

- Reports detailing compliance against legislative requirements.

RECOMMENDATION

The Information, Technology and Governance Sub Committee is asked to:

- **NOTE** updates relating to
  - Digitisation
  - Records Destruction
  - Restricted Access to Central Medical Records Libraries
  - Medical Records Library
  - Decommissioning of Whitchurch Hospital
  - 2018/9 Caldicott Principles in Practice (CPiP) Assessment

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

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

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

Report Title:	**Transformation programme – Report on enabling digital and information workstreams**								
Meeting:	Information Committee						**Meeting Date:**	29.01.19	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**		**Y**
Lead Executive:	Sharon Hopkins								
Report Author (Title):	Nigel Lewis / Andrew Nelson / Mark Cahalane								

SITUATION

The committee has asked for a report on progress of the two transformation work streams relating directly to digital and information. These are both large work streams with a major cultural and behavioral change components. They are progressing reasonably well.

BACKGROUND

The Transformation Programme has been developed to support the implementation of our strategy 'Shaping our Future Wellbeing'. At present it comprises seven formal enabling work streams of which two relate directly to digital and information. Both of these are contained within the digital strategic outline case 2019. This was also developed to support the delivery of SoFW as well as aligning firmly to the All Wales strategic work. The two work streams are 'Digitally enabled Workforce and Organisation' and 'Accessible Information'.
The development of these is overseen through the transformation team, utilising highlight reports (See Appendix 1 below as an example), reporting progress and issues to the Health Service Management Board. The Board itself considers the programme as a whole.

ASSESSMENT

Digitally enabled workforce and organisation:
The programme scope was completed in September 2018. It has four key activities:

1. Information value realisation (driving operational efficiency from e-records)
2. Accessing e-records (user and function based design)
3. Developing staff digital capability
4. Service engagement

The work concentrates into the organisation and acknowledges the second phase of work will engage our patients, communities and public. We have, in January 2019 become a signatory to the Wales digital inclusion charter which is supportive to the work.
The plans against each of the four areas are developing well and will be finalised during January and February with the commencement of the Director of Digital and Health Intelligence.
The key risks at this stage are:

1. Resistance to changes within the organisation
2. Affordability of proposed changes within the organisation (most especially funding for

digital change co-ordinators).
3. Resource limitation against Mark Cahalane (limited resource, lent from MHCS)
4. Timescales of re-organisation within digital services.

Accessible Information:
This programme is progressing at pace across a wide range of activities. Two key areas are the development of Dashboards specific to user requirements and the introduction of a new product 'signal from noise' (SFN) working with an external company. These were reported on in the last Board report. The work with SFN has required significant attention to information governance requirements to enable its implementation. This work has been extended to enable further data sources to be utilised (WAST and Cardiff Local Authority) . The programme of work is concentrating on unscheduled care systems flow over the winter months and it is too early to report outcome.
The SFN work is being extended to support partnership working within the Regional Partnership Board which is important for our programme of work on 'me, my home and my community'. This work has formed the core of our successful proposal to the Welsh Government Transformation fund.

The key risk to this programme of work are:

1. Insufficient resource - scarce
2. Mal-alignment of initiatives
3. Non-compliance with standards
4. Non-compliance with GDPR

Potential Digital Transformation Fund
There is a likelihood that resource to support digital transformation will become available in 2019/2020. Work is currently underway to develop a proposal against this possibility. The proposal will seek to pace up developments required to support delivery of the IMTP linked to SoFW.

ASSURANCE is provided by:

Governance arrangements in place to secure development of the enabling workstreams plans and delivery of the plans with escalation as required. Regular highlight reports are delivered to both the transformation team and to the Health services Management Board.

All work is linked to the delivery of SoFW and our IMTP , both of which are supported by the Digital outline case

RECOMMENDATION

The Committee is asked to:

- Note the programme of work

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	Y	6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	Y	7. Be a great place to work and learn	Y
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	Y
4. Offer services that deliver the population health our citizens are entitled to expect	Y	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	Y
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	Y

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention		Long term	Y	Integration	Y	Collaboration	Y	Involvement	Y
Equality and Health Impact Assessment Completed:	Not Applicable								

Appendix 1:

Programme Management Office

Delivering and accelerating Transformational Change

Project Highlight Report

Project Name	Digitally Enabled Workforce	Senior Responsible Officer	Sharon Hopkins
Reporting Period	October 2018	Project Manager	Mark Cahaliane/Joy Whitlock

Project Milestones	Date
Management Exec and HSMB Meetings	w/c 3rd Sept'18
Take further input from IT and Transformation Consultant (M. Bailey)	w/c 10th Sept'18
Follow up meeting with CEO and Deputy CEO	19th Sept'18
Investigate options and experiences elsewhere... Cerner site visits.	w/c 4th October' 18
Re-Meet Len Richards (CEO) re: Cerner and Cerner site models.	5th Nov
JD's for CB Co-ordinators drafted to HR	W/C 19th Nov

Project Update

Project Objectives	Status
Include the main headlines about what the project is set up to deliver (taken from the POD)	Progress: Green
1. Currently the initiative is in 'scoping and design' stage.	
2. Identify means to unlock staff efficiency or practice via greater digital support.	Benefits: Green
3. Implement Management Executive supported initiatives to deliver greater efficiency via digital.	

Key Accomplishments	Risks and Issues	
Provide information about what the project has achieved this period 1. *Deliver paper to Management Exec and HSMB.* 2. *Work up action plan for CEO/Deputy CEO support.* 3. *Visit to Cerner sites (Phoenix, Kansas) to counterpoise the proposed model against international exemplars.*	*What is getting in the way of the project achieving its objectives? Include a description of the risk and also an indication of the level of risk (High / Medium / Low)*	
	Resource availability of Mark Cahaliane	High
	Affordability of major initiative actions/findings	Medium
	Resistance within the organisation to structural changes suggested.	Medium
	Re-Organisation within Informatics	Medium

Upcoming Activities	Decisions, Discussions and Actions
Provide information about what the project plans to do next period: *1. Commence Action plan changes to IM&T organisational structure. Commencing with the establishment of the Digital Design Group TOR and members, and Job Specifications for CB Digital leads.*	*Include items for discussion, decisions and/or actions that need to be taken outside of the project:*

Appendix 2. **Transformation Enabler**: Digitally Enabled Workforce – Action Planning

Version: 1.0 **Author**: Mark Cahalane

	Organisational objective	**Action needed:**	**Risks/Issues/Costs:**	**Owner:**
Information Value Realisation	Efficient/cost effective working practices ***enabled*** by e-records that provide comprehensive clinical information which is *shared* and *re-used* across settings of the uHB. Outcomes: - Reduces keying into e-records for staff - Reduces re-asking of patients - Reduces unnecessary variation - Enables improved clinical decisions by providing latest known information drawn from the numerous uHB e-record systems. - Potentially increases time to care. - Potentially increases time for and the means too 'read across' what is known about the patient/ person in order to treat them uniquely.	1. Data acquisition from major uHB e-records (Community, Theatres, Mental Health, Inpatient, Outpatients) to be modelled and early operational efficiencies identified e.g. the transfer of the core nursing assessment, observation and discharge documents from acute to community and vice versa. 2. Undertake a uHB wide digital e-record architectural review, to consider how e-record is stored and re-used by the uHB to deliver safe efficient care. 3. Bring findings and business case to BCAG.	Workload against under pressure/rare uHB digital design and architecture staff. Assure synergy between this 'regional' work, and the National programme currently in initiation phase for a National clinical data record/store. Costs unknown at this time, but the work will be iterative and benefits/value driven.	**Digital Design Group**

Digital Design Group	A means of assuring waste, variation and un-coordinated digital initiatives are limited across the uHB. Also a cohesive mechanism for uHB staff and services to engage with *digital services* (D.P, I.G, digital strategy, cyber security, digital support, and infrastructure).	1. Agree a structure and TOR for a Digital Design Group (DDG). 2. Agree a MOU with uHB clinical boards for the DDG to hold a role in any and all initiatives they are undertaking with digital content/requirement/ aspiration. 3. Embed 'DDG review' and 'DDG agreement' into the emerging uHB 'project controls'. 4. Acid test the group against existing initiatives	Workload of the senior Informatics team to agree and establish the mechanisms (i.e. review and decision making function) of this group. Agreement of CBs to this body… although this can be non-compulsory. The uHB must attach significant value to the DDG. Risk of this body actually or being seen to stymie or delay digital improvements. No costs are expected.	**Informatics Executive**
Tools for Jobs	A workforce supported by digital tools designed for the working environment and workload of staff. Examples would be the rollout of the 1000 community netbooks that connect our staff to PARIS from the 'coffee table' or 'bedroom' of patients. In an acute environment, this may mean the provision of an observations app for staff to record. In a community environment this may mean a phlebotomy app for our 'phlebotomy only' teams.	1. Embed as a design principle of the Digital Design Group (DDG). 2. Engage with the Welsh digital eco-system programme to realise the opportunities for secure applications to interact with uHB core systems and with the shared record (see Information Value Realisation).	This has to be considered in the round, as the universal viewing offered by paper in acute requires a universally available viewing facility for digital record. Split paper and e record keeping is perhaps the biggest challenge to acute digitisation. Costs are unknown at this time, as this is a design principle to be applied to all digital initiatives.	**Digital Design Group**

User Interface Focus	Staff acceptance of new digital ways of working is a barrier to adoption, and thus service change driven by digital facility. Assuring high standards of user experience (UX) across the uHB will speed up the acceptance of digital tools into clinical services.	1. Consider the role of UX, and decide on a) Training b) Ongoing consultancy or c) A new post for digital services. 2. Action the decision on a UX way forward.	Funding may not be available to enhance existing staff or fund onward consultancy/role. Some uHB digital solutions are National or are 3rd party and thus inflexible to UX change request. Costs will depend upon the outcome of the review.	**Digital Design Group**
Staffing capabilities	Working efficiency is impacted by a staff resource that is imperfectly aware of the digital tools to assist their jobs and imperfectly supported in gaining greatest value from those tools.	1. Integrate digital literacy in to existing LED development programmes, induction and other internal courses/opportunities. 2. Provide ongoing support to staff by developing and maintaining interactive e-learning and 'how to' videos. 3. Recruit for digital literacy. 4. Talent management - establish the digital competency framework (NWIS) 5. Bi-Annual showcase of digital facilities.	Synergy with existing HR/OD&T plans? Potentially negative impact on talent pool from which CaV may recruit. Costs would be negligible as OD&T and HR change is perpetual. Bi-Annual showcase would be a relatively minor resource impact on digital services.	**OD&T** **HR** **Digital Training/ Support services.**

Digital by Design	The uHB seeks most cohesive engagement between operational services and digital services in order to avoid misunderstandings and enhance co-ordination and communication between operational need and digital delivery. This has been most heavily tested and implemented in MHCS/ARIS based services with the 'change co-ordinator role' owned/funded by scoped clinical boards.	1. Work up role and JD for 'clinical board digital leads'. 2. Gain CB support for these roles.	Funding model for these roles would need to be agreed. These can/should ideally be existence staff, and absorbed within operational staff churn within a set period of time. CBs may not agree to the value of the role. PARIS services may assist with this matter.	**Informatics Executive**
Testing Hub	The uHB wishes to assure our digital tools and systems are a. Operationally accepted, b. System tested (as a tool/system/app) and c. Environment tested (i.e. as a working digital whole (interaction between systems, environment and staff). Breakdown in this leads to non-acceptance of digital change, waste, and loss of digital facilities for staff.	1. Assign a Testing Manager or robust testing strategy across uHB digital tools. 2. Assure Operational testing hub in TESCO house is made and remains fit for purpose for digital assurance.	Costs of a cross uHB testing lead to deliver this assurance (this may be re-assignment or employment).	**Informatics Executive** (this roll *must* have independence)
Equality and Spread	uHB seeks assurance that best practice and tooling in use in one environment of its business is replicated as widely as possible. At present striking examples of best practice (e.g. e-DAL in acute, and the Co-Ordinator roles in community) are not replicated and spread.	1. Identify value driven plan to spread uHB best practice across clinical boards. 2. Deliver initiatives, as prioritised and funded.	Costs will exist, however if initiatives are universally valuable, then their value will deliver a business case for expansion and spread.	**Digital Design Group** **Informatics Executive**

APPENDIX 3

Accessible Information - workplan Update - 26th October 2018

Title	Objective	Progress	Status
1a) Clinical info model – referrals	Presently most clinical information in the hospital system is either recorded directly to the paper case record, or is recorded in an unstructured and uncoded fashion, not to standards. The intention is to both make best use of this unstructured data by text mining approaches and to enable the UHB to record the data to technical standards so the data can be used and in a way that minimises any loss in clinical productivity. A further key objective is to reduce reliance on paper which greatly increases UHB's risk of non compliance with GDPR	Joint project with NWIS initiated - will scope out ability to automate semantic text mining available to a sufficient degree of sensitivity and specificity over 6 months until March 2019	Behind schedule - but capability to deliver likely from 1/10
1b) Clinical info model – outpatients		Stage 1 has gone live and being rolled out. Solution to collect clinical information via tablet / phone now identified and being put in place. Development to support virtual fracture clinic commenced	On target
1c) Clinical info model – IP (nursing e-docs, pt obs, critical care)		National options appraisal proceeding e- obs case progressing nationally.	Won't deliver til March-19
1d) Clinical info model – theatres (e.g. Op notes)		Not yet commenced	Not commenced
1e) Clinical info model – EU/AU		Intention is to review in light of O/P COM development and the new ECDS dataset requirements. Requires UHB gaining access / developing expertise to semantic text mining capabilities	Delayed
2) Patient level costing	Improve costing modules to support UHB's decision making and benchmarking incorporating the full re-write of data modelling scripts to improve costing returns	Progressed to validation stage requiring finance and info input. When data is returned by external supplier - intention is to then both link data in IW and analyse output for benchmarking and decision support	On target

	as mandated by WG - by the information and finance departments	purposes	
3) Ophthalmology measures	Enable the switch to intelligent targets for waiting times incorporating F/Ups & for glaucoma patients to be seen by non-medicas via new ophthalmology systemsrecording clinical information	OBCs for Eye referral and patient management systems supported at NIMB and progressing. COM enhanced to support eye measures and calculate target dates in place. However engagement and support for clinical workflow not completed. A report was submitted to WG	Functionality in plan, report made but problems with engagement
4) Data acquisition – Pharmacy(WIP), PARIS (CRTs), Canisc, maternity (SPOF), Pathology (Automating for PROMs & Finance), PROMs, GP OOH, Primary care data, Sepsis {avg is 4 weeks developments per system in addition to project mgt and spec etc)	Presently there are numerous systems which are neither interoperable with the UHB's other systems and which store data which is not routinely available for wider use, beyond that of the individual department. Data acquisition programme is required to make data available on a timely basis and in a manner by which it can be linked to other activity relating to the clinical event, pathway etc. This is an enabler step before it can be modelled and data visualisation applied.	PARIS views developed, validation being completed. Significant project. Challenges identified with links to NWIS Pharmacy data set.	Resource constraints
5) Demand capacity for community and GP practices & clusters (plus associated transformation pathways e.g. EOL care)	To support GP sustainability to improve the clinical and cost effectiveness of our health and care management approach, there is a requirement for casemix / skill mix level demand capacity analysis for GP practices and clusters	Post LMC presentation, project group being established to acquire data and deliver BI and analytics products	Numerous constraints

