Bundle Information Technology and Governance Sub Committee 31 October 2018

Agenda attachments

00. Draft Agenda for Public meeting Oct 18.doc

1	PART 1: ITEMS FOR ACTION
1.1	Welcome and Introductions
1.2	Apologies for Absence
1.3	Declarations of Interest
1.4	To receive the minutes of the previous IT&G Sub Committee meeting held on 13th June 2018 1.4 Minutes June 2018 PUBLIC-FINAL vs 1.1.doc
1.5	To receive and review the Action Log from IT&G meeting held on the 13th June 2018 1.5 Action Log-Public.docx
1.5.1	Review of IG arrangements & support
1.5.2	IG Mandatory training
1.6	Chair's action taken since last meeting
1.7	IG/IT Risk Assurance Framework 1.7 ITGSC IT and Informatics Risk Reg Oct 2018.xlsx
1.8	Key Strategic Issues
1.8.1	Transformation Board Progress
1.8.2	Failure of Services at National Data Centres 1.8.2 Failure of Services at National Data Centres.doc 1.8.2 Appendix 1 - Active Directory System Failure Technical Report v2 (002).pdf 1.8.2 Appendix 2 - NWIS Briefing Doc Data Centre Outages May 2018.docx
1.8.3	Welsh Government Review of Governance of NHS Informatics in NHS Wales 1.8.3 WG Review of Governance of NHS Informatics in NHS Wales.doc 1.8.3 Appendix 1 - Health Informatics Review.pdf
1.9	Work Programme Highlight Reports:
1.9.1	Work Progress Highlight Report WCP 1.9.1 - WCP Progress Plan Oct 2018.doc 1.9.1 Appendix 1 - WCP Progress Report Oct 2018.xlsx
1.9.2	Digitisation of Medical Records 1.9.2 Digitisation of Medical Records Oct 2018.docx
1.9.3	WCCIS 1.9.3 WCCIS.docx
1.9.4	WLIMS Highlight Report Oct 2018 1.9.4 WLIMS Highlight Report October 2018.doc
1.10	Audits:
1.10.1	IMT Audit Assurance / Action Plan 1.10.1 Master IMT Audit Assurance - Action Plan October 2018.docx
1.10.2	Information Commissioners Office Visit - Action Plan 1.10.2 ICO Visit Action plan.docx
1.10.3	Combined ICO / GDPR Action Plan 1.10.3 Combined ICO GDPR Action Plan Cover paper.docx
1.10.4	ICO GDPR Audit Action Plan 1.10.4 ICO GDPR Audit Action Plan Updated.docx
1.11	Periodic items for assurance:
1.11.1	Report of Caldicott Guardian including 2017/18 CPIP Self Assessment 1.11.1 Caldicott Guardian Report.docx

1.11.2	Update on anomalies between the outstanding ICO actions and the CPIP self assessment 1.11.2 Addendum Caldicott ICO reconciliation.docx
1.11.3	Report from the SIRO including Review of IG arrangements & support 1.11.3 SIROIntegrated IG Report.docx
1.11.4	Integrateg Governance Report
1.12	Specific items for attention
1.12.1	GDPR Update and Action Plan App1 & App 2
1.13	Controlled documents Framework Update 1.13 Controlled Documents Framework FINAL.docx
2	PART 2: ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE
2.1	Sub Group Minutes, NIMB Minutes of Meeting on 16th August 2018 2.1 NIMB minutes - 16 August 2018.docx
2.2	Capital Management Group Minutes of Meeting on 20 August 2018 2.1.1 Capital Management Group Minutes held August 2018.docx
2.3	Any Other Business
2.4	Review of Meeting and Items to Bring to the Attention of the Board/Other Committees
2.5	Date and time of next meeting to be confirmed

INFORMATION, TECHNOLOGY AND GOVERNANCE SUB-COMMITTEE MEETING

on 31st October 2018 at 12.30pm
Corporate Meeting Room, Headquarters, UHW

AGENDA

PART 1: ITEMS FOR ACTION		
1.1	Welcome and Introductions	*Chair Oral*
1.2	Apologies for Absence	*Chair Oral*
1.3	Declarations of Interest	*Chair Oral*
1.4	To receive the minutes of the previous IT&G Sub Committee meeting held on 13th June 2018	Chair
1.5	To receive and review the Action Log from IT&G meeting held 13th June 2018	Chair
1.5.1	Review of IG arrangements & support – update	Executive Director of TIIC and Deputy Chief Executive
1.5.2	IG mandatory training – *(Board action – UHB18/117)*	Chair
1.6	Chair's action taken since last meeting	Chair
1.7 1.7.1	**IG / IT Risk Assurance Framework:** Joint IM&T Risk Register	Executive Director of Therapies & Health Science and Executive Director of TIIC
1.8 1.8.1	**Key Strategic Issues:** 8.1 – Transformation Board Progress	Executive Director of TIIC and Deputy Chief Executive *Verbal Update*
1.8.2	Failure of Services at National Data Centres *App1: Active Directory System Failure Technical Report* *App 2: NWIS Briefing Doc Data Centre Outages May*	Executive Director of Therapies & Health Science
1.8.3	Welsh Government Review of Governance of NHS Informatics in NHS Wales	Executive Director of Therapies & Health Science

	App1: Health Informatics Review	
1.9 1.9.1 1.9.2 1.9.3 1.9.4	**Work Programme Highlight Reports:** Specific Programmes • WCP Progress report *App1: Progress Report Oct 2018* • Digitisation of Medical Records (*QSE action 18/087*) • WCCIS • WLIMS	Executive Director of Therapies & Health Science
1.10.1 1.10.2 1.10.3 1.10.4	**Audits**: IMT Audit Assurance / Action Plan Information Commissioners Office Visit – Action Plan. Combined ICO / GDPR Action Plan - *new combined action report*	Executive Director of Therapies & Health Science Executive Director of TIIC and Deputy Chief Executive Executive Director of TIIC and Deputy Chief Executive
1.11.1 1.11.2 1.11.3	**Periodic items for assurance:** Report of Caldicott Guardian including i) 2017/8 CPIP-Self assessment - ii) Update on anomalies between the outstanding ICO actions and the CPIP self-assessment. Report from the SIRO including Review of IG arrangements & support – *update* Integrated Governance Report	Medical Director SIRO *(Executive Director of TIIC and Deputy Chief Executive)*
1.12	**Specific items for attention:**	
1.13	Controlled Documents Framework Update	Executive Director of TIIC and Deputy Chief Executive
PART 2: ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
2.1	**Sub Group Minutes:** NIMB Minutes of Meeting on 16th August 2018	

2.2	Capital Management Group Minutes of Meeting on 20 Aug 2018	
2.3	Any other Business	Chair
2.4	Review of Meeting and Items to Bring to the Attention of the Board/Other Committees.	Oral *Committee Chair*
2.5	**Date of next meeting: 29th January 2019 9am Corporate Meeting Room HQ UHW**	

UNCONFIRMED MINUTES OF A MEETING OF THE PUBLIC INFORMATION TECHNOLOGY AND GOVERNANCE SUB COMMITTEE HELD AT 1pm ON 13 JUNE 2018 HQ MEETING ROOM, UHW

***Present*:**

Eileen Brandreth (Chair)	Independent Member, Information, Communication and Technology
Dr Sharon Hopkins	Director of Public Health/Deputy Chief Executive
Dr Graham Shortland	Medical Director (Caldicott Guardian)
Dr Fiona Jenkins	Executive Director of Therapies & Health Science
Peter Welsh	Director of Corporate Governance/SIRO
Andrew Nelson	Assistant Director of Information and Performance
Paul Rothwell	Senior Manager Performance and Compliance
Allan Wardhaugh	Assistant Medical Director
Christopher Lewis	Deputy Director of Finance

***In Attendance*:**

Andrew Crook	Head of Human Resources Policy and Compliance
Sandra Whitney	IT Programme Manager

Apologies:

Nigel Lewis	Assistant Director of IT and Strategy

ITGSC 18/032 WELCOME AND INTRODUCTIONS

The Chair opened the meeting and advised members that she had been working with the two Executive leads to address strategic issues and provide assurances with the agenda.

ITGSC 18/033 DECLARATION OF INTEREST

There were no Declarations of Interests noted.

ITGSC 18/034 MINUTES OF THE MEETING HELD ON 6 MARCH 2018

The minutes of the above meeting were agreed as a correct record.

ITGSC 18/ 035 REVIEW OF THE ACTION LOG

The action log was reviewed and noted. The following updates were provided:

a) **Governance of F.O.I Requests**

An update was provided by Andrew Nelson and improved compliance with timescales was ongoing to address long term solutions and in the meantime Senior Coding Staff were helping with F.O.I requests.

b) **GP Pilot Cluster**

Update provided by Paul Rothwell and delays were highlighted due to privatisation of work for G.P.D.R introduction.
Sharon Hopkins confirmed that the necessary work would be progressed and reported to the next meeting.

Other Matters Arising not on the Action Log

1. **Therapies and Healthcare Scientist Conference**

Fiona Jenkins advised the conference was being held next week and Cabinet Secretary was attending.

2. **HSMB**

Sharon Hopkins provided feedback from HSMB and reasonable improvements have been noted since that discussion.

3. **Welsh clinical Portal**

Fiona Jenkins provided Welsh Clinical Portal update and slides will be circulated to members assurance provided that roll-out was taking place.

4. **WI-Fi Funding**

To be discussed at Charitable Funds Committee on 19th June 2018. Noted legal advice has been sought and endowment funds can be used for that purpose if the Committee agree.

5. **Caldicott Self Assessment**

On the agenda

6. **Enhanced Procedure Workflow for Incident Reporting**

An update would be provided at the next meeting. Paul Rothwell provided an update on the current position

7. SIRO Report

This is covered in minute 18/042 (e).

8. Update on I.G, Policy

This is covered under ITGSC 18/044 (Controlled Documents Framework).

9. Blood Bank and Cellular Pathology

On the agenda

ITGSC 18/036 CHAIRS ACTION SINCE THE LAST MEETING

Noted the Chairs Action had been taken since the last meeting to approve the submission for the Healthcare Standard 3.4 (IM & T, Information and Information Governance).I

ITGSC 18/037 RISK ASSURANCE FRAMEWORK

Risk Register
The Director of Therapies and Health Sciences introduced the paper and highlighted the following:

The Sub-Committee attention was drawn to the IT risks rated red and the available resources available and need to prioritise these against available resources.

The Cyber Risk and IG register were noted as red rated.

The Sub-Committee was informed that the IG/IT would be merged as one register for the next meeting.

Action: Paul Rothwell / Sandra Whitney / Sian Rowlands

Digital Enabled Organisation

Fiona Jenkins reported the following;

- The 'Cardiff and Vale Way' is the UHB transformation programme and I.T workstream is fundamental to this to provide a digital enabled organization.
- A project structure was outlined to progress this work
- Further updates will be provided at future meetings once this initial scoping work has been completed.

The Sub Committee gave their full support to this work and noted progress report being presented to the Board meeting in July and highlight report to the October meeting of the Sub – Committee.
Action: Fiona Jenkins

ITGSC 18/038 KEY STRATEGIC ISSUES

Report against National Strategy Policy and Implementation.

The Director of Public Health introduced the above and the following were noted:

- Position paper to be received at the October meeting
- This would need to reflect the changing landscape in-respect of the Parliamentary review and other Strategic matters.

ITGSC 18/039 WORK PROGRAMME HIGHLIGHTED REPORTS

a) Delivery of IMTP

The Executive Director of Therapies and Health Science & Director of Public Health introduced the paper. The Sub-Committee was advised that the UHB is moving towards being digitally enabled, however the pace and the ambition is being constantly refined in response to resource availability. This paper provides an exception report on the high priority programmes within the Informatics plan for 2017/18 and the working plan for 2018/19.
The UHB has made good progress in delivering the following informatics priorities:

- Digitising the Clinical record and the second stage of the clinical information model development programme
- Supporting GP out of hours services
- Delivery of the Ophthalmology informatics programme

The following comments were noted:

- The UHB has not signed the Deployment Order for the new WCCIS. The Chief Executive has written to the Director of the programme to express concerns and these comments have also been raised with Welsh Government.
- Fiona Jenkins highlighted recent problems with the current system in respect of LIMS System. Meeting being arranged with NWIS to discuss these concerns.
- The importance of the governance arrangements for this was also raised.

W.C.C.I.S

It was also noted that other Health Boards had also not signed the Deployment Order for W.C.C.I.S and had raised concerns.

The Chair agreed to raise the concerns at the Strategy and Delivery Committee.

Action: Eileen Brandreth

High priority programmes where there are delays and or risks to successful delivery are:

- WCCIS and WLIMs
- Development of PARIS for integrated data and record availability
- Elements of the data acquisition and data management programme
- Delivery of national strategy programme

The Sub – Committee **NOTED** the update and concerns expressed. The Chair agreed to raise this with the Chair of Strategy and Delivery Committee for these concerns to be raised at the next Committee meeting.

Action: Eileen Brandreth

b) Specific Programmes - WLIMS

The Director of Therapies and Health Science introduced the paper and emphasized the importance of moving to WLIMS in order to manage the risk of services remaining on Telepath, However this needs to be balanced against the risk of migrating to a system with known stability issues.
Currently live on the system are medical Biochemistry and Haematology, with Cellular Pathology and Blood Transfusion currently on Telepath. The planned go live date for Cellular Pathology was Monday the 21st May. During the week starting the 14th of May 2018 on two consecutive days the system was unavailable for prolonged periods of time. This raises a significant concern of system stability, particularly in advance of a planned further go live. The second outage on the 15th of May was reported as a server capacity issue. Ongoing server capacity issues were recognised by the clinical teams as whilst the system may not be down there are repeated instances where the speed of the system is reported as significantly slow.
Due to the repeated failures experienced the service undertook a clinical risk assessment of Cellular Pathology going live. This was critical to undertake as the impact of a large service moving onto the system may have implications both locally and nationally. Due to the recent unplanned downtime, the validation and verification of the system was incomplete and would introduce unnecessary risks. Therefore system safety and regulatory compliance could not be assured.
On the basis of the risk assessment Cardiff and Vale choosing to proceed with the go live of the system with the information currently available on

system performance will place unnecessary clinical risk on patients across Wales. On this basis the recommendation of the Clinical Board to Management Executive was that Cellular Pathology services were not to proceed to a go live.

The Director of Therapies and Health Science spoke to CE of NWIS and they agreed that the planned Cellular Pathology go live on Monday 21st May would be delayed until the capacity issue had been fixed, WLIMS was stable and there was a reasonable period of error free running. Also the outages had adversely impacted on our planned readiness activities and there was no opportunity for us to recover our position.
The sub-committee was advised that the UHB remain committed to the implementation of all modules of WLIMS and we are using this delayed period of time to continue our readiness activity. We will continue to work closely with NWIS and the national Blood Transfusion WLIMS Board to address the existing stability and performance issues which will need to be resolved prior go live of the Blood Transfusion module. This update was communicated by the CEO to the WLIMS SRO.

The Sub-Committee noted that the module for Blood bank is of greater concern. This is considerably more complex and has a much higher sensitivity to system unavailability. There is no confirmed date for it to be made available and less confidence in the resilience of the system to provide this. One other Health Board has already taken a tactical step and procured an alternative product until they can be assured that this module will be available appropriately in the national solution.

It was noted that the UHB is currently reliant on the Telepath system to provide blood bank services. Supplier support for this is due to end in September 2018 and to date, there has been no agreement about extension although NWIS are engaged in dialogue about this. Should this not be in place by September UHB would be running a critical service on an unsupported platform. If it is provided, the underlying infrastructure is aging and this could represent an increasing risk in relation to cyber security.

The Caldicott Guardian for the UHB noted his extreme concern about this situation and will be liaising with the other Caldecott Guardian's in Wales about this risk. Director of Therapies has been asked to consider this and recommend what Cardiff UHB should do during the next 12 to 36 months in relation to Blood bank services. Until this plan is in place, this represents a considerable risk to the ongoing provision of these services at Cardiff.

The Chair agreed to raise this with the Chair of the Strategy and Delivery Committee

Action: Eileen Brandreth

The Sub-Committee **NOTED** the course of actions being taken and concerns expressed.

ITGSC 18/040 AUDITS

Internal Audit Action Plan

The Sub–Committee **RECEIVED** and **NOTED** the above report and noted maternity had now agreed to the outstanding development required free of charge with the company to close the last risk outstanding.

ITGSC 18/041

Information Commissioners Office Visit and ICO/DPA Action Plan Update

The Director of Public Health presented the above which provided an update of the above report submitted to the last meeting. It was NOTED that by implementing its GDPR Action Plan (ITGSC 18/043) the UHB was making progress in terms of implementing the action plan agreed with ICO in relation to compliance with the Data Protection Act (DPA) 1998. The following key areas were noted:

- Improved staff awareness of relevant legal requirements via GDPR awareness sessions and production of Podcast.
- Greater engagement with Clinical Boards and Corporate Depts
- Updated privacy notices for the public and staff. These set out the legal basis for the UHB to process personal data relating to its patients and staff.
- Updating of agreements with third parties to formalise responsibilities relating to the handling of Patient Identifiable Data (PID)

The Information Technology and Governance Sub Committee:

- **NOTED** this update in relation to progress made following the last report to the Committee in relation to the action plan agreed with ICO following its audit of UHB compliance with the DPA
- **NOTED** that a further update in this matter will be submitted to the next Committee meeting as part of the formal report of the Information Governance Executive Team.

ITGSC 18/042 PERIODIC ITEMS FOR ASSURANCE

a) Report of Caldicott Guardian

The Medical Director presented the report of the Caldicott Guardian. The following key points were NOTED:

- The 2017/18 CPIP Self Assessment exercise had been closed off at national level by NWIS. Consequently it was not practical for the UHB to complete this exercise. The Chair reiterated the importance of the UHB undertaking a review to understand the apparent inconsistency between the score given to the ICO DPA audit and the Caldicott Assessment for 2017.
- The Chair requested that 3 Executive leads should consider which Management Group would consider the Strategy for the UHB for digitalization- Sharon Hopkins to update at the next meeting.
  Action: Sharon Hopkins
- There was significant concern about the fact that Whitchurch hospital had still not been completely cleared of records. This matter had been raised at HSMB. It was agreed to hold a further visit to Whitchurch and provide assurances at the next meeting and ask Clinical Boards to action urgently if required. Agreed Graham Shortland / Peter Welsh to visit Whitchurch with the Clinical Board to receive assurances required.

  Action: Graham Shortland / Peter Welsh

b) Integrated Governance Report

Sharon Hopkins thanked Paul Rothwell and those involved in maintaining the I.G service within the Health Board. The following were highlighted:

- Improvements required in certain areas where there are targets but measures are in place to make the necessary improvements.

The Chair raised concerns about whether the level of FOI compliance could be sustained given the staffing pressures faced by the IG dept.

The following comment was made:

- The importance of the I.C.O follow-up action plan must be reflected in the G.D.P.R action plan. Sharon Hopkins agreed to bring the back to the next or subsequent meeting of the sub-committee.

  Action: Sharon Hopkins

c) National Health Care Standards Compliance

Report noted and submitted under Chair's Action.

d) IMTP Capital report

The Sub-Committee **NOTED** the report.

Fiona Jenkins raised that this had been discussed at the Capital Allocation Group and the Management Executive Team and concerns on the allocations were noted. The Chief Executive had written to the Chief Executive of NHS Wales to secure further funding for the infrastructure. A response has been received dealing the capital allocation received by the UHB.

The Chair expressed concerns on the I.T allocation for 2018/19 (£250k) which was not sufficient to maintain I.T infrastructure services required. The implications of this would be raised by the Chair to the Strategy and Delivery Committee. Allan Wardhaugh confirmed that this was also a view from clinical teams.

Action: Eileen Brandreth

Sharon Hopkins advised that the Capitol Allocation programme was endorsed at the last Board meeting but acknowledged the risks associated with this.

e) Report from SIRO

The Sub-Committee received the report and the Sub-Committee noted change to the Executive lead for SIRO from the Director of Corporate Governance to the Director of Public Health & Deputy CEO.

ITGSC 18/043 GDPR UPDATE AND ACTION PLAN

The Executive Director of Public Health presented the paper which gave an overview of steps being taken to implement the General Data Protection Regulation (GDPR) which came into force on 25 May 2018.
The UHB is a health and care organisation but its generation and use of data, which is often personal and sensitive, makes it equivalent to a medium sized data management company, and widely impacted upon by data protection legislation. Whilst preparations have been in train for some time we are not yet compliant. However we are making good progress in the areas identified as early priorities by the Information Commissioner's Office and are at a similar level of readiness to other Health organisations in Wales.

The Sub-Committee noted:

- The key impacts on the UHB brought about by the GDPR are:
- New accountability requirement means that the UHB is required not only to comply with the new law, but to demonstrate that we comply with the new law.
- There are significantly increased financial penalties possible for any breach.

- There is a legal requirement for personal data breach notifications to be sent to the ICO within 72 hours.
- The UHB may no longer charge patients or staff for providing them with copies of records, thus reducing income.
- Introduction of tighter for evidencing that consent has been obtained where this is the legal basis of processing patient personal data.
- Appointment of a Data Protection Oofficer is mandatory for the UHB.
- Data protection impact assessments are required for all new processing of large volumes of patient data and adoption of technologies incorporating patient data
- Data protection issues must be addressed in all information processes at an early stage
- There are specific requirements on us to ensure that our patients and population are aware of how their information is being used.

As with the DPA audits and monitoring of the action plan, the ICO considers itself to be a "proportionate regulator". Their expectation is that the UHB is able to evidence that we have been making good progress in terms of implementing the key structures that underpin the implementation of GDPR by the 25th May. In particular the UHB understands that early priorities should be:

- A good training and awareness programme
- A DPO being in post and the role being actively discharged
- Accurate Information Asset Register(s)
- Publication of our Privacy notice
- GDPR compliant Subject Access Procedure being operational
- GDPR compliant Incident Management arrangements

As evidenced by the Status Report, we consider that progress is being made in all of these areas, assisted in part by the huge profile GDPR is receiving nationally in the news, and by communication campaigns run by other businesses. However there is variation in the progress made at departmental level, with much to do if the UHB is to have consistently good information asset registers and levels of staff awareness across the UHB. In addition to these specific requirements there are many further actions required (as identified in the status report) in order for the UHB to move towards full compliance and to continue to be able to mitigate the risks of being non-compliant beyond May.

The Sub-Committee **NOTED** that:
The programme is overseen by the IG executive team and scrutinised by the Information, Technology and Governance subcommittee of the Board. The key potential risks posed by GDPR, which the IG executive group are managing including need to discharge our statutory duty, Financial penalties and Financial Ability to Act.

ITGSC 18/044 CONTROLLED DOCUMENT FRAMEWORK (CDF) POLICIES AND PROCEDURES

The Director of Public Health presented the above report which detailed:

The Controlled Document Framework (CDF) which 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.
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.
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), IG Toolkit and to improve future audits that may be undertaken.

Progress on the framework development would be brought to the next meeting.

The Sub-Committee:

- **NOTED** that it has not been possible to update 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 – agreed with the Director .
- **AGREED** that work should now be undertaken to update the UHB Information Governance policy using the equivalent policy being developed by the Information Governance Managers Advisory Group (IGMAG) Wales as an exemplar.
- **AGREED** that, in the interests of efficiency, this approach will be followed for future UHB IG policies and procedures where such documentation is considered appropriate to the UHB operating environment.

ITGSC 18/045 ITEMS TO RECORD AS RECEIVED AND NOTED

- NIMB Minutes September and November 2017
- Capital Management Group Minutes January 2018

ITGSC 18/046 ANY OTHER BUSINESS

There was no further business discussed

ITGSC 18/047 DATE OF NEXT MEETING

Date of next meeting – 31ST October 12.30pm in the Corporate Meeting Room HQ.

Signed ……..

Date ……..

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

ACTION LOG FOLLOWING INFORMATION TECHNOLOGY AND GOVERNANCE SUB COMMITTEE 13 JUNE 2018 MEETING

MINUTE	DATE	SUBJECT	AGREED ACTION	ACTIONED TO	STATUS
Items outstanding					
ITGSC 18/029 and 18/041	6/3/ and 13/618 and 8/8/17	CPiP report	Submit final 2017/8 compliance report to ITGSC	Paul Rothwell/Ann Morgan	Update given in report of Caldicott Guardian
ITGSC 18/028 and 18/035	6/3 and 13/6/18 and 8/8/17	GP Pilot	Three month pilot report to be submitted to the next meeting.	Paul Rothwell	Evaluation on hold
ITGSC 18/029	6/3/18	(v) Closure Of Medical Records Libraries	Review whether the unavailability of medical records/lost records were given the correct risk rating	Peter Welsh	Update given in report of Caldicott Guardian
18/025/18/028 & 18/048	6/3/18	Review of Information Governance function	Management Executive to carry out review. Include risk assessment in relation to delivery of FOI 20 day response target.	Management Executive	Update given in report of SIRO/Integrated Governance report.
ITGSC 18/031	6/3/18	GDPR Action plan	Escalate compliance concerns to Strategy and Delivery Committee meeting on 13 March 2018	Eileen Brandreth	Report given to S & D committee.

					Key actions subsequently taken set out in combined ICO/GDPR Action Plan
			Progress plan. UHB privacy notices for staff and patients updated to reflect GDPR. Awareness posted via posters. Podcast produced to promote awareness of "12 IG Commandments" and made available widely to staff via multiple commandments	Paul Rothwell/Ann Morgan	Update set out in combined ICO/GDPR Action Plan
Actions complete from last meeting					
ITGSC 18/037	13/6/18	Combined IT/Information/IG Risk	Merge risks into one combined register	Paul Rothwell/Sandra Whitney/Sian Rowlands	Merged register presented. Format under review as part of review of ongoing development of CRAF
ITGSC 18/039	13/6/18	WCCIS	Raise concern at Strategy and Delivery Committee that other Health Boards had not signed the deployment order for WCCIS.	Eileen Brandreth	Agenda item 9.1 Oct 31st 2018
		WLIMS	Raise concern at Strategy and Delivery Committee at proposed withdrawal of supplier support for Telepath system to provide blood bank services.	Eileen Brandreth	Agenda item 9.1 Oct 31st 2018
ITGSC 18/042	13/6/18	Decommissioning of Whitchurch	Visit Whitchurch to provide assurances at next ITGSC meeting and ask Clinical Boards to action urgently if required	Graham Shortland/Peter Welsh	Detailed report submitted to private meeting