Title	Objective	Progress	Status
6) Open up the UHB data by putting in place key requisites for best practice re Data Protection / GDPR & Cyber security (In particular fine grain auditing of the warehouse - other elements includes GP DPO, CLDC & GDPR compliant toolkits to support data sharing in line with legistlation)	By upgrading the UHB's oracle architecture to latest version UHB & introducing access controls (via fine grain auditting) the UHB can widen access to the warehouse and clinical data stored whilst safeguarding our population;s data. As part of this we will need to continue to improve the UHB's practices, processes and knowledge of data protection legislation and best practice in order to enable maximum value of our data to be realised on a sustainable basis	Architecture for mobile apps to read /write to UHB Data repository being constructed. Pen testing and guidance on use next step. WASPI ISP in place. UHB Data protection contract now national best practice. Cyber security plan to attain cyber security essentials plus approved (WHC req & Stratia review) in principle by mgt exec but not funded.	Accelerating
7) Dashboard models & development – including (Clinical Activity, Stroke (WIP), Medicine, Emergency General Surgery, Transformation KPIs, Referrals, Outpatients (starting with Urology), Sepsis, Dermatology, C&W, GPOOH, theatres)	Provision of appropriate telemetry to support, transformational improvement and operational delivery	Medicine, EGS, Consultant clinical activity portal and EU dashboards live / UAT in month	On target
8) Single Cancer Pathway demand capacity	To support the UHB's knowledge and ability to transform cancer services	Being taken forward in line with national programme and availability	Delayed (SPOF - Short term sickness)

9) Major trauma case	To prepare for the UHB being a major trauma centre a prediction of demand by service and element of the pathway is required	WAST data to analyse triage tool and consequences acquired. Morphed to joint SWP type programme	Resource constraints
10) Mortality & outcome monitoring	To improve the use of data & systems to improve clinical outcomes and provide assurance to our population and stakeholders of our processes for improvement and audit in this area	Analysis and data available, requires user acceptance testing and re-release of CHKS	On target
11) Performance measures - strategic	The UHB's board has identified the need for the UHB to monitor and report on strategic measures and progress in addition to those identified as the NHS delivery framework	Paper produced proposing approach - requires exec consideration. Delivery framework data requirements identified low level of additional work. Post sign-off operational dashboard will be developed	Awaiting Exec response to proposal
Title	Objective	Progress	Status
12) PROMs & PREMs	Use PROMS & PROMs across the organisation in order to i) evidence the effectiveness of care and treatments upon which decisions to vary treatment and access can be based ii) Support co-production / shared decision making by providing patients and clinicians with far more comprehensive information on the outcomes of treatments. iii) Enable the UHB to benchmark across organisations, regions and networks to improve	15000 generic records Overall response rates remain around the 10% but vary depending on the specialty (data issues aside) between 6% to 16%. 670 have repeated submission with > 28 days between them. WPRS development not undertaken but work around in place to support condition specific pathways to be entered. PMS developments delayed due to other priorities. Some work arounds in place but hindering roll outs of condition specific conditions.	Behind schedule & numerous constraint. Anticipate spurt of progress over next quarter

	clinical performance , drawing on the example of Bupa. iv) enable clinicians to use PROMs data as a clinical tool in guiding care, (eg referral and follow up practices, comparing outcomes for different treatment approaches) to ensure that the people who receive health care are those that will benefit from it the most. v) Address high-level questions about productivity and performance in the UHB by measuring improvements in patient health.	Test messaging pilot delayed due to patient portal rollout. ALAC and Haematology (nurse led transplant) using 'in clinic' solution to collect generic forms for their patients. Gynae Oncology collecting generic using patient leaflets inviting patients to go online but stressed by clinicians as to the importance Processes in place and collecting the specific condition pathways for Orthopaedic Shoulder, elbow and hand. Advanced discussions with hip and knee to replace amplitude collection (with Phil Thomas currently but hoping to go live soon) Advanced discussions with Lung Cancer to commence soon. Advanced discussions with Ophthalmology to go live with Cataract's soon Advanced discussions with Heart failure service to go live soon. Tool currently in test. Early discussions with ENT to go live with condition specific (sino nasal and tonsillectomy) Early discussions with Haematology consultants NETs tool in test to go live in medical endocrinology with collection to follow	
13) DNA / FAB / deep learning	Targeted patient specific interventions based on data science approach to identifying likelihood of a patient DNAing will	Neural network tool developed and tested. PMS updated. Model now being loaded and tested Presently delayed whilst COM and ophthalmology developments complete	Load & test stage

	be tested with the intention of finding cost effective solutions to reducing DNAs via the booking process		
14) Benchmarking – NHS benchmarking, CHKS & Albatross	To increase the take up, awareness and use of these products across the UHB as decision making tools	Intention is to use existing fora to increase awareness and use of the UHB's existing benchmarking tools procured under national licenses. Thus far surgery and patient safety have taken up the CHKS product.	Resource constraints
15) Winter planning transformation	1) Support the early delivery of whole system improvements in patient flow and capacity management in order to address near term challenges and develop long term resilience to variation in demand. , 2) Support, enhance and expand the current service improvement and development programme to increase the capacity and capability to deliver transformational change and continuous improvement across all sectors of care. 3) Provide the information and quantitative service improvement tools in the areas of frailty, falls, #NOFs and COPD	Canterbury and Lightfoot workshops undertaken. Evaluation now being undertaken, with plans for ongoing procurement being considered.	On target

REPORT TITLE:	**UPDATE ON WELSH GOVERNMENT RESPONSE ON PUBLIC AUDIT COMMITTEE REPORT ON INFORMATICS IN WALES**								
MEETING:	IT&G SUB COMMITTEE					**MEETING DATE:**	**29/01/19**		
STATUS:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**		**X**
LEAD EXECUTIVE:	DEPUTY CHIEF EXECUTIVE								
REPORT AUTHOR (TITLE):	IM&T PROGRAMME MANAGER								
PURPOSE OF REPORT:									

SITUATION:

The Public Accounts Committee (PAC) agreed to undertake an inquiry into the Auditor General for Wales report produced on 'Informatics systems in NHS Wales' published January 2018 and to inlcude coverage of the following issues:

- The Welsh Governments leadership role for informatics in NHS Wales, including for example, ensuring NHS bodies agree what 'Once for Wales' means in practice.
- The work the Welsh Government is doing to better understand the costs of delivering its vision for informatics and how that could be funded given the downwards trend in spending on ICT and the £484 million estimate of the cost of deliering the vision for informatics on top of current budgets.
- The extent of resourcing and investment at a local level
- The effectiveness of governance and accountabilility arrangements in light of conerns identified by the Auditor General and the recommendations of the Parliamentrary Review to being bodies such and NWIS within a strengthened central NHS Wales Executive function.
- Local leadership, including clinical leadership, and perspectives on the factors behind slow progress in delivering the electronic patient record.
- Workforce challenges, including recruitment and retention of ICT specialists.
- Getting greater clarity about whether the intended benefits of investment are being achieved.

Durring the course of the inquiry the Auditor General also wrote to the PAC regarding concerns about ICT outages at NHS bodies. The outcome of these concerns is a separate review being undertaken to review the Architecture of NHS Informatics in Wales. This review is underway and likely to be published April / May 2019.

The outcome of the overall PAC inquiry has led to five recommendations being submitted to Welsh Government. This report to the IT&GSC outlines the 5 recommendations submitted and the responses provied by Welsh Governement.

REPORT:

BACKGROUND:

The PAC review resulted in five recommendations:

Recommendation 1 – We recommend that the Committee receives six monthly updates from the Welsh Government on progress in implementing the digital recommendations in the Parliamentary Review and the Auditor General's report in order to enable us to revisit these issues at a later date.
Recommendation 2 – The Committee was also very concerned by the evidence we heard on system outages, infrastructure and resilience. Given recent evidence of further outages since we took evidence, we would like further assurance from Welsh Government that the systems are resilient. We recommend the Welsh Government set out a clear timetable for putting the digital infrastructure of NHS Wales on a stable footing.
Recommendation 3 – In the discussions on the use of Cloud computing and the impact of recent outages, it was deeply concerning that, when many consumer systems appear to have very robust performance and up-time, the NHS in Wales is struggling to run its own data centres with 21 outages in the first 6 months of 2018 – one outage every 9 days. The Committee recommends a review of the senior leadership capacity in terms of skillset and governance within both NWIS and the wider NHS Digital Team.
Recommendation 4 – NWIS is currently overstretched and improvement requires far more than simply pouring more money into the existing organisation, which is unlikely to achieve significantly different results. We recommend that any additional funding apportioned to NWIS needs to be tied to reorganisation to achieve the improvements that are required.
Recommendation 5 – We recommend that NWIS looks to increase its work with other public bodies, including those from UK Government. This approach could work on a number of levels, from the sharing of good practice on recruitment to the creation of Government Digital Service which could work across multiple agencies.

Full details of the PAC Report can be seen in **appendix 1** of this report. Since publication of the report Welsh Government have provided responses to the each of the five recommendations which can be seen in **appendix 2** of this report.

ASSESSMENT:

All organisations in Wales have reviewed the Auditor General for Wales report on Informatics Systems in NHS Wales and provided feedback. Welsh Government have since reviewed the recommendations provided in the PAC report and provided a response to each of the five recommendations (appendix 2). The UHB will continue to work with Welsh Government, NHS bodies and NWIS to review progress on the recommendations provided by the Public Accounts Committee.

RECOMMENDATION:
For assurance purposes the IT&GSC is asked to note the UHB is fully engaged with Welsh Government and NWIS in regards to progress on the recommendations to the PAC report and the Informatics Systems in NHS Wales report.

SHAPING OUR FUTURE WELLBEING STRATEGIC OBJECTIVES RELEVANT TO THIS REPORT:			
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	x
2. Deliver outcomes that matter to people	x	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	x
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time	x	10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Please highlight as relevant the Five Ways of Working (Sustainable Development Principles) that have been considered. Please click here for more information											
Sustainable development principle: 5 ways of working	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 1

FULL PAC REPORT AS AN ATTACHEMENT

APPENDIX 2

Response to the Report of the National Assembly for Wales Public Accounts Committee Report on Informatics Systems in NHS Wales.

Y Pwyllgor Cyfrifon Cyhoeddus / Public Accounts Committee PAC(5)-01-19 P1

Response to the Report of the National Assembly for Wales Public Accounts Committee Report on Informatics Systems in NHS Wales.

The Welsh Government acknowledges the findings of the report and offers the following response to the five recommendations contained within it.

Recommendation 1 – We recommend that the Committee receives six monthly updates from the Welsh Government on progress in implementing the digital recommendations in the Parliamentary Review and the Auditor General's report in order to enable us to revisit these issues at a later date.

Accept – We recognise the Committee's concerns and we have initiated actions to improve the pace of delivery, most of which were already in train ahead of the Committee's final report. The Committee has recognised that evidence gathering by the Wales Audit Office for its Review began some 2 years ago and since that time, a number of improvements in our whole system governance of informatics programmes and digital change have been put in place.

The National Informatics Management Board was repurposed to ensure a focus on how the Health Boards and NWIS were working together to improve the delivery of the agreed *Informed Health and Care: a digital strategy for health and care* and this was reflected in the evidence provided to the Committee. In addition, the Committee will be aware of the commitment to increase investment in and focus on digital and informatics contained within *A Healthier Wales* which was issued earlier this year as the joint health and social care long term plan for Wales. This was in response to detailed commentary from the Parliamentary Review about digital opportunities and progress and informed by engagement across service users and providers.

I would expect that regular reporting will give the Committee an opportunity to see progress in respect of the recommendations in the Parliamentary Review and the Auditor General's report. In addition to Welsh Government making additional investment available, within six months the three-year National Informatics Plan will be in place and the reviews of the digital architecture and governance of informatics in NHS Wales will have been completed.

Recommendation 2 – The Committee was also very concerned by the evidence we heard on system outages, infrastructure and resilience. Given recent evidence of further outages since we took evidence, we would like further assurance from Welsh Government that the systems are resilient. We recommend the Welsh Government set out a clear timetable for putting the digital infrastructure of NHS Wales on a stable footing.

ccept– As would be expected, I can assure you that critical systems are regularly and routinely tested to ensure that they are fit for purpose. Data centre services in Wales are provided within a quality environment that has been independently accredited to ensure that standards meet ISO requirements. The last accreditation was in September 2018 and all ISO accreditations are up to date.
The Committee will wish to be aware that NWIS is putting greater focus on undertaking routine maintenance (e.g. firmware upgrades) and in undertaking upgrade activities outside of core working hours. In the past five years £9.3m in additional funding has been provided by Welsh Government to fund essential replacements. NWIS is developing a business case to secure additional funding to reduce the likelihood of further downtime. We also expect each Health Board and Trust to have appropriate business continuity plans in place, including the use of the Joint Emergency Services Interoperability Principles for managing major ICT or cyber security incidents.

Welsh Government will continue to prioritise funding towards critical systems and this will be reflected in the three-year all-Wales National Informatics Plan which will go to the National Informatics Management Board (NIMB) in December. This will be further informed by the output of the architecture review due to commence early in the New Year. We will expect each Health Board and Trust's Integrated Medium Term Plan (IMTP) to reflect this nationally agreed agenda.

Recommendation 3 – In the discussions on the use of Cloud computing and the impact of recent outages, it was deeply concerning that, when many consumer systems appear to have very robust performance and up-time, the NHS in Wales is struggling to run its own data centres with 21 outages in the first 6 months of 2018 – one outage every 9 days. The Committee recommends a review of the senior leadership capacity in terms of skillset and governance within both NWIS and the wider NHS Digital Team.

Accept–The "Use of Cloud" Task and Finish Group developed guidance for the use of Cloud services in NHS Wales. This guidance encourages the use of cloud services alongside traditional software and infrastructure deployment models within the business case process and in April 2018, the NHS Wales Informatics Management Board, which includes representatives of Welsh Government, NWIS and each health board and trust in Wales, approved the guidance document for publication.

NWIS has worked on the adoption of new cloud services for several years and currently supports more than 10,000 users, using Microsoft Office 365 cloud services for email, file storage, Skype and other services. NWIS is also supporting Health Boards who are working on using PowerBI (Business Intelligence services) using the Cloud. One of the suppliers of GP systems for NHS Wales (is using 'UKCloud' to host the systems for its GP practices.

In addition to this, NWIS has worked with Microsoft and NHS Wales organisations over the past 18 months to put the underpinning systems in place to allow NHS Wales organisations to be able to consume cloud services from Microsoft Azure. We are committed to significantly increase investment in digital infrastructure, technologies and workforce capacity, supported by stronger national digital leadership and delivery arrangements, as already promised in *A Healthier Wales*. The Committee will also be aware of the commitment in *A Healthier Wales* to review hosted national functions, which includes NWIS, with the aim of consolidating national activity and clarifying governance and accountability. This was discussed in evidence to the Committee.

The leadership requirements across the whole system are a feature of the review of governance of informatics which will report to Welsh Government in January. This review , started earlier this year , has interviewed around one hundred people engaged in digital leadership and informatics management, including clinicians, across the NHS and will report early in the New Year . This action was already in place in advance of the Committee's recommendations, generated by the Parliamentary Review. Importantly this will be a whole system review and not limited to a review of NWIS capability and capacity.

Recommendation 4 – NWIS is currently overstretched and improvement requires far more than simply pouring more money into the existing organisation, which is unlikely to achieve significantly different results. We recommend that any additional funding apportioned to NWIS needs to be tied to reorganisation to achieve the improvements that are required.

Accept – We have always recognised the complexity and the challenges in delivering our vision of a single electronic record and previously accepted the WAO recommendation earlier this year to commission a review of our approach to building the digital architecture to support this. This work is now in train and will ensure that current market developments are considered as well as providing an overview of the rationale for local v national systems. This will build upon last year's decisions including the agreement to mandate national data repository systems, the setting up of the Welsh Technical Standards Board and to develop plans for a "National Data Resource" which will enable us to make a step change in how we capture , manage and use the data that we have across our health and care systems**.**

These actions as well as the governance review and the establishment of the NHS Executive, as signalled in *A Healthier Wales*, will inform the future shape and structure of informatics in the NHS in Wales and help to respond visibly to the Committee's concerns. The increased investment in digital committed to in *A Healthier Wales* will be advised by the three-year National Informatics Plan.
I trust the Committee will acknowledge that there will need to be continued investment in NWIS for the business-critical support and developments, delivered nationally, for which it is responsible, while these actions are underway.

The Committee will also wish to note that NWIS-driven initiatives have resulted in cost benefits, as well as operational ones. As examples: NWIS negotiations with Microsoft three years ago saved 40% on licensing costs of an Enterprise Agreement; the Picture Archiving and Communications procurement (PACS) saved £15m – against current Health Board-level contract costs; the GP systems and services procurement represents a saving of £1m per year on the core contract cost; and the deployment of a managed-print service across all GP practices is anticipated to generate savings in the region of £4m across the seven-year term. I am content to share further details of value for money in respect of National ICT implementations. It is important to recognise the responsibility of each Health Board and Trust to work alongside NWIS in the development and delivery of national systems and align their local investment plans to achieve the agreed national vision for an integrated electronic patient record.

Recommendation 5 – We recommend that NWIS looks to increase its work with other public bodies, including those from UK Government. This approach could work on a number of levels, from the sharing of good practice on recruitment to the creation of Government Digital Service which could work across multiple agencies.

Accept - We recognise that sharing of good practice is essential as the NHS in Wales continues to deliver high quality services. This is important when addressing the challenges of recruiting quality staff within the digital space and there are opportunities to share, learn and adapt.

NWIS is increasingly working and exchanging information with other public bodies from within and outside Wales, such as Local Authorities, particularly in the implementation of WCCIS, and with the National Cyber Security Centre at a UK-level.

We also told the committee of Welsh Government engagement with NHS Digital, the Department of Health, the Scottish Government and Northern Ireland. We will facilitate and encourage more engagement, building on existing contacts and example of innovation. This will include engagement with the Digital Health Ecosystem Wales, the multi-stakeholder entity, including health, academia and industry, established under *Informed Health and Care*. The NHS clinical informatics community is also directly represented on the Welsh Government's Digital Transformation Panel.

The Welsh Government works across multiple agencies by working closely with the Office of the Chief Digital Officer to share lessons learned across the wider public sector in Wales.

As referenced above, the NHS's Welsh Technical Standards Board has accepted the GDS Digital Design Principles and the Welsh Government Digital Service Standards to ensure a consistency of approach when developing new services.

National Assembly for Wales
Public Accounts Committee

Informatics Systems in NHS Wales

November 2018

www.assembly.wales

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Copies of this document can also be obtained in accessible formats including Braille, large print, audio or hard copy from:

Public Accounts Committee
National Assembly for Wales
Cardiff Bay
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National Assembly for Wales
Public Accounts Committee

Informatics Systems in NHS Wales

November 2018

About the Committee

The Committee was established on 22 June 2016 to carry out the functions set out in Standing Orders 18.2 and 18.3 and consider any other matter that relates to the economy, efficiency and effectiveness with which resources are employed in the discharge of public functions in Wales.

Committee Chair:

Nick Ramsay AM
Welsh Conservative
Monmouth

Current Committee membership:

Mohammad Asghar AM
Welsh Conservative
South Wales East

Neil Hamilton AM
UKIP Wales
Mid and West Wales

Rhianon Passmore AM
Welsh Labour
Islwyn

Adam Price AM
Plaid Cymru
Carmarthen East and Dinefwr

Jenny Rathbone AM
Welsh Labour
Cardiff Central

Jack Sargeant AM
Welsh Labour
Alyn and Deeside

The following Members were also members of the Committee during this inquiry:

Vikki Howells AM
Welsh Labour
Cynon Valley

Lee Waters AM
Welsh Labour
Llanelli

Contents

Chair's foreword

In 2003 the iPhone was yet to be invented and Google Gmail and Skype were yet to take off. It was in this same year that the Informing Healthcare strategy was launched, with an electronic patient record for Wales at its heart. The other technological innovations of that year have not only been realised, but leapfrogged several times, and yet NHS Wales remains far away from a seamless electronic portal for patient records.

The fact that NHS Wales still refers to its digital programme as "Informatics" is emblematic of how dated its approach is. The Auditor General's report into Informatics Systems in NHS Wales, and the subsequent Public Accounts Committee hearings, uncovered a raft of problems. Many of their digital projects are behind schedule, and some are only on schedule because their timescales have been reordered to show them on track. Lines of accountability are unclear, there is widespread dissatisfaction across the NHS at its performance, and in the first six months of this year alone its major systems have gone down 21 times. And yet the Chief Executive responsible for hosting NWIS described its ambitions as world leading.

We believe that NWIS is primarily focused on running outdated IT systems. At a time when the potential of digital healthcare is capturing the imagination and improving patient outcomes, just 10% of NWIS activities are focused on innovation.

Our inquiry has raised serious question marks about the competence, capability and capacity across the health system to deliver a digital transformation in Welsh healthcare. And yet we discovered a culture of self-censorship and denial amongst those charged with taking the agenda forward – in NWIS, itself as well as its partners in the health boards and the Welsh Government.

Despite the clear failing to deliver, the Auditor General found NWIS to be "overly positive" in its progress reporting. Despite the Welsh Government and NWIS accepting all of the Auditor General's recommendations, we found little reason to be optimistic that things were changing. We trust our inquiry and this report will be a wake-up call to all those involved in harnessing the power of digital innovation to improve healthcare in Wales. We believe it's time for a reboot.

Recommendations

1. Introduction

1. Informatics systems can help the NHS to deliver better outcomes for patients and make efficient use of financial and human resources. The Welsh Government, NHS Wales Informatics Service (NWIS) and the NHS bodies work together to deliver informatics systems for the NHS. The Auditor General for Wales (the Auditor General) published his report on informatics systems in NHS Wales on 10 January 2018. The report considers whether NHS Wales can achieve the intended benefits from its investment in updated clinical ICT services. The Auditor General's report focussed on six specific systems as indicators of the wider approach to informatics:

- Radiology systems (RADIS and the Picture Archiving Services – PACS);
- Laboratory system (Welsh Laboratory Information Management System (WLIMS);
- Myrddin – the main patient administration system;
- Community Systems – My Health online (GP system for appointments and repeat prescriptions) and Choose Pharmacy.

2. The Auditor General's report concludes that although the vision for an electronic patient record is clear and key elements are in place, there have been significant delays in delivery. There have been some important developments during the period of the review, but there are still some key weaknesses in arrangements to support and oversee delivery and to ensure the systems deliver the intended benefits. The NHS has recently identified that significant additional funding will be required to deliver the vision, but further work is required on the detailed plans and to confirm the funding arrangements.

3. In publishing the report, the Auditor General emphasised that:

> "Putting the vision of an electronic patient record into practice means all parts of NHS Wales, including Welsh Government, need to take some tough decisions, particularly on funding, priorities and enabling clinicians to have the time and space to lead on this agenda. Unless it addresses the issues identified in my report, the NHS risks further

> frustration amongst frontline staff and ending up with systems that are already outdated by the time they are completed."[1]

4. The Welsh Government has produced a response in which it accepts all 13 recommendations. The Parliamentary review of Health and Social Care published its report on 16 January 2018. The review made a series of recommendations, some of which are relevant to informatics. The key messages of the Parliamentary Review, notably around clarifying strategy, priorities and governance, resonate with those of the Auditor General's report.

5. The Committee agreed to undertake an inquiry into informatics systems in NHS Wales, and to include coverage of the following issues:

- The Welsh Government's leadership role for informatics in NHS Wales, including, for example, ensuring NHS bodes agree what "Once for Wales" means in practice.
- The work the Welsh Government is doing to better understand the costs of delivering its vision for informatics and how that could be funded given the downwards trend in spending on ICT and the £484 million estimate of the cost of delivering the vision for informatics on top of current budgets.
- The extent of resourcing and investment at a local level.
- The effectiveness of governance and accountability arrangements in light of concerns identified by the Auditor General and the recommendations of the Parliamentary Review to bring bodies such as NWIS within a strengthened central NHS Wales Executive function.
- Local leadership, including clinical leadership, and perspectives on the factors behind slow progress in delivering the electronic patient record.
- Workforce challenges, including recruitment and retention of ICT specialists.
- Getting greater clarity about whether the intended benefits of investment are being achieved.

6. The Committee has also identified concerns about the delivery of informatics systems in its work on medicines management. It has also raised concerns about

[1] Auditor General for Wales Report: NHS Wales Informatics Services, January 2018

the delivery of a National Nutrition and Catering IT Solution (NNCIS) and the Welsh Community Care Information System (WCCIS). The Committee considered further correspondence from the Welsh Government in respect of these two systems on 12 March 2018.

7. During the course of our inquiry, the Auditor General wrote to us regarding concerns about ICT outages at NHS bodies. His letter included a board paper considered by Velindre NHS Trust, highlighting concerns about outages of national informatics systems – CaNISC, the cancer system, and WLIMS. Given the seriousness of the issues, the Committee decided to extend the scope of its inquiry to take further evidence on system outages and infrastructure.

8. This report does not seek to replicate the extensive written and oral evidence we have received and instead sets out the Committee's views on the key issues we considered. Transcripts of all oral evidence sessions and written evidence received can be view in full at:
http://senedd.assembly.wales/mgIssueHistoryHome.aspx?IId=20803

2. Committee's Findings

Overall views

9. Digital transformation requires an open culture, the Committee found that the culture at NWIS was the antithesis of this. We are particularly concerned at the apparent lack of openness and transparency across the whole system. The Auditor General's report identified a pattern of the organisation being "overly positive" in reporting its progress. The Committee's evidence gathering found examples of this again and again. Troublingly this mind-set seems to be consistent with that of the health boards, and the Welsh Government teams working alongside NWIS, as the Committee found a collective reluctance to openly discuss the true state of progress.

10. We found that witnesses were reluctant to be critical of progress or arrangements on the record. Some written evidence from two parts of the NHS was remarkably similar and the Committee was left with the impression that we were getting a pre-prepared line. As a result the Committee could have little confidence in many of the assurances we were given by NWIS and the Welsh Government.

11. If the problems with NHS informatics are to be addressed, then an open and honest reflection on the current state of play and the barriers to progress is essential. Indeed, it is quite possible that this culture has prevented the Committee from hearing a comprehensive range of issues and problems – in short, we remain unsure of the scale of the issues.