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	10/31/2018	Capital / HR / Service Interruptions	DoTh	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. Significant progress has been made with capital investment in 14/15, 15/16, 16/17 and £2.652 in 17/18. 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	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 Infrastucture	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	10/31/2018	Service Interruptions	DoTh	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. Significant progress has been made with capital investment in 14/15, 15/16, 16/17 and £2.652 in 17/18. 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	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 Infrastucture	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	10/31/2018	Service Interruptions	DoTh	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. Significant progress has been made with capital investment in 14/15, 15/16, 16/17 and £2.652 in 17/18. 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	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	10/31/2018	Service Interruptions	DoTh	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. Significant progress has been made with capital investment in 14/15, 15/16, 16/17 and £2.652 in 17/18. 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	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	10/31/2018	Service Interruptions	DoTh	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. Significant progress has been made with capital investment in 14/15, 15/16, 16/17 and £2.652 in 17/18. 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	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	Virtulisation	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	10/31/2018	Service Interruptions	DoTh	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. Significant progress has been made with capital investment in 14/15, 15/16, 16/17 and £2.652 in 17/18. 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	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	10/31/2018	Service Interruptions	DoTh	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. Significant progress has been made with capital investment in 14/15, 15/16, 16/17 and £2.652 in 17/18. 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	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	10/31/2018	Cyber /Service Interruptions	DoTh	**3**	**5**	15	10	MODERATE	The UHB has less than 200 x XP PC's remaining on the Domain a number of which are due to aplication software not being able to "run" on Windows 7 and Windows 10 Operating Systems.	The Firepower Firewalls have been configuered to stop ALL Internet access, if/when a possible serious virus attack is identiied and will implmeneted immedialtly.	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	10/31/2018	Health & Safty	DoTh	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	10/31/2018	Cyber /Service Interruptions	DoTh	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
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.		10/31/2018	Clinical Service Interruptions	DoTh	5	4	20	10	MODERATE	The UHB is engaged with NWIS and other Health Boards to evaulate options avialable to migigate this risk.	Active options being pursued include: Extend Hard Ware support, Extend Software support, accelarate migration. There was an Extraordniary 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.	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** WCCIS Risk: The delivery and implementation of a single instance National Mental Health, Community and Therapies System (WCCIS) requires significant resources to co-ordinate workstreams 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.				DoTh	4	4	16	10	MODERATE	Update 6/6/2018: 2 BA posts funded locally for 2018 only; timing of implementation will be based on objective assessment, to be synchronised Cardiff Council. WCCIS is 'live' in 12 Local Authorities and partially in 1 Health Board.	UHB working with NWIS, WG and Regional IHSCP on review of WCCIS deliverables including Health functionality, information standards, data migration and reviewed commercial arrangements	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	1/1/2019	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 opther stakeholders resulting in their unwillingness to share / divulge essential informatio, Significantly financial penalties	9/28/2015	11/1/2018	Governance / Clinical	DOI/SIRO	**4**	**4**	16	**9,(3x3)**	MODERATE	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 occassions, and UHB close to agreement.	Ongoing implementaiton of GDPR/ICO action plan		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
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	11/2/2018	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	11/3/2018	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	11/4/2018	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	11/6/2018	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	Acceleration of programme		S & D
Using information effectively and ethically	DPA related agreeme 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	11/7/2018	Governance	SIRO/DOI	4	4	16	7 (x3)	MODERAT	Library of outline documents for sharing data available with completion supported by corporate informaiton 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 fulfill 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	11/8/2018	Governance	DOI	3	3	9	8 (x3)	MODERAT	NIIAS, mailmarshall and local solutions in place. Options for fine grain auditting 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	11/9/2018	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 Inormatics 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	11/10/2018	Governance	DOI	3	3	9	8 (x3)	MODERAT	N/a - the UHB cannot insure against this liaibility and a third party organisation would not give an indemnity because no insurer would cover the errors etc by another organsation over which it effectively had no control			S & D
Effective governance, leadership and accountability	Governance framework (IG policies and procedures)	Risk: IG policies and procedures are not up to date/do not cover all relevant areas. Procedures are not aligned to relevant national policies. Consequence: Lack of clarity in terms of how the UHB expects its staff to work to in order for relevant accountabilities to be discharged.	2/16/2018	11/11/2018	Governance	SIRO/DOI	4	4	16	6 (x3)	MODERAT	Update: Controlled document framework requirements delayed due to resource constraints			S & D

FAILURE OF SERVICES AT NATIONAL DATA CENTRES	
Name of Meeting : IT&G Sub Committee	**Date of Meeting** 31st October 2018

Executive Lead : Executive Director of Therapies & Health Science
Author : IT Programme Manager
Caring for People, Keeping People Well : This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy.
Financial impact : N/A
Quality, Safety, Patient Experience impact : Service interruptions
Health and Care Standard Number 3 & 4.2
CRAF Reference Number
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by: The Infrastructure Management Board, whose members include representatives from all of the Health Boards and Trusts, has discussed these issues in detail and has overseen all activities in terms of both the remedial actions, as well as the additional measures that we are taking to provide further assurance.

The Committee is asked to: Note the content of this update

SITUATION

The purpose of this report is to inform the IT&GSC of an array of failures that have occurred to date this year from the National Data Centre's in Newport (NDC) and Blaenavon (BDC).

Full copies of the System Failure technical reports are attached within **appendix 1** of this report.

BACKGROUND

On the 24th January 2018 at 11:47, a firewall policy was "pushed" to the four core Check Point firewalls situated in both National Data Centers managed by NWIS. Shortly after this policy push an issue occurred which caused an immediate failure of the Blaenavon Firewalls, meaning that the National IT systems hosted within BDC were inaccessible to all staff across NHS Wales. 50 minutes later the issue occurred at the NDC thus preventing access to the National IT systems hosted in both NDC and BDC.

On the 21st March 2018 an intermittent connectivity issue affected a number of NHS Wales IT Systems running from the Blaenavon Data Centre. This was immediately detected by automated monitoring systems and engineers undertook a dual- prolonged approach to resolving the issues. One focused on fixing the problem and the other was to switch services over to run from the Newport Data Centre. Full network stability was restored by 17.45, which restored most services, with confirmation that all services were running normally by 19.00. Services running out of the Newport Data Centre were not affected.

On the 24th April 2018 a blade server chassis (known as the DTP chassis) suffered a failure which resulted in a loss of some network connectivity for servers in the chassis. Engineers worked with the supplier (HP) to resolve the issue but the condition worsened as the evening progressed. Overnight, engineers undertook a dual-pronged approach to resolving the issues. One focused on troubleshooting the problem and the other was to switch services over to run from the Newport Data Centre. The issue was diagnosed as a network loop running through the blade server chassis. Network stability to the chassis was restored by 09:55 Wednesday 25th and services were brought back on-line and/or made resilient again during the day.

On the 3rd August 2018 NWIS experienced some problems with the Active Directory System operating across NHS Wales. Whilst this did not have a significant impact on Services and no Patient Harm has been identified as a result, it did have an affect with some Users ability access some Services for a short periods of time on the day.

Appendix 2 is a summary of outages this year 2018

ASSESSMENT AND ASSURANCE

The Infrastructure Management Board, whose members include representatives from all of the Health Boards and Trusts, has discussed these issues in detail and has overseen all activities in terms of both the remedial actions, as well as the additional measures that we are taking to provide further assurance. To this end they have commissioned external reviews of the following:

- Data Centre Networks and Firewalls
- NWIS Citrix estate (used in the delivery of LIMS, WPAS, CANISC and others).
- Backup systems

These reviews are in addition to the regular audits that are completed by NWIS and their ISO Accreditation status for ISO 20000-1 IT Service Management, which has recently been reaccredited. NWIS will continue to work closely with each organisation and recognise that reliance on digital technology has increased over recent years. This makes it all the more important that we continue to invest in the resilience of these services and regularly test any contingency plans.

APPENDIX 1

159-20180803 -
Active Directory Syst

NWIS Briefing Doc
Data Centre Outage

APPENDIX 2

SUMMARY OF OUTAGES TO DATE 2018

Logged	Resolved	Downtime	Summary	Impact	Root Cause
02/08/2018 21:42	05/08/2018 22:37	4375	Corruption of the contents of the shared directory that stores the server copy of the domain's public files that must be shared for common access and replication throughout a domain, across all domain controllers caused loss of access to Nationally hosted systems and services.	All Nationally hosted Services across NHS Wales	Corruption of the contents of the shared directory that stores the server copy of the domain's public files that must be shared for common access and replication throughout a domain, across all domain controllers.
23/07/2018 10:49	23/07/2018 11:16	27	Users reported that they were unable to log in to WCP. Logging in kept on timing out	WCP is not available for HDD, ABM and ABHB. Patient lists confirmed as being affected in BCU. All Wales Services also affected including WAP and MPI	A Change was initiated this morning by Infrastructure Services to replace a faulty ACE Load Balancer to ensure the restoration of resilience within the data centres. An error with the configuration of this load balancer caused a conflict with the primary device causing the outage
18/07/2018 05:58	18/07/2018 09:20	202	The access control database for ABHB ran out of space in TRRR	GPTR users could not place tests within WCP	The ‘Access Control’ database for ABHBs TRRR hit its full capacity of 2gb

/2018 09:19	13/07/2018 10:41	82	On Friday 13th July 2018 at 09:11 around 200 servers were affected by an antivirus update, which updated the individual server firewalls preventing access to users. This update had previously been deployed within the test environment without issue whilst under change control. In total approximately 100 calls were received in relation to this outage, and the outage lasted approximately 1 hour and 22 minutes An MI review will be undertaken in due course.	This update prevented users from accessing the following systems: Canisc WLIMS WPAS MPI InSe Owing to the nature of these systems there was a further knock on impact to downstream systems such as: WRIS WCP Choose Pharmacy NIIAS	The root cause has been identified as the deployment of an anti-virus patch which blocked access to around 200 servers across the National Data Centres.
07/07/2018 08:35	07/07/2018 15:56	441	Users have informed of not being able to access Lab results entry or authorise results	affecting all health boards	The problems was related to a file share - there was a high threshold that was reached causing the server to fall over.
05/06/2018 08:25	12/06/2018 10:18	10193	Outlook.com was blocked by the firewall, following an automatic software update. 489 users reported the issue, however it is understood that the impact on staff was greater. Microsoft sites were added to the whitelist, which resolved the issue. The problem was intermittent and access to email was available via an email web client.		Outlook.com was blocked by the firewall, following an automatic software update.

17/05/2018 08:36	18/05/2018 08:23	1427	A high number of connection failures were caused by a combination of patching and storage issues. This led to intermittent outages over the period. Work was done to restore service overnight.		
15/05/2018 14:41	15/05/2018 18:24	223	WLIMS experienced a degradation of service and would not allow additional users to log into the WLIMS system in the afternoon.		This was a result of the number of users exceeding the CITRIX farm capacity, this was due to too many duplicate/disconnected user sessions.
15/05/2018 07:50	15/05/2018 09:11	81	Prescription Tracking System was unavailable as the web server was down.		The servers unable to restart owing to lack of free space.
14/05/2018 08:51	14/05/2018 14:53	362	Canisc users reported freezing following the implementation of a Change to allow MTeD discharge messages into WCP. This caused high CPU usage on SQL and Citrix.		Implementation of a Change to allow MTeD discharge messages in to WCP
24/04/2018 16:54	24/04/2018 00:00	-1014	There was an issue with the Blade Chassis causing some virtual machines to shut down, affecting multiple Services.		The investigation is ongoing.

29/03/2018 15:43	29/03/2018 20:07	264	Users unable to access WLIMS		There is a link between LABDB and back up - the backup that was run soon after the capacity increase, did not thaw as expected and DCS had to manually intervene. The reason may have been that the backup did not thaw (script is basic that talks to DB servers, there are 3 freeze commands and it issues 3 thaw commands). In this case, the thaw command did not issue as the disc could not sever itself for the next command. There is uncertainty on whether the backup may have been too soon that may have caused the problem. It appears that change 57906 was implemented successfully and the problems started to arise when the backup was manually run. DCS will work with HP to investigate this in more detail. As a result the Citrix servers were affected due to the number of disconnected sessions, which halted without warning. The issue was exasperated by removing Citrix servers from the farm and rebooting them sequentially, resulting in the remaining Citrix servers trying to support user traffic during the peak period of the day. i.e. There was no enough capacity in the farm to adopt this approach.

23/03/2018 08:27	23/03/2018 15:54	447	the DB mirror broke at 23:20 last night and we currently have the whole GP Links system down as a result		Static IP Addresses are being removed from Windows 2008 R2 VMWare servers after the installation of KB4088875 and KB4088878 Microsoft updates
21/03/2018 15:47	04/04/2018 11:33	19906	System Failure in Blaenavon Data Centre		A root cause could not be found. However the software versions were identified out of date by approx 8 years. An action plan is in place to update theses
01/02/2018 08:42	06/02/2018 15:07	7585	Users unable to access Canisc		There were a number of issues relating to this initial call and subsequent problem record remains unresolved
31/01/2018 13:30	23/02/2018 10:06	32916	Users getting Citrix Interruption Errors. Citrix Storefront unavailable		There were a number of issues relating to this initial call and subsequent problem record which remain unresolved
24/01/2018 15:50	25/01/2018 08:44	1014	OPSF failed between BDC/NDC Core Firewalls & Core Switches		The cause of the incident has been confirmed as a problem with the Check Point firewall equipment which occurred when a routine firewall change was applied.
15/01/2018 11:53	15/01/2018 12:32	39	user has been logged out of WCCG, when they try to get back in they get an error message		Monthly patching change caused server issue which subsequently caused Start-Over error messages for any users within WCCG Live. Problem occurred due to incorrect procedure followed to patch server.

12/01/2018 15:24	12/01/2018 15:47	23	WCP is inaccessible in ABHB, CAV, POW and CTT.		Human error – a missed number meant a planned NetScaler change being applied for WPAS (suggestion was ABMU preparatory configuration) led to the WCP IP range (on the same subnet mask) being overwritten.
09/01/2018 08:01	09/01/2018 10:45	164	all users in the site this morning after clicking on the WCCG icon, get an error message saying "WCCG is currently unavailable, please try again later" and are unable to access it.		Primary ACE Load Balancer in BDC failed with a fan issue. The device was over 8 years old
06/01/2018 18:35	06/01/2018 21:29	174	Users from all Health Boards were unable to login to Trak Care Lab or users who were logged in, were unable to use the application as it had froze.		A combination of a defragmentation task, an R-Sync issue and a purge script all occurred at the same time to cause the issue

159-20180803 - Active Directory System Failure Technical Report

This report provides the technical findings into the Active Directory System Failure which occurred on 3rd August 2018

Version No. 2.0
Status: Approved

Author: Keith Reeves
Approver: Carwyn Lloyd-Jones

Date: 17/08/2018

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159 – 20180803 Active Directory System Failure Technical Report

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1 Introduction

This interim report is in relation to the Active Directory System Failure which was experienced on 3rd August 2018.

This report reflects an initial technical assessment of the incident, based on information available at the time, and the steps taken to resolve it.

A further comprehensive review is underway to look at the incident that occurred, as well as any contributory factors, which may relate to the outage or any impact caused by it. This will include any previous occurrences or potential related events.

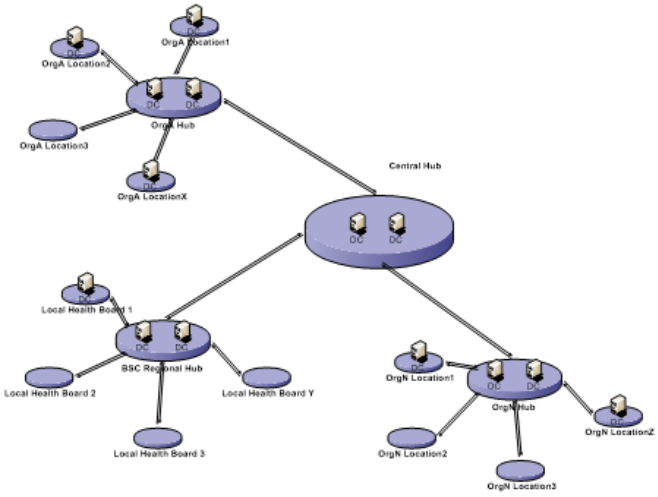
The outcome of the review will then be used to implement any changes necessary in order to prevent another similar failure, and to identify any lessons learned to lessen the impact of any future incidents.