12. We are concerned that the NHS is still not fully ready to openly recognise the scale and depth of the problems. The Committee is concerned that this cultural problem may be masking wider and deeper problems which we did not uncover. We believe a fundamental change in behaviour from NWIS and the wider NHS Digital team is required if progress is to be made.

13. Overall, the Committee is deeply concerned about the slow pace of delivery of modern informatics systems across the NHS in Wales and the underlying weaknesses in support and oversight arrangements. It is apparent that nobody is happy with the current state of affairs. NHS bodies are frustrated with the slow-roll-out and problems with systems they have and concerned about confused accountabilities. NWIS is frustrated at the lack of direction from the wider NHS. The greatest frustration is that electronic records lead to better patient care and

outcomes but in too many cases, the NHS relies on outdated, paper based records.

14. The Committee had hoped to see that the pace of change had picked-up, however this was not evident. The Chief Executive of NHS Wales' acceptance of the WAO report was published in March 2018, and in his letter he referred to the 18 months of work undertaken. This suggests that the initial evidence was gathered approx. 2 years ago – September 2016.

15. The Committee recognises that while the Auditor General was undertaking his work, the Welsh Government and the wider NHS were taking steps to begin to address many of the issues. We welcome the positive response to the Auditor General's recommendations. Nonetheless, we remain concerned about the pace and urgency of action as we saw little evidence of change.

16. While welcoming the positive response to the Auditor General's report, the Committee considers our review of informatics to be unfinished business. Given the detailed recommendations of the Auditor General's report and those of the Parliamentary Review of Health and Care, we are not making detailed recommendations of our own to the Welsh Government. Instead we strongly endorse the existing recommendations.

Recommendation 1. We recommend that the Committee receives six monthly updates from the Welsh Government on progress in implementing the digital recommendations in the Parliamentary Review and the Auditor General's report in order to enable us to revisit these issues at a later date.

Recommendation 2. The Committee was also very concerned by the evidence we heard on system outages, infrastructure and resilience. Given recent evidence of further outages since we took evidence, we would like further assurance from Welsh Government that the systems are resilient. We recommend the Welsh Government set out a clear timetable for putting the digital infrastructure of NHS Wales on a stable footing.

17. The Committee heard differences of opinion on the merits of the use of Cloud computing as opposed to data centres. We did not see sufficient evidence of a deep level of Technological or Digital understanding and little evidence that the benefits of Cloud computing are being fully identified neither does there appear to be any grasp of the opportunities presented by the Cloud. We heard no substantial evidence of take-up of Cloud services from NWIS.

Recommendation 3. In the discussions on the use of Cloud computing and the impact of recent outages, it was deeply concerning that, when many consumer systems appear to have very robust performance and up-time, the NHS in Wales is struggling to run its own data centres with 21 outages in the first 6 months of 2018 – one outage every 9 days. The Committee recommends a review of the senior leadership capacity in terms of skillset and governance within both NWIS and the wider NHS Digital Team.

Strategy

18. The high level vision for NHS Informatics in the areas the Auditor General examined is clear. In essence the NHS will have an electronic patient record that is made up from lots of different systems that talk to each other, rather than one single system that tries to do everything. However, despite some recent developments, there remains a need for greater direction and clarity on the "Once for Wales" approach to developing and rolling out the systems that will go into a patient record.

19. While the vision is clear, it is now quite old. The vision for the electronic patients record was set as part of the Informing Healthcare strategy in 2003. The world of informatics and digital technology has moved on in the intervening 15 years. We were therefore pleased to see that the Welsh Government in response to the Auditor General's recommendation, will commission a review of its approach to infrastructure and system design as part of the NHS Wales Informatics Management Board (NIMB) forward workplan. This will include developing an understanding of what is currently available on the market and best practice.

20. It is important that any strategic review considers both aspects of this understanding - market availability and best practice. As we explain below, it may be that the NHS Wales existing reliance on the mixed economy for the provision of NHS software is not the best strategic approach.

21. The Auditor General reported that the NHS had agreed a new definition of "Once for Wales". However, we are unconvinced that the definition has resolved the underlying tensions and differences. We heard mixed evidence on whether there was now a clear agreement and common understanding on the balance between all-Wales systems and local discretion based on common standards. Some witnesses placed an emphasis on common standards whereas others focussed on the need for more mandated systems across Wales. It was unclear to us whether the tensions between the two have been resolved. Evidence from Health Boards reflected a keenness for commons standards while NWIS were

more focussed on rolling out single systems across Wales. We therefore think that there is more work for the Welsh Government and NHS bodies to do in order to fully address the Auditor General's recommendations around clarifying what "Once for Wales" means in practice.

22. The Committee heard a lot of evidence about a lack of clear strategic prioritisation. The Auditor General's recommendations called for clearer prioritisation. This call was echoed in the Parliamentary Review, which called for a "stop-start-accelerate" review on informatics.

23. All of the witnesses appeared to recognise that NWIS was being asked to do too much within its current resources and needed clearer priorities. We were pleased to hear from witnesses that the National Informatics Management Board (NIMB) is now having a strengthened focus on prioritisation in a national informatics plan for 2018 – 19. We were also told that prioritisation would be a key feature of a three-year plan from 2019 – 20. However, we are concerned that while there is much focus on the need for clearer priorities on ICT systems there is also discussion about the introduction of new systems, for example around GP access. Generally, the witnesses struggled to set out things that NWIS should stop doing.

24. While welcoming the steps in the right direction through the NIMB, we are unconvinced that the NHS as a whole, including the Welsh Government, has yet fully grasped the need for tough decisions on priorities. The NHS must face up to the reality that, in the absence of a significant change in the funding for NHS informatics, prioritisation must mean stopping doing things. That may help NWIS to get some projects over the line, as the Chief Executive of the NHS described it. But prioritisation inevitably means non-priority projects getting delayed or not even getting started. Prioritisation is not a silver bullet and still means it could take many more years for an electronic patient record to be put in place.

25. Our key concern is that without a step-change, by the time a full electronic patient record is achieved, key systems will be out of date. During our evidence sessions, Members discussed how technology is moving on, for example, with private companies offering online access to GPs within 20 minutes on mobile devices for a relatively small fee. Conversely, as the Auditor General makes clear, the NHS Wales GP application, My Health Online, is not delivering anything like the benefits it set out to achieve. While there are discussions about improving My Health Online, it is hard to see how these will be achieved in a reasonable timeframe without adding to an already full priority list.

Finances

26. In his evidence, the Chief Executive of NHS Wales recognised that finance is a significant constraining factor. The Auditor General's report suggests that spending on ICT across the NHS had been falling – with reductions in NWIS' core budget and spending on ICT by individual NHS bodies. The Auditor General estimated that the NHS as whole spends less than 2% of its budget on ICT. Within NWIS' budgets, a small proportion (10%) of its budget is for developing new systems.

27. It was clear from the evidence that some difficult decisions are required in terms of whether and how to provide the significant extra funding that is needed to deliver the vision and work with the NHS to strengthen collective financial planning for informatics. We know that the cost of delivering the vision in each NHS body and NWIS' contribution to National systems is tentatively estimated at £484 million on top of existing budgets, with £195 million capital and £288 million revenue. Of this £484 million, £196 million is identified as needed by NWIS, with the rest required by Health Boards and NHS Trusts. The Welsh Government accepted the Auditor General's recommendation to carry out a full cost-benefit analysis of the investment. This is tied to wider reviews of the overall approach to infrastructure and system design and prioritisation.

28. The Auditor General's report states that there is a clear strategy for Welsh Government Electronic Patient Record, the development of separate systems from a number of suppliers. Whilst this was an understandable approach a decade ago (when the programme was begun) there are two factors which the Committee is very concerned about:

a. Software development has enjoyed huge positive changes over the past 10 years – the processes and tools for building software are now significantly advanced.

b. As the NHS becomes increasingly dependent on its digital technology, this cannot in turn become a dependency on the private sector. Building our own systems can be a better solution than simply buying them in via large procurement execrcises.

29. The Welsh Government has not yet committed to providing significant extra funding and given this estimate was produced in 2016 there appears to be a lack of urgency making a decision to do so. There is a need for clarity from Welsh Government as to whether the tentative estimate is in the right ballpark, and the witnesses we asked thought it was, and whether significant resources will be set

aside and over what time frame. We heard positive comments about the £10 million in capital provided by the Welsh Government for NHS ICT in 2017-18. Yet the estimate shows that far more than this amount a year will be required. We heard ideas about using pots of innovation funding and the Integrated Care Fund. We are concerned that this appears to be dealing at the margins when a much more fundamental decision about setting aside significant amounts of funding, or a fundamental re-think on the ambition and timings, now needs to be made. Given that many of NWIS projects are either behind schedule, or are operating to revised schedules, the Welsh Government must consider whether it can have confidence in the competence and capability of NWIS as currently constituted.

Recommendation 4. NWIS is currently overstretched and improvement requires far more than simply pouring more money into the existing organisation, which is unlikely to achieve significantly different results. We recommend that any additional funding apportioned to NWIS needs to be tied to reorganisation to achieve the improvements that are required.

30. We reiterate the point made earlier that without significant additional resources, we do not think that an electronic patient record can be rolled-out in a reasonable timeframe. By additional resources, we do not necessarily mean new money for the NHS that would otherwise go to other public services. A key rationale for the electronic patient record is that it makes services more efficient and reduces mistakes, which are costly to put right. The NHS as a whole needs to take a longer-term, collective view of investment in informatics, on an invest-to-save basis.

31. We believe that Welsh Government should be very open-minded when looking at the funding options for NWIS. It is clear that there needs to be a shift away from CapEx towards more revenue-funding. Also, we have the view that Digital / IT is still seen as a cost-centre, rather than an opportunity to improve patient care and experience, and reduce the overall Administration and Clerical budgets.

Governance and leadership

32. The weaknesses in NWIS' governance arrangements, including a lack of independent scrutiny and unbalanced reporting of progress, are of significant concern to us. The Committee started this inquiry confused about the governance arrangements for NWIS and ended it still unsure as to how they work. There is a complex arrangement whereby Velindre NHS Trust hosts NWIS and is accountable for certain aspects of its activity. But NWIS is accountable to Welsh Government for its performance and delivery of informatics services.

33. It is clear that these arrangements cause confusion in practice, notably where there are major incidents with a system. It is clear from the evidence that senior NHS executives are not sure who is accountable for NWIS nor how they are held to account. While several spoke of the NIMB, we understand that the main role of NIMB is to show collective leadership rather than specifically scrutinise and how NWIS to account. Despite their evident dissatisfaction about progress we saw no evidence that health board executives are scrutinising the work of NWIS (indeed there was confusion amongst them about how they would do this). NIMB covers roll-out of new ICT systems, which is only a small proportion of what NWIS does. We consider that a simpler and more transparent arrangement is required.

34. Witnesses seemed reluctant to defend or criticise the governance arrangements for NWIS. There was nonetheless acknowledgement of a need for change. The Committee welcomes the commitment to reviewing and updating NWIS' governance arrangements in response to the Auditor General's recommendations and the Parliamentary Review of Health and Care. The Committee awaits with interest further details on what the new arrangements will be and how they will work. We agree wholeheartedly with the Auditor General that they should ensure a greater degree of transparency and independent scrutiny than occurs at present. We anticipate that any new, thorough Governance, may in the short term serve to uncover more problems than it fixes.

35. On the subject of transparency, we agree that any new arrangements need to ensure balanced reporting of progress in the delivery of informatics systems. The Auditor General concluded that NWIS reporting was not balanced and was overly-positive. We agree and at times during the evidence, we heard a similar unbalanced picture. We were told Wales was "world class" and ahead of other parts of the UK. We were given lists of achievements without context. Of course, we understand the desire and need to celebrate successes and achievements. But at times, some of the evidence felt completely at odds to the picture painted by the Auditor General and also did not chime with what Committee members regularly hear from NHS staff.

36. There is considerable confusion around leadership of informatics in Wales with multiple individuals described in our evidence as having leadership roles and responsibilities. There are senior officials in Welsh Government with leadership roles. There is an NHS Wales Chief Information Officer and NHS Wales Chief Clinical Information Officer. There is also a lead Chief Executive for ICT, who is the Chief Executive of Velindre NHS Trust, which hosts NWIS. In his evidence to us, the Chief Executive of NHS Wales recognised that there is scope for confusion.

37. We also think that there is scope to strengthen the capacity of Welsh Government and NHS bodies to direct, challenge and act as an intelligent client to NWIS. We were not convinced that the senior Welsh Government officials and top NHS executives have the detailed technical understanding needed to give NWIS a clear direction and challenge its performance and decisions.

38. In clarifying national leadership we would endorse the Auditor General's view that Welsh Government needs to ensure that the roles of NHS Wales Chief Information Officer and NHS Wales Chief Clinical Information Officer have sufficient authority and prominence, given that they are currently located in a hosting agency that does not fit into the overall NHS Leadership structure.

39. We are also concerned about leadership at board level and agree with the Auditor General's findings that there is scope to strengthen this. We note that NHS Wales lags behind the private sector in having informatics and ICT expertise represented at Board level. The Welsh Government accepted the Auditor General's recommendation and is considering the merits of board representation as it responds to consultation on its "Services Fit For the Future" White Paper. We were disappointed with the reluctance of health boards to consider the need for greater representation of informatics expertise at board level. We understand the point made by the Chief Executive of the NHS, that other areas can make a case for greater representation at board level and there is a risk that adding more people leads to an unwieldy board. However, informatics is so fundamental to the future of healthcare that we consider the case for stronger board representation to now be compelling.

40. Leadership in Digital / IT will always be a challenge, given the complexity of the subject and the rapid pace of change. Even high-performing organisations will struggle to compete for the best leadership. Across NWIS and Welsh Government, we believe there is a clear need for improvement in Leadership. We would encourage Welsh Government to consider adding between 5 and 10 new, senior leaders into NWIS, possibly on a medium-term basis. Only this level of leadership change is likely to resolve the cultural issues

Delivering new systems

41. During our inquiry, the Welsh Government agreed to adopt the Government Digital Service design principles under a new Welsh technical standards board. The standards adopted by the Welsh Government are based on the principles of the Agile approach to developing digital services. The Auditor General's report notes that there are potential benefits to this approach, which involves a strong focus on user needs and a more iterative, step-by-step approach to developing

applications. However, we share the concerns of both the Welsh Government and Auditor General that wider changes are needed to make this approach work.

42. The Welsh Government told us of its concerns that the approach to business cases, using the 5 case model, may be too rigid as it involves specifying everything up front. This would indeed seem to run counter to an iterative approach. The Committee welcomes the work the Welsh Government is carrying out, alongside colleagues in the NHS in England and with the Treasury in London, with regard to how the Welsh Government adapts its business case process to allow it to take full advantage of the digital approach and agile approach to developments.

43. The Agile approach also depends fundamentally on the engagement of the users of systems, in the case of NHS systems this is usually clinicians. The Auditor General reported that NWIS' staff are frustrated at the difficulties they experience in getting clinicians to engage with the design and testing of systems. The Committee notes the recent development of a network of Chief Clinical Information Officers across the NHS. We hope that this will provide the clinical leadership that the informatics agenda urgently needs.

44. However, leadership should not fall to a small group of interested clinicians. There is a bigger challenge around engaging clinicians on the opportunities and importance of getting involved in work to develop and test systems. There is also a clear need for NHS bodies to find ways of freeing up clinical time, so that clinicians can do this important work without feeling like they are neglecting the day-job.

45. The Auditor General's report raises concerns about NWIS' workforce planning and highlights some of the difficulties NWIS has recruiting and retaining experienced ICT developers. NWIS reported that it has now developed a workforce strategy and was managing recruitment difficulties by working closely with education institutions. However, we remain concerned about gaps in NWIS' capacity and capabilities to deliver. When we asked the Chief Executive of NHS Wales whether there was an issue with NWIS competence his answer gave us only limited assurance that he has confidence in NWIS' capabilities.

46. We have some sympathy for NWIS in the question of recruitment given they are operating within the constraints of the NHS Wales pay scales and cannot use financial incentives to attract digital staff. There is significant demand for skilled technical staff, a situation we do not expect to change for some time. Other work of the Committee and Assembly has highlighted this across the private sector. However, we are aware that some of the other Public Sector bodies in South Wales seem to have a far more successful approach. For example, anecdotally we

understand that the DVLA and ONS, who both employ large teams of Digital / IT staff have been proactive in their recruitment campaigns in attracting candidates to digital roles. In other areas of this report we highlight the long-standing cultural issues within NWIS. We are concerned that the difficulties in hiring staff may, in part, be linked to these deep-seated cultural problems.

47. It is not credible to assume that the reputational damage arising from recent criticism of NWIS has not impacted the attractiveness of NWIS as an employer in a market for technical skills which will always be very competitive. The Committee believes that a more radical solution be considered. A lot of the work of NWIS is not NHS-specific (This includes cyber security, Cloud computing and software development processes), much of this is undertaken across all of the public services in Wales, especially South Wales which we believe already has well regarded Digital functions such as those at the DVLA and ONS.

Recommendation 5. We recommend that NWIS look to increase its work with other public bodies, including those from UK Government. This approach could work on a number of levels, from the sharing of good practice on recruitment to the creation of Government Digital Service which could work across multiple agencies.

48. We are concerned about the quality of some key national systems and with a lack of monitoring data it is unclear whether they are delivering the intended benefits. We note that the witnesses report that NWIS is now providing a more balanced picture in its reporting to the NIMB, including more context on the actual use and roll-out of systems. The Committee looks forward to seeing some balanced reporting on the benefits in the public domain.

49. The Auditor General highlighted concerns about the quality of management information being produced by the national systems. Senior NHS officials who had experience of working in England were keen to emphasise that they had access to better information, generally in the form of a “dashboard”, than was available in Wales. NWIS told us that the issues vary from system to system but there is ongoing work to improve the management information and develop standard reports. However, NWIS also said that there is a gap across the NHS in terms of the skills needed to generate useful management information reports. Without honest reporting it will prove impossible improve governance and indeed overall performance.

Data outages and resilience

50. The Committee is deeply concerned about the evidence it received about data outages and resilience. There have been 21 outages of national systems between January and July 2018. We were particularly concerned to hear from Velindre NHS Trust of the negative impacts on patient experience and on staff morale. The Welsh Government and Velindre NHS Trust witnesses assured us that no patients had come to harm. We queried how it was known that these incidents had not caused harm especially in relation to cancer patients where timeliness of decisions and interventions can be essential. The Chief Executive of the NHS explained that there was a need for more work to be done to ensure impact on patients was more fully understood and captured.

51. We heard that NWIS and Welsh Government recognise the concerns of NHS bodies and clinicians and is taking action to put things right. We heard that some of infrastructure in the NHS' data centres was over seven years old and needed replacement. NWIS reported that it had been working on replacing this infrastructure over the past two years. In addition, Welsh Government provided funding of £1.32 million to upgrade the WLIMS infrastructure and the data storage was upgraded, replacing hardware which is over seven years old. In the meantime Cloud infrastructure is being routinely adopted elsewhere and NHS Wales is falling behind. In a letter dated 29 August 2018, the Director of NWIS wrote to the Committee stating that the costs of upgrading the infrastructure would be £5.5 and £6m. We are concerned that any investment of this kind could be seen as throwing good money after bad, when the alternative is to switch existing system to a modern Cloud infrastructure.

52. We also received evidence from unpublished NWIS reports, that NWIS needed a greater focus on undertaking routine maintenance. The evidence suggests that this will be expensive in resources and will negatively impact on the delivery of new projects. We are concerned that NWIS is having to strike an impossible balance between maintaining infrastructure and delivering new systems. It is a no-win scenario with either more delays to much needed new systems or risks of serious incidents and outages. This is essentially robbing Peter to pay Paul and not an acceptable or sustainable position.

53. We struggle to understand how NWIS finds itself in this position where it has not made appropriate plans for suitable maintenance of its infrastructure. It is symptomatic of a wider concern that the Committee has during this work – as we begin scrutinising one area, we find that other, equally serious question arise

elsewhere. As a consequence we are anxious that our scrutiny has merely scratched the surface of NWIS' problems.

54. The Committee heard that NHS bodies were able to put their business continuity plans in place, which limited the impacts of the outages. However, there were some weaknesses in the way NHS bodies, Welsh Government and NWIS communicated during data outages. The Committee was pleased to note that there is an identified example of good practice, with Abertawe Bro Morgannwg UHB's use of the Joint Emergency Services Interoperability Principles (JESIP). The Welsh Government's recent letter to the Committee sets out that the principles should be shared among others asking that they consider them for use within their organisations to support business continuity.

55. The Committee was alarmed by some of the evidence it heard in relation to the cancer system. We were told CaNISC has a red risk rating because Microsoft stopped providing support for the system in 2014. Witnesses flagged concerns that it is a cyber-security risk as there is additional work to plug security holes and apply "patches". It is positive that the process is in train for replacing CaNISC. But the Committee is concerned that it has taken so long to reach the stage of having a business case, when it must have been clear long ago that it needed replacing.

56. The Committee would like to see CANISC replaced urgently and as soon as is practicably possible. Given the red risk rating and the cybersecurity issues, there is a compelling argument for accelerating the work if possible. However, the Committee recognises that this would require careful consideration of the knock-on consequences.

57. In many ways the evidence we received on service outages and resilience was a microcosm of the wider picture. Funding is stretched, with NWIS balancing the competing priorities of sustaining infrastructure while under pressure to deliver new systems. There are deep concerns about the lack of clarity around accountability and responsibility when things go wrong and putting things right again. We heard of delays in NWIS, in this case in producing reports on the incidents. We also heard of difficulties in sometimes getting NHS bodies to engage with NIWS in identifying the causes of problems. We remain concerned that the issues around system outages have not yet been fully resolved. Recent correspondence from Cardiff and Vale University Health Board reported that there had been a further incident in August 2018, lasting 3 days.

REPORT TITLE:	**Welsh Community Care Information System (WCCIS)**								
MEETING:	**IT&G Sub Committee**						**MEETING DATE:**	**29/1/2019**	
STATUS:	**For Discussion**		**For Assurance**	**x**	**For Approval**		**For Information**		
LEAD EXECUTIVE:	**Executive Director of Public Health / Deputy Chief Executive**								
REPORT AUTHOR (TITLE):	**Regional WCCIS Project Manager**								
PURPOSE OF REPORT: To provide an update on the local, regional and national progression of the Welsh Community Care Information System.									

SITUATION:

The WCCIS product continues to fall functionally short of the UHB's ambition for a Mental Health and Community System supporting fully integrated record keeping across health and social care.

Despite this, local foundational work to support the UHB's preparedness for adopting WCCIS continues, including:

- Work enabling the sharing of 'summary' and 'archive' views of the existing Paris system;
- Reviews of functional (gap) analyses against the procurement Statement of Requirements, Show and Tell review sessions, CareDirector 5.2.12.1 testing defects and CareDirector 5.2.13 developments;
- Alignment of scoped services on Paris to nationally agreed forms and assessments, where available.

REPORT:

BACKGROUND:

Region

The regional WCCIS team, local MHCS team and wider clinical community in the UHB continue to play an active role contributing to the national programme, supporting 27 national professional groups, forms development, system testing, Change Advisory Board, Configuration Group, Technical Assurance Group, National Use Case Development, Data Migration Group and Reporting Group.

The regional focus to date has been upon implementation and support within the Vale of Glamorgan. The region has taken a unique approach within Wales by ensuring the configuration of the system is focused upon a region-wide service model that is led by service need.

The Vale of Glamorgan implementation has acted as a pathfinder for the region, holding valuable knowledge on the implementation and use of WCCIS. Careful planning has ensured that the infrastructure will be in place to support a single point of referral capability and fully integrated record keeping for key operational services across the region, and not just the Vale. Adoption of the finance functionality in the Vale is now under way, but region-level benefits will be reliant on the supplier delivery of comprehensive system functionality.

National Programme

The focus of the national programme is currently on the testing of version 5.2.12.1 of WCCIS, development of use cases for 5.2.14, and NWIS development of interfaces to other national products. Use cases for functionality to support the go-live of ABHB services in June on version 5.2.13 of WCCIS have been submitted to the supplier.

ASSESSMENT:

Key Issues

1. The WCCIS product remains functionally inferior to the existing MHCS system (Paris) in CaV, and does not deliver to the procurement requirements;
    a. Semi-annual releases result in slow development cycles; developments are chargeable;
    b. There is little/no capability for local or regional system development or customisation;
    c. The WCCIS mobile app remains restricted to ‘pilot’ status in lieu of procurement functionality being delivered;
2. The UHB and Region have no representation on the National Leadership Board, National Programme Board or Service Management Board;
    a. The success of the national programme is judged on implementation of the product, not the realisation of benefits;
3. There is currently no viable economic business case for adoption of WCCIS in CaV;
    a. Costs of adoption and implementation outweigh the tangible financial benefits of doing so;
4. Funding to support readiness work is sparse; funding to support implementation has not been identified;

    a. NWIS has a dual role, both in determining the allocation of dedicated funding and in applying to the same funds to support the national team;
    b. The ICF no longer has a dedicated ring-fence for WCCIS;
    c. Welsh Government IM&T capital has not been allocated to WCCIS (local decision);
    d. Stipulations on Welsh Government funding increasingly require a DO to be in place for WCCIS;
5. The contractual model does not allow for a partial-scope implementation, and requires commitment to a timescale for full implementation and payment of the full maintenance costs;
    a. The revised "phased" contract model allows for a staged implementation, but still includes a backstop date for commencement of full payment of maintenance fees;
    b. The 'Community Nursing' contract proposal allows for a limited-scope implementation, but also includes a backstop date for commencement of full payment of maintenance fees;
6. The UHBs larger local authority remains committed to its existing Social Care platform, negating benefits from shared record keeping across the two organisations, should the UHB choose to adopt WCCIS.

These six programme-level issues overlie a number of system and technical issues including, but not limited to;

- Limited capability for migration of data from existing systems;
- The lack of a national 'archive' solution for data which cannot be migrated;
- No data warehouse provision; reporting capabilities are limited;
- Significant data quality issues (100k+ duplicate clients in the ABHB region alone)
- Absence of standardisation across social care providers, negating many of the benefits of a single-instance system.

It is crucial that the UHB remains an active contributor to the national WCCIS programme; whilst the short term benefits to doing so are minimal, in the longer term it will ensure that the UHB is in an informed and prepared position when objective assessment identifies tangible benefits to adoption of the national product.

To date, funding for the regional posts supporting WCCIS adoption and involvement has come from a ring-fenced portion of the Integrated Care Fund and a more minor element of Welsh Government Capital. The ring-fence concludes in March 2019, and there is no anticipation of further capital monies from Welsh Government.

A business proposal has been passed to the Regional Partnership Board to secure funding for 2019/20 supporting the sharing of patient/client records across organisational boundaries in the region, and retaining an active stake in the national programme.