2 Background and Terminology

Active Directory

The NHS Wales Active Directory deployment was originally configured based on a design developed for NHS Wales by Microsoft in 2007 and approved for implementation. This was reviewed and redesigned in 2014, in collaboration between Trustmarque and NHS Wales.

The approach taken satisfied the design principles laid out for the NHS Wales infrastructure at the time of deployment. A simplified diagram of the structure is as follows:



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A central hub contains two domain controllers. This central hub is connected to organisational hubs, which contain further domain controllers, which connect to individual locations, which may contain further domain controllers. This forms what is known as a snowflake structure.

Any manipulation of data within the directory, which is made to the domain controllers in the central hub, is then replicated through the organisational hubs, and on to any further domain controllers located in connected locations.

This design offers the following benefits:

- Most flexible – allows for any restructuring
- Simplest – users cannot get confused which is their logon domain
- Easily allows for complete autonomy of each local organisation in respect to their resources – servers, workstations, user accounts, groups…
- Consistent – where it matters – while allowing local IT to enforce their decisions
- Allows to perform any low-level, technical AD administration (replication configuration and maintenance, etc.) only once – potential for cost saving
- Nation-wide, ideal platform for national messaging solution
- Can easily cope with the scale – 100,000+ users
- Last but not least, the design follows current Microsoft recommendations

Domain Controllers

A domain controller is a server on a Microsoft Windows network that is responsible for the authentication, authorisation and enforcement of client policies. Each domain controller contains user account information to authenticate users, provide access, and enforce any security policies for a Windows domain.

System Volume (SysVol)

The System Volume (SysVol) is a shared directory that sits on a domain controller and stores the server copy of the domain's policies and configuration that must be shared for common access and replication throughout a domain.

This folder also contains user login scripts and group policy objects, which set settings and parameters for users and computers (e.g. set proxy servers, disable access to certain settings, etc.).

3 Situation

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At 21:42 on 2nd August 2018, a user in Cardiff and Vale identified an issue, where the email mailbox was missing from Active Directory for a single user. On further investigation, a wider issue in the National Active Directory was identified, where data was missing from within the database.

NWIS continued the investigation through the night in collaboration with their suppliers, and to resolve this issue the intention was to undertake a restore of the missing data from a backup, which had previously been taken prior to 11:00 on 2nd August 2018.

In order to restore the deleted objects, a restore of both the Active Directory database and SysVol took place. This was undertaken in conjunction with, and under guidance provided by, the supplier. Whilst the authentication element of Active Directory was seemingly unaffected, the 'SysVol' share attempted to perform a simultaneous replication of the restored data with all domain controllers, whilst the attempted restoration was taking place. This replication meant that SysVol was not consistent across all domain controllers within the domain as the restored files were replicated from the authoritatively restored copy.

This caused user disruption and loss of access to some National Services that primarily use thin client technology or Citrix as a method for users to access. In addition, there were local issues across Health Boards affecting some users, including loss of print capability, accessing local systems, and shared files and folders. The impact was variable in that some Local Health Boards and Trusts (LHBs) were affected more than others.

A Major Incident was declared at 08:49 on the 3rd August 2018, impacted support teams were convened, and LHBs and Welsh Government were made aware, whilst investigations and response plans were prepared.

A number of technical workarounds were implemented as interim measures by NWIS and the LHBs, to ensure that impact was minimised to end users. A number of technical and managerial conference calls were held throughout the event, with LHBs being communicated to at appropriate times.

At 15:00 on the 3rd August 2018, it was agreed between ADIs and NWIS to stop replication to prevent the issue spreading further.

A second managed restore and replication activity was then planned, in consultation with the NWIS supplier, and the ADIs, using the previous night's backup. This was agreed with ADIs and was scheduled to be undertaken, by NWIS and their supplier, over the weekend of the 4th and 5th of August 2018.

The restore and replication activity commenced at 12:30 on the 4th August and was completed on the 5th August at 20:05, restoring access to services albeit with some remedial activities required by Application Services following prior failover of Services.

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The following National services had calls raised with the National Service Desk, which provided evidence of the impact of this outage.

- Canisc
- GP Test Requesting
- Hosted Messaging Service (email)
- INPS Vision
- Integration Services
- Welsh Clinical Portal including Welsh Care Records Service
- Welsh Laboratory Information Management Service

4 Outcomes

4.1 Corrective Actions

A number of technical workarounds were implemented as interim measures by NWIS and the LHBs, to ensure that access to business and clinical systems was restored as soon as possible.

Replication was stopped to prevent the issue spreading further.

A restore and replication activity was then undertaken on the SysVol contents to restore service.

4.2 Preventative Actions

NWIS, in consultation with the Infrastructure Management Board, approved a temporary Change freeze for Infrastructure Services for a period of seven days, to allow for monitoring and stable running.

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Appendix A Document History

A.1 Revision History

Date	Version	Author	Revision Summary
10/08/2018	0.1	Keith Reeves	First Draft
15/08/2018	0.2	Keith Reeves	Second Draft following peer review
15/08/2018	0.3	Keith Reeves	Clarification on points following peer review, and removal of track changes
16/08/2018	0.4	Keith Reeves	Amendments following response from Lead Infrastructure Design Architect
17/08/2018	V1.0	Keith Reeves	Submission to Directors for sign off
17/08/2018	V2.0	Keith Reeves	Amendments following review by Director of NHS Wales Informatics Service, Director of ICT, and Director of Application Development and Support.

A.2 Reviewers

This document requires the following reviews:

Date	Version	Name	Position
15/08/2018	0.2 | 0.3 | 0.4	Michelle Sell	Chief Operating Officer
15/08/2018	0.2 | 0.3 | 0.4	Simon Williams	Head of Service Management
15/08/2018	0.2 | 0.3 | 0.4	Steven Howlett	Principal Service Management Specialist
15/08/2018	0.2 | 0.3 | 0.4	David Rees	Service Management Specialist
15/08/2018	0.2 | 0.3 | 0.4	David Owen	Lead Infrastructure Design Architect
15/08/2018	0.2 | 0.3 | 0.4	Peggy Edwards	Head of Clinical & Informatics Assurance

A.3 Authorisation

Signing of this document indicates acceptance of its contents.

Author's Name:	Keith Reeves
Role:	Service Management Lead
Signature:	17/08/2018 X  Keith Reeves Service Management Lead Signed by: Keith Reeves (Ke125547)

-FINAL-

159 – 20180803 Active Directory System Failure Technical Report

Approver's Name:	Andrew Griffiths
Role:	Director of NHS Wales Informatics Service
Signature:	17/08/2018 X Carwyn Lloyd-Jones Carwyn lloyd-Jones Director of ICT Signed by: Carwyn Lloyd-Jones (Ca000262)

A.4 Document Location

Type	Location
Electronic	

A.5 Report Distribution (NWIS)

Title	Date	Audience
159-20180803 – Active Directory System Failure Technical Report v2	15/08/2018	Director NHS Wales Informatics Service Director of ICT Director of Applications Development & Support Chief Operating Officer Head of Clinical & Informatics Assurance

Data Centre Outages Briefing Document

Version No. 2
Status: Final Draft

Author: Carwyn Lloyd-Jones

Date: 23/05/2018

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1 INTRODUCTION

Since January 2018, there have been three issues at the national data centres which have caused concurrent outages to multiple national services hosted at these data centres. This document provides a summary of the root cause for each incident, what action was taken to rectify the issues and goes on to describe a series of planned work to reduce the likelihood of similar outages.

2 SUMMARY OF OUTAGES

2.1 January 24th 2018

2.1.1 Summary

On the 24th January 2018 at 11:47, a firewall policy (ruleset) was "pushed" to two pairs of Check Point firewalls situated in both Blaenavon and Newport Data Centres managed by NWIS. This is a routine activity sometimes carried out several times a day. Shortly after this policy push an issue occurred which caused an immediate failure of the Blaenavon pair of firewalls, meaning that the National IT systems hosted within BDC were inaccessible to all staff across NHS Wales. 50 minutes later the same symptoms occurred at the NDC thus preventing access to the National IT systems hosted in both NDC and BDC.
Network connectivity was restored at 15:45 at the Newport Data Centre and 16:10 at the Blaenavon Data Centre. All hosted services were confirmed to be operational by 17:30.

2.1.2 Root Cause

Following an extensive review, involving NWIS networking and design teams, the firewall manufacturer (CheckPoint) and a 3rd party appointed by CheckPoint, the cause of the incident has been identified as a two factors:

- At the Blaenavon Data Centre (BDC), a transient high level of CPU utilisation on the firewall which coincided with the policy pushing process. This policy push added additional processing load which caused the policy to fail to apply correctly and resulted in the firewalls no longer participating in a networking routing protocol thus preventing traffic flowing in/out of the data centre.
- As a result of the firewalls at the BDC failing, network traffic at the Newport Data Centre (NDC) increased substantially and the firewalls hit a configured connection limit. This resulted in a similar situation as at the BDC, thus preventing traffic flowing in/out of that data centre as well.

2.1.3 Action to mitigate recurrence

CheckPoint installed the firewalls in summer 2017 and they reviewed the configuration that had been applied at the time. They recommended a series of configuration improvements for the equipment at both sites, including:

- Assigning more processing resources to the firewall tasks and dedicating some processing capacity (CPU cores) to specific tasks. This will prevent the same high CPU condition occurring again in future.
- Implementing more granular monitoring of the CPU utilisation.
- Simplifying and changing the order of the rules in the firewall rule table to allow more work to be undertaken by dedicated hardware chips in the firewall appliances rather than by the CPU.

The first two were undertaken shortly after the event and the last is a longer term, ongoing action.

2.2 March 21st 2018

2.2.1 Summary

At 15.45 on 21 March 2018 an intermittent connectivity issue affected a number of NHS Wales IT systems running from the Blaenavon Data Centre. This was immediately detected by automated monitoring systems and engineers undertook a dual-pronged approach to resolving the issues. One focussed on fixing the problem and the other was to switch services over to run from the Newport Data Centre. Full network stability was restored by 17.45, which restored most services, with confirmation that all services were running normally by 19.00. Services running out of the Newport Data Centre were not affected.

2.2.2 Root Cause and mitigation actions

A network engineer was making a routine change to the network – adding in a new network device (Fabric Extender) to provide extra capacity at the data centre. Whilst the engineer was working on the equipment, the network at the site became unstable and resulted in intermittent network connectivity. Some users in some LHBs/Trusts were unaffected with others being unable to access some/all services at that data centre. The networking team worked to troubleshoot the issue and captured logs from the affected devices and after approximately 1 hour initiated a reboot of 4 networking switches (in a sequence to avoid affecting users who were not affected by the incident). This reboot cycle took around 20 mins and cleared the problem.

The networking team, external maintainer (Maintel) and the manufacturer (Cisco) have analysed the work that the engineer was undertaking along with the captured logs, but have not been able to identify a link or a specific root cause. However, there have been no indications of any similar problems and the network has been stable since the incident.

2.2.3 Next steps

NWIS are in the process of procuring an independent 3rd party to review the network design, software versions and management procedures to see if there are any areas for improvement.

NWIS will undertake component failure tests as part of the planned data centre testing activity, scheduled for Autumn 2018.

2.3 April 24th 2018

2.3.1 Summary

At 16:54 on Tuesday 24th April 2018 a blade server chassis (known as the DTP chassis) suffered a failure which resulted in a loss of some network connectivity for servers in the chassis. Engineers worked with the supplier (HP) to resolve the issue but the condition worsened as the evening progressed. Overnight, engineers undertook a dual-pronged approach to resolving the issues. One focussed on troubleshooting the problem and the other was to switch services over to run from the Newport Data Centre. The issue was diagnosed as a network loop running through the blade server chassis. Network stability to the chassis was restored by 09:55 Wednesday 25th and services were brought back on-line and/or made resilient again during the day.

2.3.2 Root cause

NWIS data centre engineers worked with HP support engineers to diagnose a root cause. The findings were as follows:

- An NWIS engineer was restoring data to a failed server from a backup. This server is located in the blade server chassis. This put a higher than usual load on the network fabric situated in the blade server chassis and the version of firmware running on the network fabric was identified as having a bug, which could be triggered under these circumstances.
- This set of conditions resulted in the network fabric causing a network switching loop which disrupted connectivity to devices in the blade server chassis and also caused disruption to some other parts of the network at the Blaenavon Data Centre

2.3.3 Action to mitigate recurrence

The DTP blade server chassis and its associated Storage Area Network (shared disk system) are in the process of being decommissioned as the infrastructure is around 7 years old. There is a duplicate infrastructure at the Newport Data Centre which is also being decommissioned. Work to accelerate the migration has started and is anticipated to take around 6 months to complete. Discussions with HP are on-going around whether or not any remedial action should be taken with the current hardware.

3 Other actions being taken

NWIS already has a number of external technical audits that are undertaken periodically on key components of the infrastructure. These include an Active Directory Risk Assessment, Exchange (Email) risk assessment and Microsoft SQL (Database) supportability reviews. Work to commission external reviews of the following will be undertaken over the next few months.

- Data Centre Networks and Firewalls
- NWIS Citrix estate (used in the delivery of LIMS, WPAS, CANISC and others).
- Backup systems

4 General observations

- All of the outages are in some way related to networking problems, albeit that they are three very different causes with different equipment from different manufacturers looked after by different teams in NWIS. However, this is not unusual as any problems that cause multiple concurrent failures are either going to be caused by failure of shared components (e.g. the network, network fabric in a blade chassis, Active Directory, Database Clusters, etc) or via some form of cyber-attack.
- The initial problem in January and the latter two problems have all occurred at the Blaenavon Data Centre. We cannot find any rationale that would explain this other than the fact that under normal conditions more services are running out from the Blaenavon Data Centre compared to Newport.
- Whilst NWIS already have a considerable investment in proactive monitoring and in planned upgrade activities, a greater focus needs to be placed on undertaking routing maintenance (e.g. firmware upgrades) which will be expensive in resources and will negatively impact on the delivery of new projects.
- The latter two problems have occurred on equipment that is around 7 years old. A greater investment is needed to replace aging infrastructure and systems before they start to fail. NWIS have been working with WG on this over the last two years and will continue to do so.
- One of the main lessons learnt from the reviews into these outages was that communication with affected organisations needed to be improved. Two actions have been taken to address this.
    - Welsh Government have worked with NWIS and LHB reps to create a new communications protocol to be used during significant outages such as these.
    - NWIS have procured a new emergency communications system (Blackberry AdHoc Alerts) to be able to more quickly notify many recipient of problems and actions being taken. This is being commissioned over the next 2-3 months and will be gradually introduced to manage future outages.
- NWIS has undertaken a review of its “System Restoration Plan for Multiple Concurrent Service Failures” and is making some changes to improve this.