RECOMMENDATION:
ASSURANCE is provided by:

- *Continued monitoring of progress of the national programme*
- *Continued involvement in national programme workstreams*

The Committee is asked to:

- *NOTE the contents of this update*

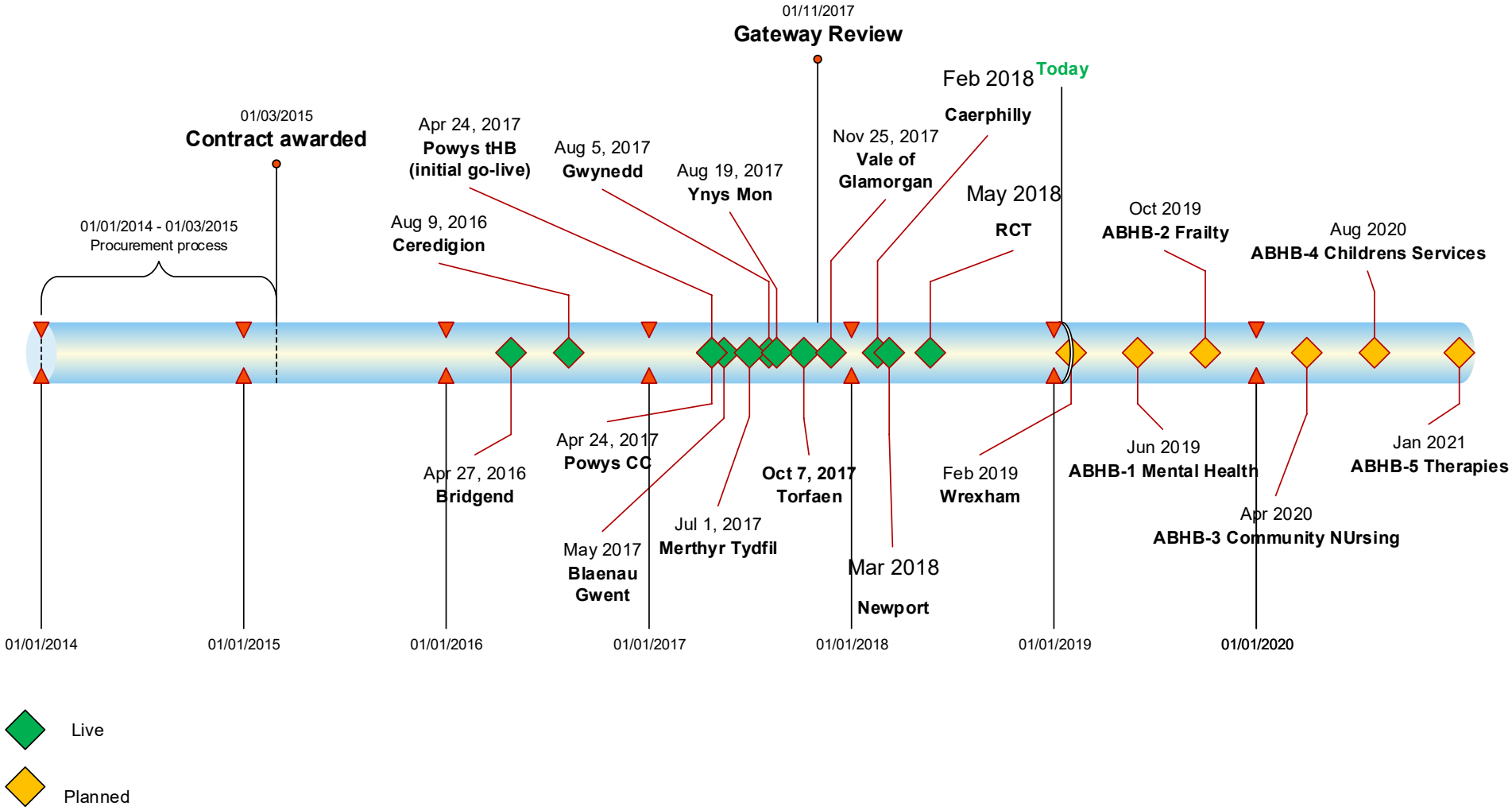
SHAPING OUR FUTURE WELLBEING STRATEGIC OBJECTIVES RELEVANT TO THIS REPORT:			
This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity 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	x
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Please highlight as relevant the Five Ways of Working (Sustainable Development Principles) that have been considered. Please click here for more information											
Sustainable development principle: 5 ways of working	Prevention		Long term		Integration		Collaboration		Involvement		

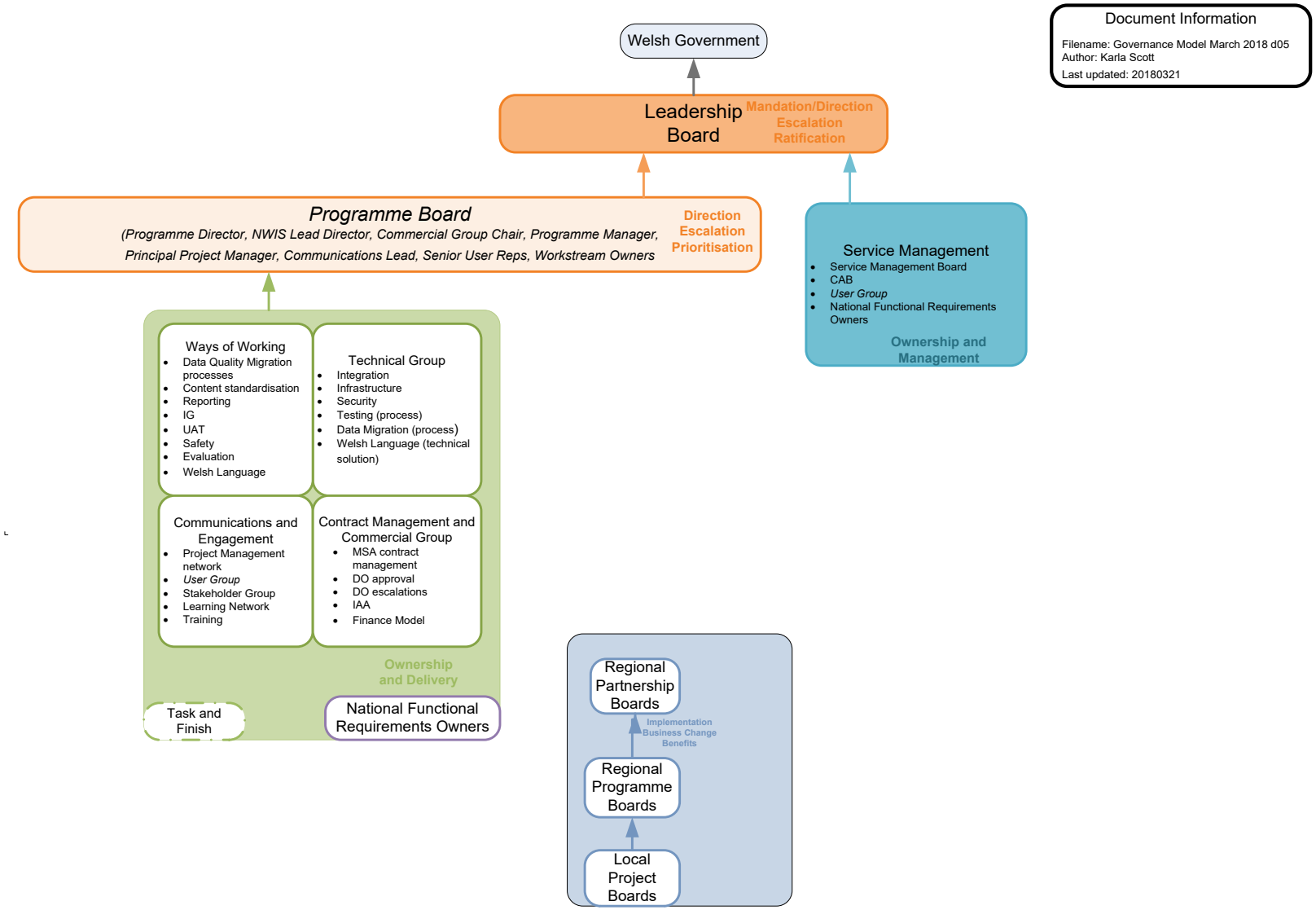
EQUALITY AND HEALTH IMPACT ASSESSMENT COMPLETED:	Not Applicable

Kind and caring / Caredig a gofalgar · Respectful / Dangos parch · Trust and integrity / Ymddiriedaeth ac uniondeb · Personal responsibility / Cyfrifoldeb personol

Appendix 1 – National WCCIS Programme Timeline



Appendix 2 – National Programme Governance Structure



REPORT TITLE:	**WORK PROGRAMME UPDATE - wLIMS**								
MEETING:	IT&G SUB COMMITTEE						**MEETING DATE:**	**29/01/2019**	
STATUS:	**For Discussion**		**For Assurance**	**x**	**For Approval**		**For Information**		
LEAD EXECUTIVE:	Deputy Chief Executive								
REPORT AUTHOR (TITLE):	**Clinical Board Director of Operations Clinical Diagnostics and Therapeutics**								

PURPOSE OF REPORT:

SITUATION:
It was agreed at an extraordinary National Pathology IT Programme Board that Health Boards which are currently running 'at risk' legacy versions of the Telepath (TPATH) software should develop plans to upgrade TPATH to a newer version and include a supporting hardware upgrade. This will significantly reduce the risks to these Health Boards associated with existing software and provide a resilient business continuity contingency in the event of further delays to the implementation of the Blood Transfusion module of WLIMS. The affected Health Boards are Cardiff and Vale UHB, Betsi Calwaldr UHB, Hywel Dda UHB and Cwm Taf UHB.

The purpose of this paper is to provide an update on the progress of the procurement and implementation processes.

REPORT:

BACKGROUND:
WLIMS is currently not sufficiently stable to start the implementation of the Blood Transfusion module as it requires 90 days of stable running. This has already impacted on the first 'go live' in ABMU which was scheduled for December 2018 but now will not happen until the New Year. The exact date will be dependent on the 90 day stable performance acceptance criterion. It is not anticipated that Cardiff and Vale UHB will be in a position to go live until sometime in 2019-20. We have not experienced 90 days stable running in Cardiff and Vale UHB since our first WLIMS go live in 2015.

On the 11th July 2018 NWIS was notified that there are security vulnerabilities in Caché and Ensemble which support our current version of TPATH. To mitigate these risks a system upgrade was recommended.

In light of this information the decision was made at the National Pathology IT Programme Board upgrade TPATH and migrate the software onto modern resilient server architectures. Cardiff and Vale UHB is coordinating this programme on behalf of the other NHS Wales organisations who are currently reliant on the vulnerable version of TPATH.

ASSESSMENT:

The procurement process for the capital replacement of the hardware and upgrade to the software was concluded on the 21st of December with all sites in Wales procuring an upgrade to the latest version of telepath and the associated hardware. Each site is now arranging their own project for go live. Cardiff and Vale are upgrading the software to test on the 16th of January with an upgrade to live in February 2019.

The hardware upgrade will be a parallel project however the lead time for the hardware is likely to lead to a transition in the new financial year.

The support contracts are being renegotiated on behalf of Wales from Clincial Diagnostics and Therapeutics on the 16th of January. This will seek to gain agreement to extend support on a year by year basis with the current supplier as to ensure an ability to transition to all wales programmes at an appropriate time without contractual ties.

RECOMMENDATION:

The Committee is asked to note the progress of moving to a sustainable platform for the services currently utilising telepath in line with the remainder of Wales.

SHAPING OUR FUTURE WELLBEING STRATEGIC OBJECTIVES RELEVANT TO THIS REPORT:			
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	X	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
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	

Please highlight as relevant the Five Ways of Working (Sustainable Development Principles) that have been considered. Please click here for more information											
Sustainable development principle: 5 ways of working	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.

REPORT TITLE:	**WELSH GOVERNMENT IM&T CAPITAL ALLOCATION PRIORITISATION – JANUARY 2019**								
MEETING:	**IT&G Sub Committee**					**MEETING DATE:**	**29/01/2019**		
STATUS:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**	√	
LEAD EXECUTIVE:	**Deputy Chief Executive**								
REPORT AUTHOR (TITLE):	**Assistant Director of IT**								

PURPOSE OF REPORT:

- **NOTE** The IT&GSC is asked to note the process in relation to sequencing of proposals for the £1,786,000 2018/19 Welsh Government Capital in support of digital related transformational activities.

SITUATION:

A discretionary allocation of £500K for Infrastructure replacement has been confirmed in relation to the previously outlined prioritised requirements of £2,130,000 for 2018/19.

Welsh Government are providing further non-recurrent discretionary funding (2018/19) of £1,786,000 to us to support investment in IM&T infrastructure to support the delivery of digital related transformational activities. Whilst organisations will be able to decide the specific areas to invest in, the expectation from Welsh Government will be that these will focus on key national priorities.

BACKGROUND:

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

The meta level objectives and design of our plan are shown in the strategy diagram in Appendix 1, with 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:

In determining our priority list for capital funding we have worked through the inter-dependencies, critical chain and appraised the cost and benefits and alternatives for delivering the 3 year programme. We have balanced the requirements to upgrade and invest in our underlying infrastructure to provide resilient services in line with the expectations of our patients and staff, whilst committing to sizeable, high impact developments that will transform how we deliver services closer to home, built around strong clusters of virtual and, community services.

The attached appendix shows the prioritisation of proposals together with details of what each investment covers and an indication of benefits in the following areas:

- Essential Infrastructure Sustainability and Modernisation Program
- Priority Digital Transformation Projects
- National Program

RECOMMENDATION:

The IT&GSC is asked to note the process in relation to sequencing of proposals for the £1,786,000 2018/19 Welsh Government Capital in support of digital related transformational activities.