WELSH GOVERNMENT REVIEW OF GOVERNANCE OF NHS INFORMATICS IN NHS WALES	
Name of Meeting : IT&G Sub Committee	**Date of Meeting** 31st October 2018

Executive Lead : Executive Director of Transformation, Improvement, Commissioning and Informatics
Author : IT Programme Manager
Caring for People, Keeping People Well : This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy.
Financial impact : N/A
Quality, Safety, Patient Experience impact :
Health and Care Standard Number 3 & 4.2
CRAF Reference Number Not Applicable
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by: The establishment of an internal Welsh Government Assurance Group chaired by the Director of Primary Care and Innovation.

The Committee is asked to: Note the contents of this report

SITUATION

As part of the Welsh Government's response to the recommendations of the Parliamentary Review of Health and Social Care in Wales ('*A Revolution from Within: Transforming Health and Care in Wales'* January 2018) and the report from the Auditor General for Wales ('*Informatics systems in NHS Wales*', January 2018), an independent review has been commissioned to identify the most appropriate and effective future structure and governance arrangements for health informatics in Wales.
The review will be undertaken by a senior team, led by Anne Jarrett from Local Partnerships1 . The work will be undertaken in the period September – November 2018 and recommendations made in December 2018. Their project brief is attached for information appendix 1

BACKGROUND

An internal Welsh Government Assurance Group, chaired by Frances Duffy, Director of Primary Care and Innovation has been set up , to oversee the review with the aim to ensure that NHS Wales has a system of health informatics that is capable of delivering the aspirations of '*Informed Health and Care'*.

ASSESSMENT AND ASSURANCE

The Welsh Government is aware that there needs to be clarity in the function, responsibility and accountability of each stakeholder organisation; a clearly defined structure for the provision of informatics; and that this structure is supported by appropriate governance.

The review will consider:

- The requirements of the whole system;
- How these functions are best organised and discharged through the various stakeholder organisations and structures;
- What leadership, operational and strategic management and governance arrangements need to be in place to deliver the system wide improvement required;
- Evidence of clear lines of accountability between NHS Wales and the Cabinet Secretary for Health and Social Services and the Chief Executive of NHS Wales.

Local Partnerships will engage closely, via e-mail introduction initially, with a wide range of partners throughout the review. In discussion and interviews the team will be gathering issues and ideas and seeking evidence to inform the development of potential future options for the structure and governance of health informatics in Wales. Interviews will all take place during the fortnight after the 8 October. Examples of models of good practice from elsewhere in UK will also be brought into consideration.

APPENDIX 1

LOCAL PARTNERSHIPS

LOCAL PARTNERSHIPS' SUPPORT TO WELSH GOVERNMENT REVIEW INTO INFORMATICS GOVERNANCE IN NHS WALES
PROJECT BRIEF

Introduction

We are pleased to be able to respond to the Welsh Government's brief for a review into informatics governance in NHS Wales (received August 31st, 2018). Set out below is our proposed project plan for the implementation of this review.

Project Scope

It is our understanding from the brief that the review must consider the requirements of the whole system and how these functions are best organised and discharged through the various delivery partners and stakeholder organisations.

Specific actions must include:

- Identifying the most appropriate and effective structure and governance arrangements for health informatics in Wales
- How future effective leadership, design and delivery of the digital and informatics requirements for service transformation can be ensured;
- Ensure that changes to the most appropriate digital, technological and infrastructure developments take place at pace and are effective
- Ensure that Welsh Government has a system of health informatics that is capable of delivering the aspirations of 'Informed Health and Care' 2
- To clarify the function, responsibility and accountability of each partner and stakeholder organisations.

The review must be aligned to the issues identified by the Auditor General's report and including reference to Recommendation 6 of that report to undertake an appraisal to strengthen governance and oversight of all NHS partners and stakeholders involved in providing access to information and introducing new ways of delivering care with digital technologies.

Welsh Government expect that final arrangements must support:

- Independent scrutiny and greater transparency of performance and progress
- Clear lines of accountability between the new structures, the Chief Executive of NHS Wales and the Cabinet Secretary for Health and Social Services.

It is also to be noted that the learning from this review will be captured to help inform thinking about the development of a proposed new NHS Wales Executive Function.

Finally, there is other work in progress, or about to begin, in Welsh Government that relate to this review into informatics governance. This includes the four workstreams in the Informed Health and Care Strategy Delivery Programme and a recently commissioned review into systems architecture. Emerging issues from these workstreams will be kept in view in order that any implications for the final outcomes of this project are identified and understood.

Project Approach

Our approach is based on four key stages of work. A project set-up meeting is also proposed as part of the project management arrangements.

The underlying principles of our approach are:

- Regular project updates and communications with client
- Engagement with and gathering of information and responses from key delivery partner organisations
- Evidence based
- Independent expert input at all stages of the project
- 'Iterative' and flexible approach to project activities to allow for response to emerging findings, new information and lines of enquiry
- Ongoing 'confirm and challenge' environment within the project team to support options development and recommendations
- Review of examples of models and good practice from elsewhere in the UK and abroad.

The four key stages of work are:

Project set-up	Agree project management arrangements and project plan
Stage 1	Review of current informatics governance
Stage 2	Engagement with delivery partner organisations
Stage 3	Options development
Stage 4	Presentation of recommendations

In addition to the Project Assurance Group meetings described below, we will hold weekly telephone calls to discuss progress and to raise any issues.

Project set-up

Key project activities	• Project start up meeting with client
Outputs	✓ Project brief: - Scope - Objectives - Key deliverables - Timeframes - Management and reporting arrangements - Key success criteria ✓ Identification of key delivery partner organisations

	✓ Summary project communication for project stakeholders
Outcomes	✓ A shared understanding of the project scope, objectives, milestones and success criteria ✓ Clear communication to stakeholders to ensure support for and engagement with project
Proposed time frame	End August 2018
	A project Assurance Management Group will be established by the client to provide project oversight. Membership will comprise: - Director for Primary Care and Innovation - Director of Transformation - Chief Digital Officer for Welsh Government - Deputy Chief Executive NHS Wales - Programme Director for NHS Finance - Independent member

1. <u>Review of current informatics governance landscape</u>

Key project activities	• Document review. Including key strategies, reviews and reports, board papers • Information gathering and fact checking with representatives of NHS Wales Informatics Service (NWIS), Velindre NHS Trust and Welsh Government • Internal project review and development workshop
Outputs	✓ Project briefing paper (1): - informatics structure and governance mapping[1]. - issues and concerns: system and organisation level - key drivers for change ✓ Common set of questions for (written) response from key delivery partner organisations
Outcomes	✓ Identification and understanding of: - current arrangements and relationships for health informatics - key issues and concerns - future drivers for system change ✓ Common approach to engagement with key delivery partner organisations
Proposed time frame	Completed by 2nd October 2018

[1] For example this could comprise a 'systems map' showing the logical relationships and influences between organisations / bodies

	The initial focus will be on identifying and reviewing the current governance arrangements in place for the provision of informatics: the profile of roles and responsibilities between organisations and the oversight and governance arrangements around these. This will represent a current 'baseline position' from which any proposed changes will be considered. Whilst this stage represents the main period of desk-based information and evidence gathering and 'research' activity, the potential iterative nature of the project's scope/key lines of enquiry means that this will be on-going throughout the work.

2. <u>Engagement with delivery partners</u>

Key project activities	• Collection and analysis of organisational responses (written and from group discussion) • Meeting with delivery partner organisations • Follow up discussions (as required)
Outputs	✓ Project briefing paper (2): - thematic analysis of key issues, challenges and proposed changes - outline framework for potential future change
Outcomes	✓ Key delivery partner organisation engagement and input ✓ Evidence gathered from a range of perspectives and analysed for common themes and differences
Proposed time frame	Completed mid November 2018
	We will meet with small groups of representatives (no more than 5) from 12-15 key delivery partner organisations. These will be determined by the client and will include, NHS Wales, NWIS, Health Boards, NHS Trusts and national agencies. A set of questions will be prepared (as an output from stage 2) and sent to the organisations in advance of the meeting. The review team will receive written responses to these questions in advance of the meeting. The meeting will present an opportunity to explore in more detail and clarify the responses that have been received from the delivery partner organisation. The information and evidence gathered from our engagement with delivery partner organisation engagement will not only further enhance our understanding of the existing system and its structures but

	also allow us to gather a range of perspectives on the current challenges, potential solutions and scope for potential system change. Post these meetings, follow up telephone discussions with representatives will be scheduled as necessary to gather any additional information or clarification that is identified to support stage 3.

3. Development of options for proposed structure

Key project activities	• Assembly of evidence base • Development of options and appraisal criteria • Appraisal of options • Expert 'confirm and challenge' input
Outputs	✓ Project briefing paper (3): - description of options for future structures and governance arrangements - appraisal of options, including key implementation enablers and challenges
Outcomes	✓ Expert input into development and testing of options ✓ Independent appraisal of robustness of options
Proposed time frame	Completed mid-November 2018
	Using the outcomes from the previous stages of work, options will be developed for a future structure for health informatics and the appropriate governance arrangements to support each option. 'Models' and 'systems' structures employed elsewhere in the UK and abroad will also inform thinking and options development. A set of appraisal criteria will be used as a framework within which to 'test' emerging options. This will include ensuring that: - the relevant recommendations from the Auditor General's report are taken into account - options are fit for purpose but retain any elements of flexibility required for future requirements.

4. Recommendations

Key project activities	• Report and recommendations drafting • Final meeting with project assurance group and presentation of recommendations
Outputs	✓ Final report and recommendations

Outcomes	✓ Independent recommendations for future structure and governance arrangements for health informatics
Proposed time frame	Completed mid-December 2018
	Through the development and 'testing' of options we will establish our recommendations going forward. We will present our recommendations in a final report and as a presentation. Membership of the meeting where we deliver our final report will be determined by the client. The final report will include an outline route map/plan for transitioning to any new proposed structure or governance arrangements.

An **outline project plan** is presented in Appendix A.

Project Team

The project will be undertaken by a core team with relevant skills and experience, supported by additional resources from within Local Partnerships as required. The team has experience of Welsh Government, the health sector, corporate governance, informatics and the approach utilised in other sectors.

The core project team will comprise:

- **Anne Jarrett, Project lead**
- **Jim Scopes**
- **Martin Dove**
- **Ian Brown**
- **David Harrison**

Pen portraits of our core team are provided in Appendix B.

Our wider team will include:

- **Val Knight** who, having spent 2 years working within Welsh Government leading the 21st Century Schools MIM programme has a thorough understanding of governance structures and requirements of Welsh Government
- **Julie McEver,** Deputy Corporate Director (Programmes and Projects) has a breadth of experience in supporting pubic bodies achieve fundamental change to the way public services are delivered.
- **Teresa Oliviere**, Head of legal, specialises in complex projects. Local Partnerships. She advises on all aspects of procurement, contracting and public administrative law.

APPENDIX A: OUTLINE PROJECT PLAN

Key project activities and deliverables	August		September				October					November				December
	20	27	3	10	17	24	01	08	15	22	29	05	12	19	26	
Project management																
Project start up meeting																
Review meeting 1																
Review meeting 2																
Final meeting and presentation																tbc
Project brief and plan																
Project briefing to delivery partner organisations (DPOs)																
Review of current governance landscape																
Information and evidence gathering																
Fact checking meetings																
Project briefing paper (1)																
Written questions for DPOs																
Engagement with DPOs																
Questions sent out																
Meetings with DPOs																
Follow up discussions																
Project briefing paper (2)																
Development of options																
Internal review and development workshops																
Assemble information and evidence																

Key project activities and deliverables	August		September				October					November				December
	20	27	3	10	17	24	01	08	15	22	29	05	12	19	26	
Development and appraisal of options																
Project briefing paper (3)																
Recommendations																
Final report																tbc

APPENDIX B: PROJECT TEAM

We propose to resource the assignment with a senior team of Local Partnerships professionals. Our core team is set out below along with their profiles. This team will be supported by additional specialist resource as required.

Anne Jarrett

Anne has worked extensively throughout her career with public service provision and particularly the health and social care sectors delivering projects with, and for, the NHS, central and local government and the third sector. The common focus has been to support the design and delivery of high quality, innovative services that are responsive to the needs of the user and maximise the value of public resources.

Anne brings a wide range of planning, analytical and communication skills to support the public service reform agenda. This includes service evaluation, options appraisal, business case development, performance and impact management, stakeholder engagement and the facilitation of collaborative working across agencies.

Anne has been with Local Partnerships since its inception in 2009 and is Strategic Director for Health and Social Care Integration. Her work in recent years has included:

- Supporting the development and sustainability of public service spin outs
- Increasing the commercial capability of third sector organisations, including "contract readiness"
- Co-management of the Department of Health's Social Enterprise Investment Fund (SEIF)
- Design and management of the Department of Health and Big Society Capital's Technology Spin-Out Fund
- Structure and governance of health and wellbeing boards
- Development of impact measurement and management systems
- Inter-agency planning for new systems of integrated health and social care
- Options appraisal for alternative service models.

Jim Scopes

Jim has over 30 years' experience within the public and private sectors as both a management consultant and civil servant. He has worked at the most senior levels in UK government on strategy development, policy implementation, change management, and programme / project management. Jim was a partner at PA Consulting working with a range of public sector clients (including DWP, Environment Agency and MoD and its agencies) before re-joining the civil service, where, as Strategy Director at HM Revenue and Customs he established the new strategy unit.

Jim's ability to forge strong relationships and build effective teams has delivered significant value to the clients and organisations for which he has worked. He has led organisational change programmes, designed and delivered new operating models / ways of working, developed and delivered assurance approaches for projects and programmes, as well as designing and implementing governance and associated reporting mechanisms. Jim's previous roles have included: Associate Director,

Sparknow Ltd. (a specialist change management consultancy); Programme Director, Assurance, Local Partnerships; Strategy Director at HMRC; and Partner in PA Consulting's Government and Public Services Practice.

Martin Dove

Martin has extensive public sector business change management and investment skills experience gained from working on the delivery of major programmes and projects. He is an experienced Assurance Reviewer and has reviewed infrastructure, facility and IT capital investment as well as mergers and acquisitions, outsourcing and shared services. He works for the Welsh Government assurance hub with reviews including the all Wales Pathology Laboratory Information Management System, Clinical Futures and the new Grange University Hospital, and the South Wales Programme. Martin has over 15 years' consultancy experience, including as Mott MacDonald's Director of UK Health and Social Care. He qualified as a Chartered Accountant with PwC, worked for CDC in Africa and Thailand and the NHS in capital programme management, resource allocation, outsourcing and as a Finance Director. He has worked as a Local Partnerships Associate for seven years.

Ian Brown

Ian has over 20 years' experience in health and central government, leading a number of major health and wider government programmes and reviews. Ian is also an accredited NHS Project Director and OGC Gateway High Risk Review Team Leader and has carried out over 200 assurance and other project specific work for clients including the Welsh Government, Cabinet Office and the Department of Health.

Ian's work includes:

- Leading various Major Projects Authority reviews on the Department of Health's Proton Beam Programme and Projects;
- Providing corporate services support to the Programme Director for a Mental Health Trust, managing a portfolio including a £80m PFI project and a team of over 25;
- Redeveloping health infrastructure, project initiation, business case development, benefits management, project management and commissioning within the health sector.
- Within the IT sector, Ian has worked on the NHS Digital – Paperless 2020 programme, DWP New State Pensions; the patient records EPR programme for NHS Wales, and IT assurance reviews for a number of public sector organisations.

David Harrison

David has worked extensively in the public and private sectors. He is a qualified chartered accountant and spent some years in investment banking before joining the public sector in the 1990s, where he became a senior civil servant (Dept of Health and HM Treasury) and, for 11 years from 1999, led the health practice of Partnerships UK (PUK).

In the summer of 2010, David left PUK and began working as an independent consultant. David works almost entirely "government-side". He continues to advise

into the health and well-being space. For some time, he has provided design and development advice to NHS England in respect of commissioning management (and informatics) support services provided to CCGs.

Most recently, at the beginning of 2018, David was commissioned by NHS England to assist in the design of the "10-Lot" *Health Support Services Framework* competition. This Framework provides access for NHS bodies and local authorities to services that can support the move to integrated models of care based on intelligence-led population health management, advanced analytics and digital and service transformation.

David acted as one of NHS England's principal quality and financial evaluators for bid submissions received from public, private and third-sector bodies seeking to gain access to this Framework. This Framework went live from August 2018 and David has been retained by NHS England to support early NHS adopters to activate the market and to run "mini-competitions" under the Framework.

As well as advisory support, David chairs Anglian Community Enterprise (ACE), a £60m turnover social enterprise spin-out from the NHS, which provides community health services, runs community hospitals and delivers health and well-being services. ACE also runs four GP practices, serving a population of circa 30,000.

David is a Trustee and Treasurer of User Voice, a charity led and delivered by ex-offenders. User Voice seeks to engage those who have experience of the criminal justice system in bringing about its reform and to reduce offending. User Voice is chaired by Noel Gordon, a non-executive director of NHS England and Chairman of NHS Digital.

WORK PROGRESS HIGHLIGHT REPORT: WCP	
Name of Meeting : IT&G Sub Committee	**Date of Meeting** 31st October 2018

Executive Lead : Executive Director of Therapies & Health Science
Author : National Programme Manager
Caring for People, Keeping People Well: This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy.
Financial impact: WG Funding has been provided until 31/03/19 only for Temporary Staff .
Quality, Safety, Patient Experience impact :
Health and Care Standard Number 3 & 4.2
CRAF Reference Number N/A
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

The Committee is asked to:

- **NOTE** the content of the update

SITUATION

The committee is asked to note this update report in relation to the implementation of the Welsh Clinical Portal in Cardiff and Vale UHB.

BACKGROUND

Cardiff and Vale University Health Board's successful implementation of the Welsh Clinical Portal (WCP) programme has moved at pace since 2015 with many active work streams which are either complete or nearing completion:

- Medicines Transcribing and e-Discharge(MTED)
- Welsh GP Record (WGPR)
- Welsh Patient e-Referral Service (WPRS)
- Electronic Pathology Test Requesting (ETR)
- Welsh Care Record Service (WCRS)
- Welsh Results Reports Service (WRRS)

The Welsh Clinical Portal is constantly evolving with new modules being provided by the NHS Wales Informatics Service to enhance the functionality available to our clinicians.

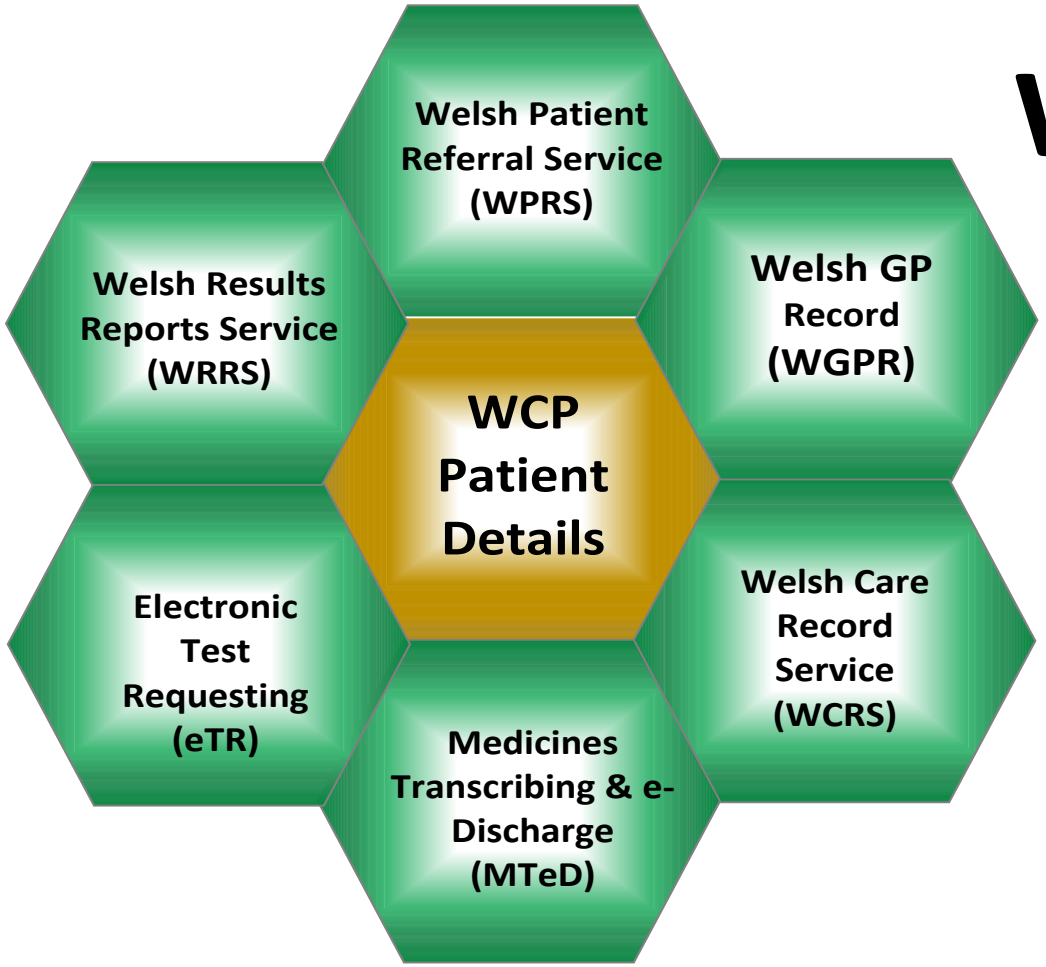
ASSESSMENT AND ASSURANCE

The future pace of delivery of the WCP into the health board is dependent on continued resource. The current funding provision does not extend beyond 31st March 2019. However the programme will continue to implement all modules of the WCP in line with the current plan.

A full status report of the current roll out plan for WCP and modules are attached as **appendix 1**

WCP_dashboard_181018.xlsx

APPENDIX 1

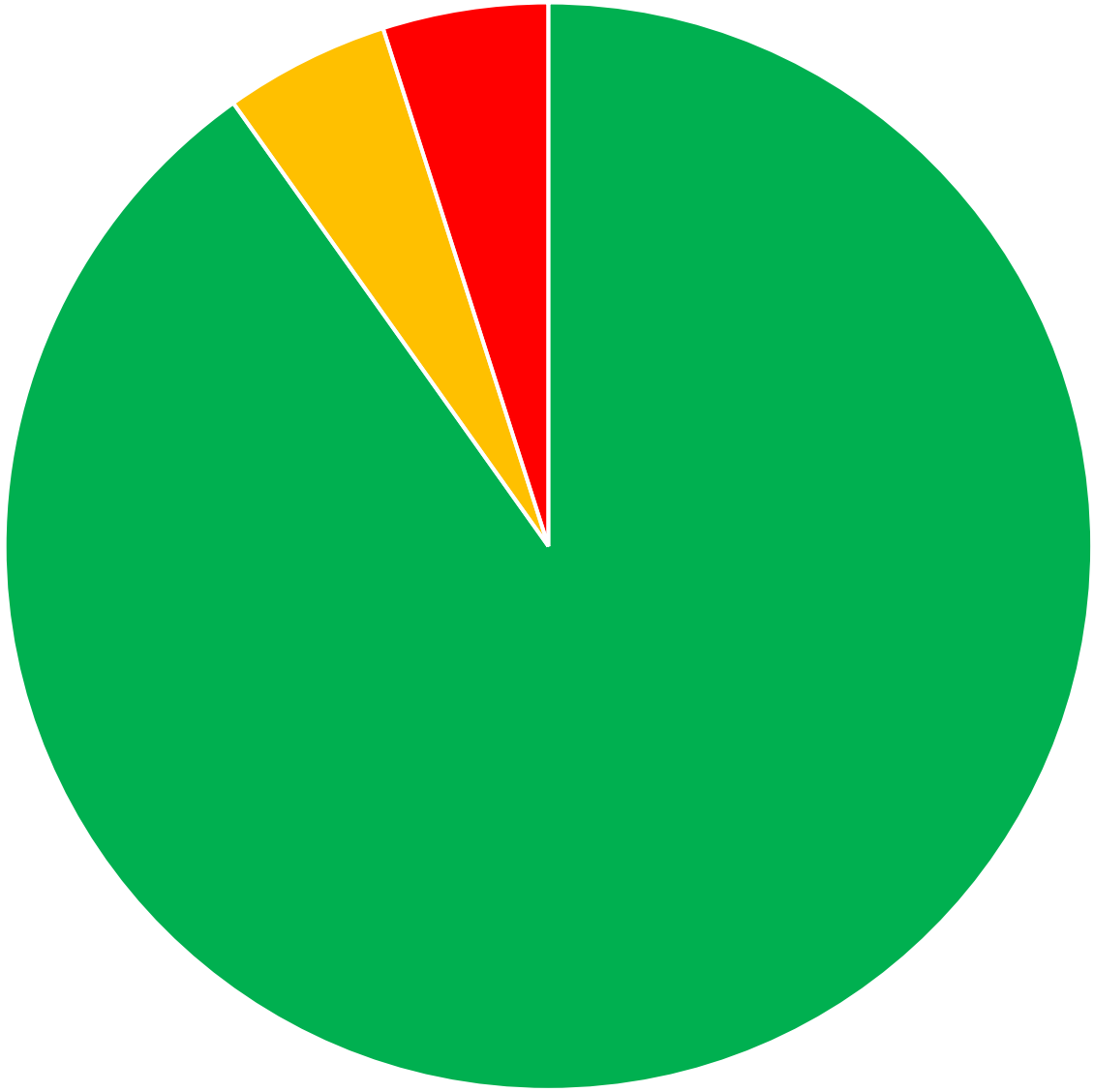


Welsh Clinical Portal

Future Enhancements

WPRS Specialities

Welsh Patient Referral Service (WPRS)