SHAPING OUR FUTURE WELLBEING STRATEGIC OBJECTIVES RELEVANT TO THIS REPORT:

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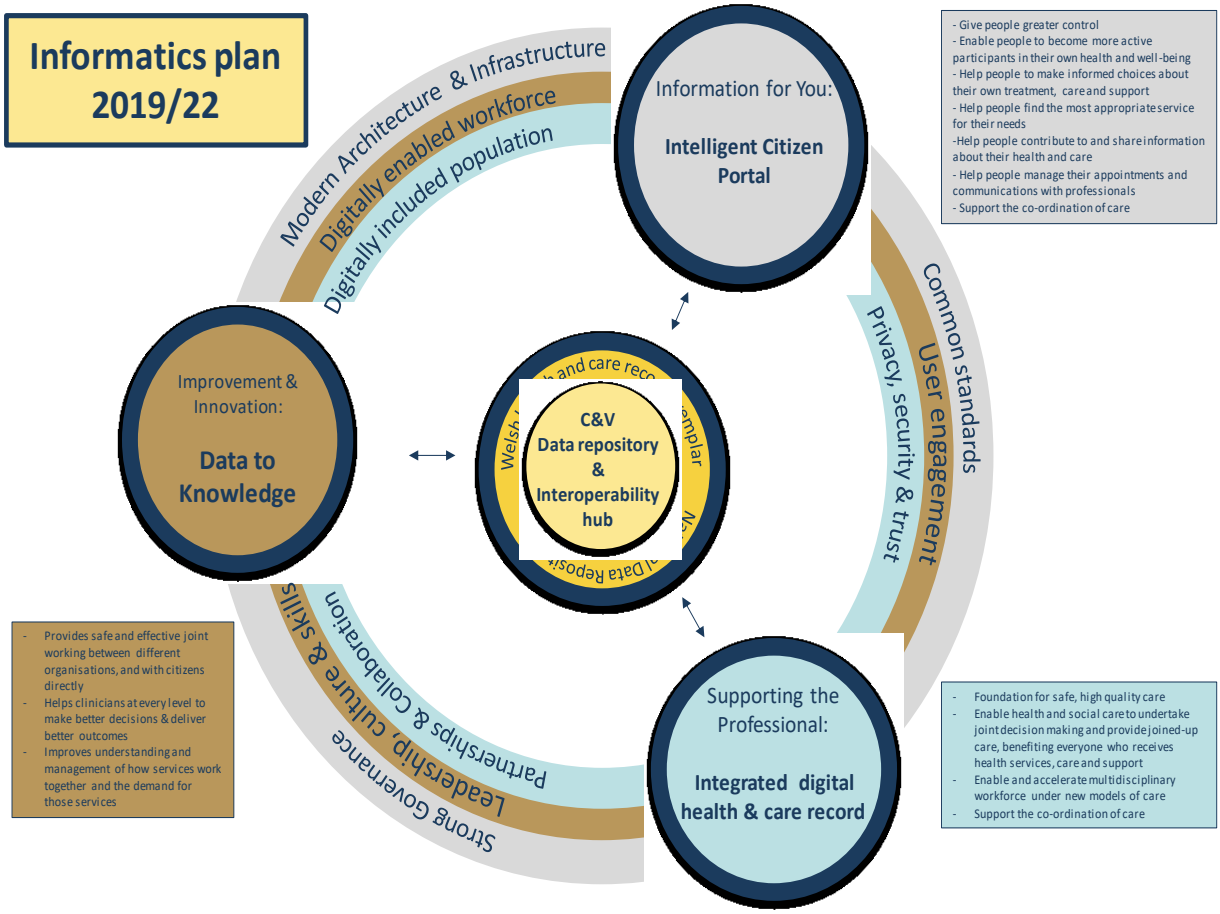
1. Reduce health inequalities	√	6. Have a planned care system where demand and capacity are in balance	√
2. Deliver outcomes that matter to people	√	7. Be a great place to work and learn	√
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	√
4. Offer services that deliver the population health our citizens are entitled to expect	√	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	√
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	

Please highlight as relevant the Five Ways of Working (Sustainable Development Principles) that have been considered. Please click here for more information									
Sustainable development principle: 5 ways of working	Prevention		Long term		Integration		Collaboration		Involvement
EQUALITY AND HEALTH IMPACT ASSESSMENT COMPLETED:	Not Applicable								

APPENDIX 1

WELSH GOVERNMENT IT CAPITAL ALLOCATION - DECEMBER 2018

INFORMATICS PLAN



WG £1,786,000 CAPITAL ALLOCATION PRIORITISATION PROCESS

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

The meta level objectives and design of our plan are shown in the strategy diagram above, with the **3 delivery programmes:**

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The assessment below shows the prioritisation of proposals together with details of what each investment covers and an indication of benefits in the following areas:

- Essential Infrastructure Sustainability and Modernisation Program
- Priority Digital Transformation Projects
- National Program

Ref	Item	Cost
A	**Essential Infrastructure Sustainability and Modernisation Program**	
		£770K

- Made up as follows :
  - EOL PC's
    - *HB owns circa 10,000 PC's with a maximum usable lifespan of 7 years.*
  - Data Centre Equipment requirements (Environment, Power, etc..)
    - *HB needs to maintain environmental conditions and power upgrades and Air Conn will requires at least 100K in the next year*
  - Network Switch Replacement
    - To continue to improve speed and resilience
  - eMail upgrade (software and hardware)
    - *Migration of users to larger capacity to cope with increasing demands*
  - Backup infrastructure
    - *Required to maintain appropriate backup windows maxing at 1 week per system per full backup.*
  - EOL Servers / Backup & DR requirements
    - *Aged hardware currently supporting around 40 of the 300+ Departmental and core systems in use at the HB*
  - Replacement Telecoms
  - Storage Increase.
    - *Storage demand increases by 200TB per annum (resilient) – cost including support infrastructure for mid-range equipment in use at the HB comes at between £1K and £1.5K per TB dependent on exact deployment. Circa £200K required – this should support CDR requirements*

Note – Total estimated value of replacement of all EOL and unavoidable increased infrastructure requirements is circa £2.5M

Direct Benefits:

- Modern infrastructure
- Resilience
- Sustainability
- Improved speed
- Software compliance
- Cyber security
- Real Time data availability

	○ Security ○ Risk Mitigation	
B	**Priority Digital Transformation Projects**	
	1. **Clinical Data Repository (CDR) - Phase 1 – including Interoperability** *Repository for all clinically integrated data including PMS, PARIS (immediate local access requirements and long term [post WCCIS] requirements, PKB, etc..]. This repository will constitute the Local implementation of a full clinical data repository (evolved over time) and provide a Core Interoperability Hub that in turn will provide clinicians with all available clinical data associated with a patient at points of care (both virtual and physical). It will also service national requirements to clinicians within other Health Boards and source, via interoperability functionality, access to clinical data sourced nationally from other HBs. Includes capacity to store and provide appropriate levels of data and performance at the clinical coal face. Additional API based access to 3 major local systems (such as Maternity) beyond PMS and PARIS is included.* *Dependencies – current existing systems and identified storage.* **Investment covers** ○ Dedicated Infrastructure ○ Application and License requirements ○ Dependencies – current systems ○ Interfacing Software ○ FHIR Facades and linkage ○ API requirements ○ Dependencies – CDR and some current systems Direct Benefits • Critical enabler to delivery of Once for Wales - supporting improvements in care & the Welsh care systems ability to deliver care around and tailored to the citizen / patient • Allows both documents, & discrete data packages with semantic meaning to be shared (inc negation) • Applications can be plugged into a basic EHR operating system and feed information directly into the provider workflow – streamlining care • Provides a future pathway to handling & connecting patient-generated health data e.g. of FitBits, Apple Watches, Bluetooth scales, blood glucose monitors, diet apps, and fitness trackers with streamlined provider workflows in a way that presents the data that is useful and actionable by clinicians & is secure (Filter & Integration) • In providing a common language it enables on the fly analysis of clinical and patient-generated health data and present users with a	**£292K**

	summary of trends that are relevant to a particular aspect of chronic disease management or patient wellness • Enables access to meaningful data across the UK for clinicians and patients • As an international standard, we will be in a much better place to realise the benefits from AI and the tools appearing from across the world. • Enables rebuild of the CRT "One List", improving communication and consequently flow between inpatient wards and the CRTs.	
	2. O/P Transformation and Real Time Clinical Data Duplication *Will enable full duplication functionality against existing Data Warehouse, BI and PMS systems which in turn will provide essential the real time data flows and analytics to address the requirements of the health board without direct impact on the Clinical demands of the CDR and day to day processing of the administrative functions associated with patient management. Will enable development paths for Mobilisation of enabled data and sharing of this data to agreed local and national standards. This will include, alongside the CDR, Virtual Clinics (including VFC) and will support essential Major Trauma Centre requirements.* **Investment covers** ○ Database Software ○ Application (Oracle Forms) Licensing ○ Required server and storage infrastructure ○ Dependencies – whilst migration will be automated there will be significant testing requirements to ensure converted forms and applications function correctly. (Some of the) **Direct benefits** • Digitises the medical record associated with all hospital non inpatient events to standards, enabling and facilitating virtual and mobile ways of working • Supports clinical workflow improving availability of clinical data and its safe custodianship • Incorporates the patient sensory and preferences programmes, improving how we communicate with patients with sensory loss and record patient consent and preferences. Information already mentioned includes: · Sight loss / blind, Hearing loss / deaf, Transgender, language preferences and then a highlighted need for interpreter, any special requirements for welsh, DOLS, DNACPR, autism, Disabilities, Transport requirements, Prevent referrals, Safeguarding, Non-disclosure of information to relatives & Vexatious patients	**£300K**

	• Enables digital dictation whilst conforming to data standards • Reduces time spent on administration • Speeds up time between clinical event and next clinician having access to the requisite knowledge • Enables the data to be shared locally & nationally & to be re-used by the patient, clinicians and system leads in real time (subject to the data repository being developed in parallel) • Enables decision support & their associated benefits in reducing waste harm and variation along the pathway • Reduces risk of non-compliance with GDPR **3. Support to Clinical Mobility and Cluster Working** *Infrastructure functionality to provide and enhance mobile system usage including essential investment into the PARIS/WCCIS mobility requirements. Improvement of primary care and acute care delivery through mobility.* **Investment covers** ○ VFC ○ MTC ○ PARIS netbooks (100K) ○ Wireless LAN Controllers ○ PARIS Patient Summary View ○ Flying Start ○ Cluster working . (Some of the) **Direct benefits** - Netbooks - The UHB leads Wales in the remote provision of e-record tools and facilities (PARIS, M.S Office, ESR, E-Expenses, Oracle, Results reporting etc...). This is achieved through the provision and support of c1000 mobile/field access devices for non acute staff. Many of these devices are now in their 9th or 8th year of service, and are both poor at acquiring the available 4g/5g signal now available, else are faulty, leading to staff having to spend time resolving issues with the support office, or returning to base to undertake write-up/duties. Replacing 150-200 of the oldest devices will allow those staff to operate more effectively, and further benefit the effectiveness of UHB delivery, as they gain efficient access to e-delivery tools, such as the on-line One-List of patients ready for acute discharge. - The Flying start and Interfacing servers - Enable the community team to undertake development of interfacing facilities both with the UHB Clinical Data repository (CDR), and to surface UHB community e-record to the GP community of Cardiff and Vale and to our two local authorities.	**£230k**

	- Virtual Fracture Clinic (VFC) - Funding for an on-line provision of physio and self help videos and resource, to which the UHB can stream low level fracture patients to avoid their need to attend fracture clinic. **4. MUSE Upgrade** *Upgrade of Muse system to enable ECGs to be accessible anywhere. A upgrade to version 9 of MUSE would enable reports to be shared with both WCP and CCP. - Cardiff LMC identified sharing of ECGs as a priority development in supporting their ability to work and reduce waste and harm* . **5. Patient Knows Best** *Provision of a patient portal. Dependencies on CDR and Interoperability processes for effective long term use.* **Investment Covers** ○ Capitalised staff ○ Licenses and equipment ○ Includes integration support, cloud hosting and infrastructure, technical and support helpdesk, programme mgt, unlimited training for professionals, comms support, upgrades and maintenance. (Some of the) **Direct benefits** • Typically consists of a browser-based system that is patient-facing via the Internet. • Patients can securely log in to that system and access a range of services. • Those services can significantly increase the patient's sense of empowerment and of their ownership of their health. • Very good fit for "Information for you" (Shaping our Future Wellbeing). • Enabler for patient management close to/at home (self-management). • Patients Know Best (PKB) is the product that stands out as by far the most rounded offering. • Patient able to view all letters addressed to themselves (new and historic). • Letters sent to patients electronically. Viewed within portal. • Patient able to view information relating to their appointment (directions, generic information on procedure, generic info on condition). Can accept, cancel, rebook. • Access to medication details. • Integration with appointments and reminders.	**£25K** **£82K**

	• Patient able to view results as both data and graphs
	• Patient able to view treatment plans
	• Patient able to provide granular consent to share details with family members, other healthcare providers, social services etc.
	• Parents able to access on behalf of children
	• Signposting to healthy living and better information sources than may otherwise be located via Google.
	• Can create forums for patient cohorts to share good practice and support each other.
	• Trial has been in place within ENT for approx. 18 months.
	  ○ Facilitates many of the service improvement initiatives that Alun Tomkinson is driving forward.
	  ○ ENT are keen move beyond trial.	

C	**National Program**	
	6. National Program *Enable wider deployment and uptake of national program functionality associated with WCP, WRRS, TRRR and WCRS.* The hardware requested will support the further rollout of the operational modules and future modules of the Welsh Clinical Portal (WCP). The procurement of additional printers will support current implementation of the Medicines Transcribing and E-Discharge and Pathology Electronic Test Requesting modules in addition to end of life hardware. The availability of additional printers will support the implementation of Electronic Test Requesting into the Outpatients Department. Without this investment the UHB would be unable to continue with the further rollout of the WCP. The next module planned to be implemented in Cardiff and Vale UHB will be the Radiology Electronic Test Requesting module. The benefits of implementing the Welsh Clinical Portal are set out in the UHB's Informatics Strategic Outline Programme and the Digital Health Strategy for Wales. Some of the immediate operational benefits are listed below: • WCP is integrated with primary care systems and other national systems to support e-communication between care settings • Clinicians have access to a single patient record in one portal without the need to access a variety of systems • Clinicians have access to patient information whenever and wherever they require it. • WCP users have the ability to view results, reports and letters for their patients regardless of where in Wales these are produced via the Welsh Results and Reports Service (WRRS) and the Welsh Care Record Service (WCRS).	**£87K**

	• The programme has extended the availability of the Welsh GP Record (WGPR) to all 'treating clinicians' with their patients' consent. • Clinicians report that having access to the WGPR supports diagnosis in urgent situations and supports fast and accurate medicines reconciliation e.g. pharmacists do not have to phone GP practices for patients' current medication information. • Electronic referrals are sent by GPs to secondary care clinicians for online prioritisation using the WCP. GPs are informed if referrals are upgraded or downgraded by the prioritising consultant in addition to whether a referral has been redirected to another consultant or specialty. • Electronic test requesting and results reporting will be available in both inpatient and outpatient settings with further investment. • The project will continue to support the improvement of the quality of electronic discharge letter production. • The extension of the use of WCP has reduced telephone calls to GP practices, saving time for both secondary and primary care staff. • Clinicians have access to the same system whichever health board they work in as the WCP is implemented across Wales.	