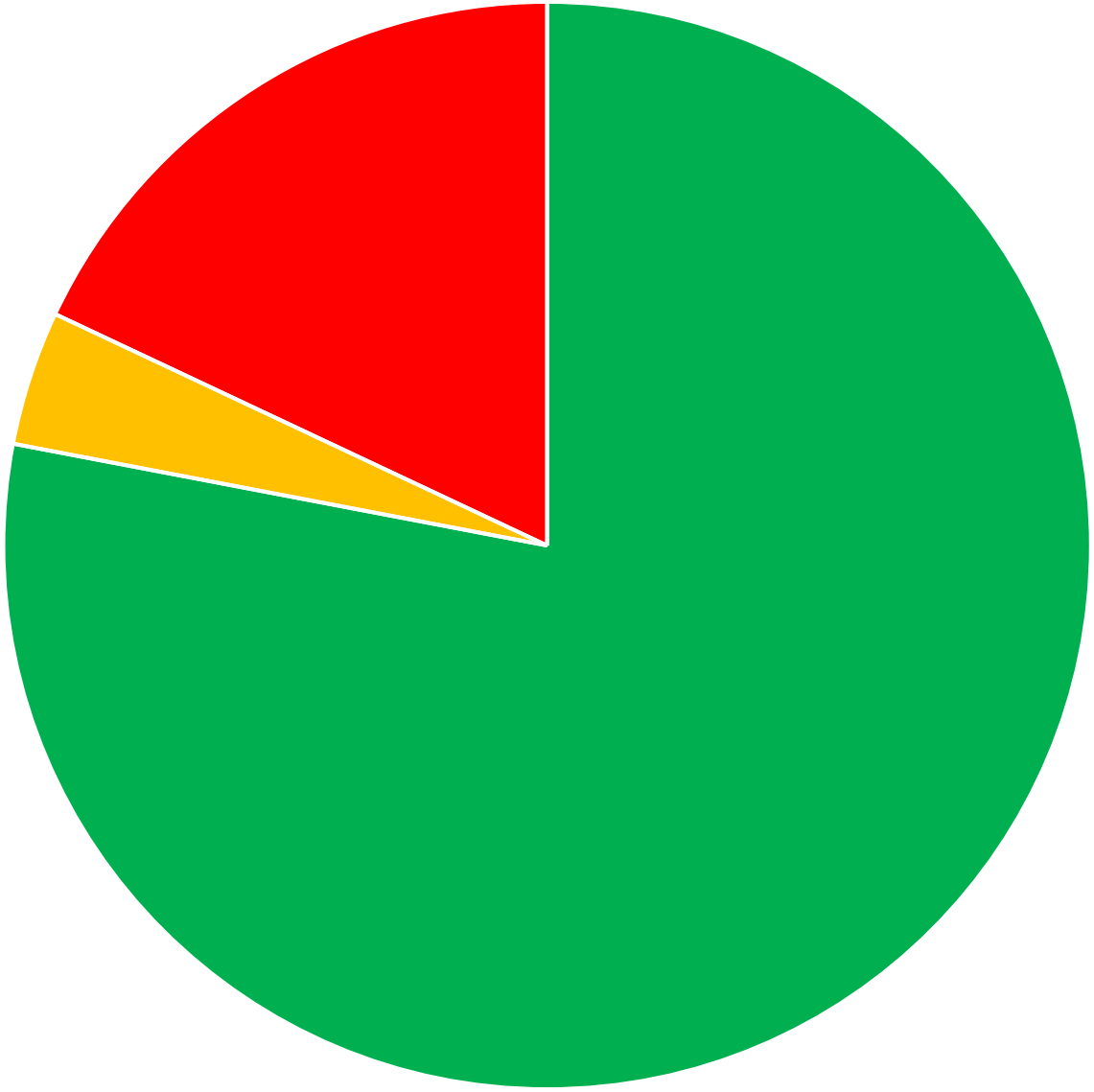


WPRS live Not live Out of scope

next page

MTeD Ward Status

Medicines Transcribing e-Transcribing (MTeD)



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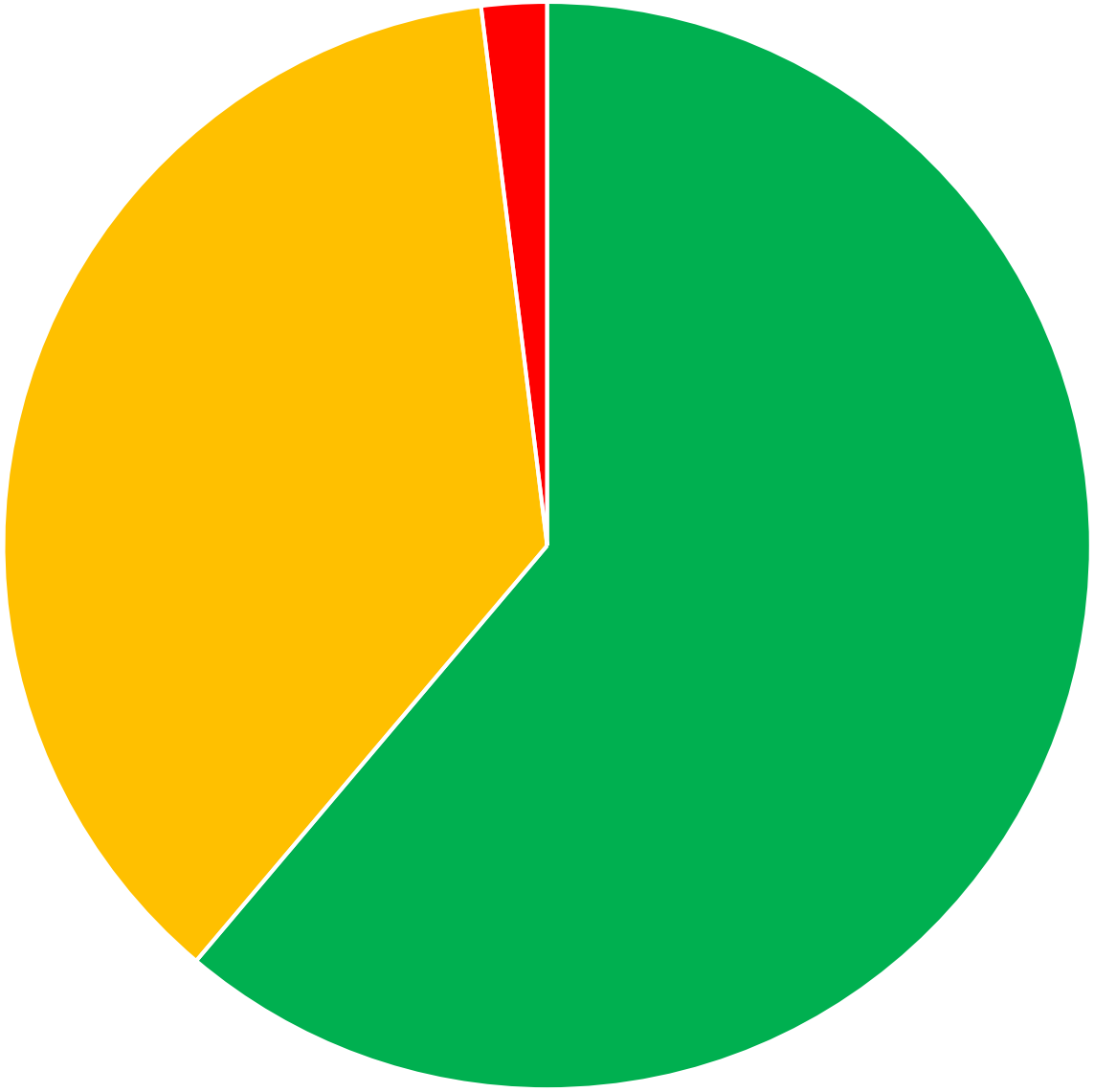
eTR Ward Status

Electronic Test Requesting (eTR)



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Welsh GP Record (WGPR)

The WGPR is not dependent on other modules of the WCP and therefore is available to all those specifically authorised from any PC in the Health Board

next page

Welsh Care Record Service (WCRS)

The WCRS is not dependent on other modules of the WCP and therefore is available to all those specifically authorised from any PC in the Health Board

next page

Welsh Results Reporting Service (WRRS)

The WRRS is not dependent on other modules of the WCP and therefore is available to all those specifically authorised from any PC in the Health Board

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Specialities live with WPRS

Service	System	Phase	Specialty
Surgery	PMS	1	Anaesthetics
Medicine	PMS	1	Bones : geri med
Surgery	PMS	1	Breast Service
Specialist Services	PMS	1	Cardiology
Medicine	PMS	1	Clinical Pharmacology
CD&T	D&T	2	CMATS
Surgery	PMS	1	Colorectal Surgery
Medicine	D&T	2	Complex Weight Management
Medicine	PMS	1	CRRU
Medicine	D&T	2	Day Hospitals
Medicine	PMS	1	Dermatology
Medicine	PMS	1	Diabetes
CD&T	D&T	2	Dietetics - Adult
Mental Health	PMS	1	Elderly Care Assessment Service (ECAS)
Medicine	PMS	1	Endocrinology
Medicine	PMS	1	Endoscopy : gen med
Surgery	PMS	1	ENT (Adult & children)
Surgery	PMS	1	ENT (Audiological Medicine)
Specialist Services	PMS	1	Epilepsy
Medicine	PMS	1	Falls : geri med
Women & Children	PMS	1	Fertility
Medicine	PMS	1	Gastroenterology
Medicine	PMS	1	General Medicine
Women & Children	PMS	1	General Paediatrics
Surgery	PMS	1	General Surgery
Medicine	PMS	1	Geriatric Medicine
Women & Children	PMS	1	Gynae Oncology
Women & Children	PMS	1	Gynaecology
Specialist Services	PMS	1	Haematology
Medicine	PMS	1	Heart failure : geri med
Medicine	PMS	1	Infectious Disease : gen med
Medicine	PMS	1	LIPID Clinic
Medicine	PMS	1	Lipids : gen med
Medicine	PMS	1	Memory : geri med
Medicine	PMS	1	Nephrology
Specialist Services	PMS	1	Neurology

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WPRS live	55
Not live	3
Out of Scope	3

Specialist Services	D&T	2	Neuro-physiology
Specialist Services	PMS	1	Neurosurgery
CD&T	D&T	2	Occupational - Hand
Dental	PMS	1	Oral Medicine
Dental	PMS	1	Oral Surgery
Women & Children	PMS	1	Paediatric Cardiology
Women & Children	PMS	1	Paediatric Endocrinology
Women & Children	PMS	1	Paediatric Gastroenterology
Women & Children	PMS	1	Paediatric Rheumatology
Women & Children	PMS	1	Paediatric Surgery
Medicine	PMS	1	Parkinson's Service
CD&T	D&T	2	Physio Neurology
CD&T	D&T	2	Physio Women's Health
CD&T	D&T	2	Physiotherapy
Medicine	PMS	1	Rheumatology
CD&T	D&T	2	Speech & Language
Medicine	PMS	1	Stroke : geri med
Surgery	PMS	1	T&O: Feet/ ankle
Surgery	PMS	1	T&O: Hands
Surgery	PMS	1	T&O: Hips
Surgery	PMS, D&T	2	T&O: Knee
Surgery	PMS	1	T&O: Paediatrics
Surgery	PMS, D&T	2	T&O: Shoulder
Surgery	PMS, D&T	2	T&O: Spine
Medicine	D&T	2	TB Service
Medicine	PMS	1	Thoracic Medicine
Medicine	PMS	1	Thyroid : gen med
Surgery	PMS	1	Urology
Surgery	PMS	1	Vascular Surgery

Specialities not live with WPRS

Service	System	Phase	Specialty	comments
Specialist Services	PMS	1	Clinical Immunology & Allergy	Waiting on additional functionality within WAP
Surgery	PMS	1	Ophthalmology	£23K required for Optom practices is CAV to be enabled with e-Ad&Comm to send referrals. Only 15/57 practices enabled.
Surgery	PMS	1	Orthoptic Clinic	

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Welsh Patient Referral Service (WPRS) : Specialties out of scope

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Clinical Board	PAS	Speciality	Exclusion Period	Reason
INTEGRATED MEDICINE DIRECTORATE	D&T	Lung Function	Temporary	Referrals are managed in WAP as majority of GP referrals are redirected from acute specialities. To move team to WCP would mean referrals are double-handled and introduce a larger workload which is not beneficial. Waiting on H2H
CD&T	D&T	Lymphoedema - Physio	Temporary	Waiting on H2H - only 30% GP referrals received - complex referral pathway
INTEGRATED MEDICINE DIRECTORATE	D&T	Smoking Cessastion	Temporary	Waiting on H2H -small number of GP referrals received - agreed ISEC 27/09/18

Future scope considerations - Welsh Patient Referral Service (WPRS)

Clinical Board	PAS	Speciality		
N/a	Myrddin	Child & Adolescent Psychiatry	Permanent	Managed by St. David's/ Llandough but in Myrddin
N/a	Stand Alone	Clinical Genetics	Permanent	use standalone system
CLINICAL ONCOLOGY	PMS	Clinical Oncology	Permanent	Christine Atkinson advised that they do not receive GP referrals (Meeting, 01/08/16)
INTENSIVE CARE MEDICINE	N/a	Critical Care	Permanent	Orla advised that Critical care would not use the system for GP referrals (20/07). Queried if they may use in the future for internal/ tertiary referrals (26/07)
INTEGRATED MEDICINE DIRECTORATE	D&T	Fracture Liaison	Permanent	The Fracture Liaison clinics do not accept referrals from GP's. Our patients are selected by the Fracture Liaison Nurses from lists of patients who have suffered fractures.
N/a	Stand Alone	Genito Urinary Medicine/ DoSH	Permanent	Use standalone system
OBSTETRICS & GYNAECOLOGY DIRECTORATE	D&T	GYNAE - URODYNAMICS	Permanent	Update following meeting with Jane Marsh & Lewis Whitehorn: Don't get direct GP referrals, patient will always see a consultant first, who would then internally refer onto Urodynamics
Children & women	PMS	Midwifer Counselling	Permanent	Jane Marsh: Obstetric activity therefore referrals are not sent from their GP
Children & women	PMS	OBST Foetal Medicine	Permanent	Jane Marsh: Obstetric activity therefore referrals are not sent from their GP
Children & women	PMS	Obstetrics	Permanent	Jane Marsh: Do not receive GP referrals
OPHTHALMOLOGY & ENT DIRECTORATE	PMS	OPHT-CASUALTY	Permanent	Don't receive GP referrals
DENTAL HOSPITAL DIRECTORATE	PMS	ORAL SURGERY NURSE	Permanent	Eira Yassien advised that nurses do not receive GP referrals
OPHTHALMOLOGY & ENT DIRECTORATE	PMS	ORTHOPTIC DEPARTMENT	Permanent	Covered as Orthoptic clinic
Children & women	PMS	PAEDIATRIC CYSTIC FIBROSIS	Permanent	Sue John advised they do not receive GP referrals (06/10/16)
Children & women	PMS	PAEDIATRIC DIABETES	Permanent	Sue John advised that these will be put on to Prof Gregory's existing list (06/10/)
Children & women	PMS	PAEDIATRIC METABOLIC MEDICINE	Permanent	Sue John advised they do not receive GP referrals (06/10/16)
Children & women	PMS	PAEDIATRIC NEONATOLOGY	Permanent	Sue John advised they do not receive GP referrals (06/10/16)
Children & women	PMS	PAEDIATRIC NEUROLOGY	Permanent	Sue John advised that Neurology do not accept GP referrals (06/10/16)
Children & women	PMS	PAEDIATRIC SURGERY URODYNAMICS	Permanent	Sue John advised they do not receive GP referrals (06/10/16)
CHILD HEALTH DIRECTORATE	D&T	PAEDIATRIC URODYNAMICS	Permanent	Update following meeting with Diane Rogers & Alicia Williams: Don't get direct GP ref's. Consultants in Surgery & Urology redirect referrals for Urodynamic tests sometimes so this will be picked up as part of PMS go live for these specialities & will be handled as a redirect list
CHILD HEALTH DIRECTORATE	D&T	PAEDS RESPIRATORY PHYSIOLOGY	Permanent	Update following meeting with Diane Roegers & Alicia Williams: Don't get direct GP ref's. Consultants in Respiratory redirect referrals for respiratory physiology (Sleep study) sometimes so this will be picked up as part of PMS go live for these specialities & will be handled as a redirect list
N/a	N/a	Palliative Medicine	Permanent	Managed by Velindre
DENTAL HOSPITAL DIRECTORATE	PMS	PARENT ORTHODONTICS	Permanent	Eira & Debbie advised that Orthodontic referrals can only be made by dentists & not GP's
N/a		*Plastic Surgery*	*Permanent*	*Managed by Morriston (Option in WCCG is under ABMU)*
DIRECTORATE OF CLINICAL GERONTOLOGY	PMS	Rehabilitation	Permanent	Hannah Mastafa advised that Rehab will not need a separate go live, it is made up of the sub specialities within Geri Med e.g. Stroke, Heart Failure etc
N/a	N/a	Sickle Cell & Thalassemia	Permanent	Managed in Butetown Health Centre, get printed and posted
Children & women	PMS	Teenager Cancer Trust Unit	Permanent	Hayley advised that her team do not send any GP referrals to TCT (25/10)
N/a	N/a	Vasectomy	Permanent	Managed by Ashgrove Surgery (Option in WCCG is under Cwm Taf)
Children & women	PMS	Well Baby	Permanent	Jane Marsh: WB is for recording purposes when babies are born in the hospital