CAPITAL MANAGEMENT GROUP MEETING
17TH DECEMBER 2018 AT 10AM
CORPORATE MEETING ROOM, HQ, UHW

Present:
Abigail Harris, Executive Director of Strategic Planning (Chair)
Marie Davies, Assistant Director of Strategic Planning
Nigel Lewis, IM&T
Fiona Jenkins, IM&T
Lee Davies, Operational Planning Director
Clive Morgan, Assistant Director of Therapies
Chris Lewis, Interim Director of Finance
Richard Hurton, Assistant Finance Director
Geoff Walsh, Director of Capital, Estates and Facilities
Nigel Mason, Business Manager, Capital, Estates & Facilities
Jeremy Holifield, Head of Capital Projects
Tony Ward, Head of Discretionary Capital

In attendance: Zoe Riden

		ACTION
1.	**APOLOGIES FOR ABSENCE** Apologies were received from	
2.	**NOTES FROM THE PREVIOUS MEETING** The minutes of the previous meeting were accepted as a true and accurate record	
3.	**MATTERS ARISING** RH noted that the spend profile of the *Acceleration and implementation of national clinical schemes* had been received. **Radio Pharmacy** GW confirmed that a project team had been established, with the initial meeting scheduled 18 December. **Asset Management** It was confirmed that ICF programme Board supported the bid submitted by PCIC for the acquisition of 200 Fairwater Road, from the LA. The bid was now with WG for consideration/approval. The property being adjacent to the Fairwater Health Centre provided an opportunity to expand GMS & Primary Care services provided from the neighbouring Fairwater Health Centre. As part of the scrutiny process, WG had raised concerns in respect of the revenue implications associated with the proposal which had not been fully identified. PCIC were in the process of drafting a business case to seek support from the UHB. GW noted that the acquisition of the property provided little risk to the Health Board as there were a number of alternative uses that the building could be used for eg. relocating the base provided at Radyr HC	

	and disposing of that site. **ICF** RH advised the group that Meredith Gardiner had issued an email to express concerns in respect of the ability of the partner organisations to identify sufficient schemes of which to spend the 2018/19 ICF capital allocation.. She had raised the question of brokering the allocation across financial years. GW raised concerns regarding this approach as accepting the full allocation would require 'paying back' the following year and apply additional pressure to the discretionary capital funding in the next financial year. Following a detailed discussion, AH requested that RH contact MG to advise her that CMG could not support the proposal, unless the funding was considered as slippage money with no 'pay back' required. AH advised the CMG that she intended drafting a letter to the Director of the ICF Programme and express the concerns on the way in which the submissions are dealt with by WG. **WEQAS** GW confirmed that he and RH had met Ian Gunney, WG, to discuss the whether there would be an opportunity to transfer revenue to capital to support the acquisition of a new building to relocate the WEQAS service. It was confirmed that WG were supportive of the proposal. WEQAS provided specialist services across the UK, from a leased facility in Llanishen. Demand for the service was increasing and there was a requirement to relocate to a larger facility and in doing so consider any further expansion that may be required in the longer term. GW and NWSSP Property had been supporting the service with identifying suitable options including, the acquisition of an existing building and working with a developer to build a new facility. WEQAS and the CD&T Clinical Board were concerned about the ability of the service to carry forward a substantial surplus should a transaction not be completed in the 2018/19 financial year. GW/RH/CL to identify the management of the revenue within the financial year, if required. **Cystic Fibrosis** AH advised CMG that she had drafted a letter to Andrew Goodall in response to correspondence received requesting an update on the Cystic Fibrosis scheme. GW confirmed that the project was out to tender and that a planning application had been submitted. It was anticipated that the BJC would be submitted in March 2019.	RH AH GW/RH/ CL

	MD/LD advised that unfortunately, the Business Case for the additional revenue had been submitted to WHSSC after the deadline but it was understood that it was being considered. **Additional Discretionary Capital Allocation** GW presented a revised Capital Plan or the remainder of 2018/19. He confirmed that the UHB had received an additional Discretionary Capital allocation of £1.914 for 2018/19 from WG and that following a review of the existing programme the following slippage had been identified: • Rookwood Roof - £0.200m • Black & Grey Theatre - £0.500m • Contingency - £0.327m In total £2.941m was available for the remainder of the financial year to support both Medical equipment backlog and estates/accommodation schemes. GW confirmed that the UHB had also received additional 'ring fenced' funding for IM&T in the sum of £1.786m. GW/CM had discussed and identified and listed the priorities for Medical Equipment and Capital Schemes, the agreed commitments were • £1.129m – Medical Equipment • £1.812m – Other Schemes (Capital) The CMG approved the proposals contained within the paper and requested that NL prepare a schedule of IM&T schemes that would be progressed from the additional 'ring fenced' allocation as the details were required by WG. AH suggested that CM collate a further list of Medical Equipment that could be used should further slippage become available. GW confirmed that, CM had the information and that it was reviewed on a regular basis. GW advised that he was yet to finalise the interim plans for the Haematology Day Unit, required to satisfy JACIE as the ENT department were not satisfied with the impact on their area. GW had received an email from the clinical lead for ENT which he had forwarded to AH for advice. AH would discuss with SC as the scheme was considered vital to maintaining accreditation and in particular demonstrating the UHB intent in supporting the haematology service. It was confirmed that work had progressed in the Women's Unit Corridor to relocate New Born Screening. The UHB were in discussion with BECT contractors to develop a cost for the overall scheme. Tenders had been returned for the Concourse Seating Area, GW noted that he had been advised to submit a bid to the Charitable funds committee. However, he had included the scheme in the revised discretionary capital programme in order to complete within the financial	NL AH/SC

	year. **IM&T Draft Plan** NL presented an additional paper on IM&T to support the IT Infrastructure, Digitally related transformation activities and national priorities. NL had a meeting scheduled with Sharon Hopkins 18/12/18 to review and agree the priorities and to develop the document and produce a supplementary list for any additional funding that may be received. RH noted that the figure for capitalising staff members had increased year on year. NL advised that additional work was required although it was linked with the key arrears and the timing of the initiatives. RH requested a conversation prior to the final draft of the report. AH advised that a business case would be required for the revenue implications of the Patient Knows Best and . AH agreed to present the draft documents to ME scheduled 17/12/18 for advice on the business cases and revenue tail.	
4.	**EXECUTIVE SUMMARY** GW presented the CRL and reported that the Discretionary Capital Funding had increased from the previous month to £14.888m and was confident with the committed schemes and expenditure within the financial year. GW was still awaiting WG approval to utilize the gain share element of the Neo-Natal scheme to progress additional infrastructure works. He was confident that this was not a significant risk but could not commit to the works until confirmation was received. Rookwood Emergency works identified a slippage of £0.499m that would be utilised within discretionary capital, however approval would be required from WG to proceed. GW noted that further work was required on the Rookwood Allocation and the Rookwood spend profile as the information was based on the works commencing on site Sept/Oct ’18. As there may be potential slippage GW would need to identify the scale and how to manage the funds.	GW GW
5.	**MAJOR CAPITAL PLANNING REPORT** **Neonatal** JH reported a delay in Neo-Natal due to unexpected roof work that had affected the date of occupying phase 2b on the anticipated earlier date. The revised date of occupancy was 26/03/2019. Phase 2a proposed date 28/02/2019. The dates were being reviewed	

	regularly with JH & KIER to identify earlier occupancy. It was confirmed that Obstetrics had been completed. MD requested confirmation of the number of cots operational. JH advised that 19 were operational with an additional 16 for special care **Rookwood** JH confirmed that activity was scheduled to commence at UHL 07/01/2019 AH enquired about the associated works at St Davids for the ECAS service and the date when they were scheduled to commence. GW advised that these works were not on the critical path and as long as they were completed in line with the end of the main contract works at UHL there was an element of flexibility. He would however provide a latest date for instructing the works. **4.1 Project Status Report** Project status reports were provided within the report for detailed reference of the ongoing schemes. GW confirmed that dashboard reports were submitted to WG on a monthly basis for each scheme. **4.2 Letters of Approval** A letter of approval was received from WG; *Award of Additional Discretionary Capital Funding of £4.700m to Cardiff and Vale UHB 2018-19.*	GW
	Discretionary Capital & Estate Compliance Report TW reported a breakeven position in Discretionary Capital with a £350k reduced budget in compliance, resultant from the increased costs of the Paeds South Refurbishment, however the budget was being managed. IT relocation to Woodland House was scheduled to complete by 21/12/2018. NL had visited the area 17/12/18. Heulwen Ward Refurbishment had commenced with the anticipated completion during the first week of January 2019 for operational use second week. LD requested that the area be operational by the first week of January 2019 as there would be potential pressure during the period. TW agreed to review the date with the contractor. TW provided an overview of the lift refurbishment programme and noted that Lift no.4 refurbishment (B Block Service Lift) had commenced, and parts had been received for Lift No3 with anticipated completion 21/12/18. West 3 UHL was due for completion by 21/12/18 with moves scheduled over the Christmas period.	TW

	Estate Compliance As a result of the need to reduce the overall compliance budget the programme was being managed mainly by the delays associated with awarding contracts via the OJEU procurement process. FJ enquired whether sufficient security had been arranged at Woodland House following the IT relocation. GW advised that 24/7 security had been arranged with an external contractor on a temporary basis. A draft job description was in process for a permanent post with UHB which would also cover a number of duties at the property. **Estates Dashboard** AH noted the additional document to the report and highlighted the energy performance across the HB. GW advised that the team review and progressively introduce improved systems to assist with the performance in this area. **5.3 Regulation 18 Areas (Restricted access due to asbestos contamination)** The schedule was included for information.	
6.	**MEDICAL EQUIPMENT REPORT** CM listed the kit that had been funded for with the discretionary capital allocation and noted that £900k of kit still required replacement. In addition, CM advised that Clinical Boards had been requested to submit further requirements in anticipation of additional WG slippage. CM provided information in the report of the requests that totalled £4.1m, and noted that an additional estimated £1m had been received following the submission of the report. CM highlighted the high risks and anticipated another challenging year in 2019-20. LD requested if there had been discussions with other health boards regarding kit in respect of the neurophysiology equipment. FJ advised that there had been discussions with ABMU who had confirmed that they would procure the same make of kit as C&V to ensure consistency to enable networkable elements. A meeting session with other health boards was scheduled for February 2019 to identify a way forward. MD noted that Cwm Taf should be advised on the kit and prioritisation should slippage money be received. MD requested CM/FJ provide and email for MD to send to Julie Keegan at Cwm Taf Health Board.	CM/MD
7.	**IM&T REPORT** NL presented the IM&T report and highlighted the additional funding and	

	allocation that was discussed previously in the meeting and advised that a conclusion would be agreed by the following meeting.	
8.	**SERVICE PLANNING** MD noted that AH/MD&GW met with Simon Dean and Ian Gunney WG 11/12/18 to discuss the development of the major schemes including the new block to the rear of the hospital that would consist of Theatre replacement, ENT, Poly Trauma with the possibility of Radio Pharmacy. AH drafted a letter to be submitted to WG following the meeting, MD advised that AH/MD/LD review the letter and accompanying paper prior to submission to the Cabinet Secretary. A follow up meeting with WG would be scheduled for January 2019 to identify commitment to the Strategic Overview paper that was submitted previously to provide assurance that the single big scheme offered the best service and best value and best capital solution that the HB can offer. MD advised that there was a willingness to brief the minister on the scheme. **Radio Pharmacy** GW noted that a Radio Pharmacy project team meeting was scheduled for 18/12/18, the meeting would identify if the service was to be included in the big scheme. **Replacement of Theatres 5&6** The scheme at UHL had progressed, MD noted that the BJC would include 3 new theatres with two identified as replacement theatres and one for future growth, with the ward to be presented as decant/ winter capacity. AH advised to note that the additional theatre provides flexibility for regional capacity, and good practice. **Hybrid MTC** MD reported that the initial project team and project board been held the previous week and that GW was progressing the procurement of the Supply Chain Partner with a view to appointing by the end of January 2019. A multi-speciality workshop was in the process of being arranged for January 2019 to identify clinical specification for major trauma theatre and vascular theatre. **Mortuary Refurbishment** GW advised that a project team had been established and a design team and contractor, kier, had been appointed through the Scape framework. At the recent project team meeting CM advised that Mr Barclay	

	(Coroner) had issued a planning programme for the feasibility of creating a central post mortem facility with the options to be available by summer 2019. The project team agreed to pause the refurbishment until the further information had been received. CMG also agreed. AH requested that CM inform the HTA. **Genomics** CM reported that the architects feasibility report had been received that noted the facility at the GE site would be suitable. CM expressed concern with regard the additional revenue funding that would be required to develop the Genomics service in the longer term and the need for WG to confirm their support. GW advised to finalise the negotiations with the landlord to identify the rental, including service charges, and the capital for refurbishment. MD advised that a comprehensive Business Case would need to be developed for consideration by BCAG. **SOFW** A follow up meeting has been scheduled with WG to discuss the Programme Business Case prior to it being considered by the WG IIB.	CM CM
8.2	**GANTT CHART** The Gantt chart was attached for information on timescales for Business Cases and Construction works.	
10.	**CAPITAL PROJECT REQUESTS** A Summary of the capital project requests was presented at the meeting which highlighted the stages of each individual. PR0016 / 17 had been added to the summary sheet, GW provided a verbal update as the requests were identified as estates work and revenue.	
10.	**ANY OTHER BUSINESS** FJ provided an email to GW/AH regarding decontamination and the requirements for a decontamination facility. AH advised to provide an outline specification to GW. CL requested the additional papers to be circulated electronically.	
11.	**DATE AND TIME OF THE NEXT MEETING** Monday 21st January 2019, 10am, Corporate Meeting Room, HQ	