Wards live with MTeD

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Clinical Board	Wards
Specialist Services & Surgical Services	A1 LINK (OESOPHAG0-GASTRO UNIT)
Surgical, Medicine, Specialist & Dental Services	A5 NORTH (HEAD AND NECK)
Surgical Services	A5 SOUTH (UROLOGY)
Medicine Services	A6 SOUTH (Stroke ward)
Medicine Services	A7 MEDICAL
Surgical Services	ANWEN WARD LLANDOUGH
Medicine & Specialist Services	B7 THORACIC MEDICINE WARD
Surgical Services	BETHAN WARD T&O
Specialist Services	BONE MARROW TRANSPLANT UNIT (Sub ward to B4H Haematology)
Specialist Services	C4 NEUROLOGY P.I.B (Day Case)
Specialist Services	CARDIAC DAY CASE UNIT UHW
Specialist Services	CARDIFF TRANSPLANT UNIT (T5)
Specialist Services	CARDIOLOGY Ward C3
Medicine & Specialist Services	CARDIOTHORACIC ITU (Ward T3)
Surgical Services	CAVOC (CHARLES RADCLIFFE (CRAD) WARD 1ST FLOOR LLANDOUGH
Specialist Services	CORONARY CARE UNIT- UHW (CCU) (C3 South - also houses Pacing Theatre)
Specialist Services	CRITICAL CARE DIRECTORATE ITU (A3N & B3S) & HDU (A3S)
Medicine Services	CYSTIC FIBROSIS UNIT LLANDOUGH
Surgical Services	DUTHIE WARD
Medicine	EAST 1 WARD
Medicine Services	EAST 2 WARD LLANDOUGH
Medicine Services	EAST 4 WARD LLANDOUGH
Medicine Services	EAST 6 WARD LLANDOUGH
Medicine Services	EAST EIGHT WARD LLANDOUGH
Medicine Services	EAST SEVEN WARD LLANDOUGH
Medicine Services	ELIZABETH (was HAMADRYAD) WARD ST DAVID'S
Medicine Services	ENHANCED CARE UNIT LLANDOUGH
Children & Women, Specialist & Surgical Services	GWDIHW WARD - INPATIENT UHW PAEDIATRIC SHORT STAY UNIT (OWL WARD)
Children & Women & Surgical Services	GWDIHW Ward DAYCASE
Medicine Services	GWENWYN (POISONS) WARD LLANDOUGH
Specialist Services	HAEMATOLOGY DAY UNIT UHW
Surgical & Medicine Services	HEULWEN WARD
Medicine Services	INFUSION ROOM LLANDOUGH (IBD)
Specialist Services	INTENSIVE CARE UNIT (ICU) LLANDOUGH
Children & Women Services	ISLAND WARD, CHILDREN'S HOSP
Children & Women & Surgical Services	JUNGLE WARD, CHILDREN'S HOSP

Medicine Services	LANSDOWNE UNIT WARD ST DAVID'S
Medicine Services	MEDICAL DECISIONS WARD (A1 SOUTH) (MDU)
Mental Health Services	MEDICAL EMERGENCY ASSESSMENT UNIT LLANDOUGH (MEAU)
Children & Women Services	MIDWIFERY LED UNIT UHW (Part of First Floor Maternity)
Children & Women Services	PAEDIATRIC CRITICAL CARE UNIT (PCCU High Dep)
Children & Women Services	PAEDIATRIC CRITICAL CARE INTENSIVE CARE UHW (PICU)
Children & Women Services	PELICAN WARD, CHILDREN'S HOSP
Specialist & Surgical Services	POST ANAESTHETIC CARE UNIT (HDU) (PACU) Ward B3 North
Children & Women Services	RAINBOW WARD, CHILDREN'S HOSP
Medicine Services	SAM DAVIES WARD BARRY
Children & Women Services	SEAHORSE WARD (CHILDRENS ASSESSMENT UNIT (CAU)
Surgical Services	SHORT STAY SURGICAL UNIT (SSSU)
Children & Women & Specialist Services	SPECIAL CARE BABY UNIT (SCBU)
Medicine Services	STROKE REHABILITATION CENTRE, LLANDOUGH
Specialist Services	TEENAGE CANCER TRUST UNIT (TCT)
Medicine, Specialist & Surgical Services	WARD A1 NORTH (MED SHORT STAY)
Surgical & Medicine Services	WARD A2
Surgical Services	WARD A3 LINK
Medicine Services	Ward A4
Specialist, Surgical & Medicine Services	WARD B1 (Cardiology)
Surgical & Medicine Services	WARD B2 VASCULAR
Specialist Services	WARD B4 HAEMATOLOGY
Specialist Services	WARD B4N NEUROSURGERY
Specialist Services	WARD B5 NEPHROLOGY
Surgical Services	WARD B6
Children & Women & Surgical Services	WARD C1 GYNAECOLOGY
Specialist & Medicine Services	WARD C4 NEUROLOGY
Specialist Services	WARD C5 CARDIAC SURGERY
Medicine Services	WARD C6
Medicine Services	WARD C7N MEDICAL
Medicine Services	WARD C7S MEDICAL
Surgical & Medicine Services	WARD T2 (Winter Pressures ward)
Specialist Services	WARD T4 NEUROSURGERY HIGHCARE WARD
Specialist Services	WD5 ROOKWOOD
Specialist & Medicine Services	WD7 ROOKWOOD
Surgical Services	WELSH CENTRE FOR SPINAL SURGERY & TRAUMA (A6N)
Medicine Services	WEST 1 WARD LLANDOUGH
Medicine Services	WEST 2 WARD LLANDOUGH
Medicine Services	WEST 3 (DENYS) WARD (Winter Pressures)

Surgical Services	WEST 4 ORTHOPAEDICS LLANDOUGH
Surgical Services	WEST 5 WARD, LLANDOUGH
Medicine Services	WEST 6 WARD LLANDOUGH
	Total = 78

MTeD live	78
Not live	4
Out of Scope	18

Wards not live with MTeD

Clinical Board	Ward	comments
Specialist Services	HAEMATOLOGY DAY CASES LLANDOUGH	Awaiting real time admissions process
Medicine Services	DERMATOLOGY TREATMENT CENTRE UHW	Awaiting real time admissions process
Children & Women Services	FIRST FLOOR MATERNITY UHW (North, East & West)	Awaiting Medication Order Sets
Children & Women Services	PAEDIATRIC CLINICAL INVESTIGATIONS UNIT (PCIU)	Awaiting real time admissions process

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MTeD - Wards Out of Scope

Clinical Board	Wards Not In Scope	Exclusion Period	Reason
Specialist Services	ARTHUR BLOOM DAY UNIT	Temp	Patients attend as day attenders and are not admitted
Medicine Services	B7 ENDOCRINOLOGY	Temp	Ward inactive
Medicine Services	C7 ENDOCRINOLOGY	Temp	Ward inactive
Surgical Services	DAY ROOM SURGICAL SHORT STAY UNIT	Perm	Patients not discharged from this temporary holding area
Medicine Services	DAY UNIT ROOKWOOD	Temp	Patients attend as day attenders and are not admitted
Medicine, Children & Women Services	DELIVERY SUITE UHW	Perm	Patients not discharged from this temporary holding area
Dental Services	DENTAL HOSPITAL FICTICIOUS BED	Perm	Patients not discharged from this area
Medicine Services	DERMATOLOGY DAY CASES LLANDOUGH	Perm	Patients admitted retrospectively
Medicine Services	ECAS ASSESSMENT WARD ROOKWOOD	Temp	Patients attend as day attenders and are not admitted
Medicine Services	ENDOSCOPY SUITE LLANDOUGH	Perm	Dr Jeff Turner believes these patients do not need a Discharge Advice Letter
Medicine & Surgical Services	ENDOSCOPY UNIT UHW	Perm	Dr Jeff Turner believes these patients do not need a Discharge Advice Letter
Children & Women Services	GYNAE FERTILITY DAY CASES	Temp	Patients attend as day attenders and are not admitted
Children & Women Services	GYNAECOLOGY DAY CASES LLANDOUGH	Temp	This unit is part of Surgical Day Unit but may become a stand alone unit
Specialist Services	HOME VISIT HAEMATOLOGY	Perm	Patients not discharged from this area
Medicine Services	RHEUMATOLOGY DAY UNIT UHW	Perm	'Cellma' in house documentation system in use
Surgical, Children & Women Services	SURGICAL DAY UNIT LLANDOUGH	Perm	'TheatreMan' in house documentation system in use
Surgical Services	THEATRE ADMISSIONS LOUNGE	Perm	Patients not discharged from this temporary holding area
Surgical Services	THEATRE DEATHS WARD	Perm	Patients not discharged from this area

Wards live with eTR

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Clinical Board	Wards
Specialist Services &Surgical Services	A1 LINK (OESOPHAG0-GASTRO UNIT)
Surgical, Medicine, Specialist & Dental Services	A5 NORTH (HEAD AND NECK)
Surgical Services	A5 SOUTH (UROLOGY)
Medicine Services	A6 SOUTH (Stroke ward)
Medicine Services	A7 MEDICAL
Medicine & Specialist Services	B7 THORACIC MEDICINE WARD
Surgical Services	BETHAN WARD T&O
Specialist Services	BONE MARROW TRANSPLANT UNIT (Sub ward to B4H Haematology)
Specialist Services	C4 NEUROLOGY P.I.B (Day Case)
Specialist Services	CARDIAC DAY CASE UNIT UHW
Specialist Services	CARDIFF TRANSPLANT UNIT (T5)
Specialist Services	CARDIOLOGY Ward C3
Surgical Services	CAVOC (CHARLES RADCLIFFE (CRAD) WARD 1ST FLOOR LLANDOUGH
Specialist Services	CORONARY CARE UNIT- UHW (CCU) (C3 South - also houses Pacing Theatre)
Specialist Services	CRITICAL CARE DIRECTORATE ITU (A3N & B3S) & HDU (A3S)
Medicine Services	CYSTIC FIBROSIS UNIT LLANDOUGH
Surgical Services	DAY ROOM SURGICAL SHORT STAY UNIT (No discharges)
Surgical Services	DUTHIE WARD
Medicine	EAST 1 WARD
Medicine Services	EAST 2 WARD LLANDOUGH
Medicine Services	EAST 4 WARD LLANDOUGH
Medicine Services	EAST 6 WARD LLANDOUGH
Medicine Services	EAST EIGHT WARD LLANDOUGH
Medicine Services	EAST SEVEN WARD LLANDOUGH
Medicine Services	ELIZABETH (was HAMADRYAD) WARD ST DAVID'S
Medicine Services	ENHANCED CARE UNIT LLANDOUGH
Medicine Services	GWENWYN (POISONS) WARD LLANDOUGH
Specialist Services	HAEMATOLOGY DAY UNIT UHW
Surgical & Medicine Services	HEULWEN WARD
Specialist Services	INTENSIVE CARE UNIT (ICU) LLANDOUGH
Medicine Services	LANSDOWNE UNIT WARD ST DAVID'S
Medicine Services	MEDICAL DECISIONS WARD (A1 SOUTH) (MDU)
Mental Health Services	MEDICAL EMERGENCY ASSESSMENT UNIT LLANDOUGH (MEAU)
Specialist & Surgical Services	POST ANAESTHETIC CARE UNIT (HDU) (PACU) Ward B3 North
Medicine Services	SAM DAVIES WARD BARRY
Children & Women Services	SEAHORSE WARD (CHILDRENS ASSESSMENT UNIT (CAU)

Medicine Services	STROKE REHABILITATION CENTRE, LLANDOUGH
Specialist Services	TEENAGE CANCER TRUST UNIT (TCT)
Medicine, Specialist & Surgical Services	WARD A1 NORTH (MED SHORT STAY)
Surgical & Medicine Services	WARD A2
Surgical Services	WARD A3 LINK
Medicine Services	Ward A4
Specialist, Surgical & Medicine Services	WARD B1 (Cardiology)
Surgical & Medicine Services	WARD B2 VASCULAR
Specialist Services	WARD B4 HAEMATOLOGY
Specialist Services	WARD B4N NEUROSURGERY
Specialist Services	WARD B5 NEPHROLOGY
Surgical Services	WARD B6
Children & Women & Surgical Services	WARD C1 GYNAECOLOGY
Specialist & Medicine Services	WARD C4 NEUROLOGY
Specialist Services	WARD C5 CARDIAC SURGERY
Medicine Services	WARD C6
Medicine Services	WARD C7N MEDICAL
Medicine Services	WARD C7S MEDICAL
Specialist Services	WARD T4 NEUROSURGERY HIGHCARE WARD
Specialist Services	WD5 ROOKWOOD
Specialist & Medicine Services	WD7 ROOKWOOD
Surgical Services	WELSH CENTRE FOR SPINAL SURGERY & TRAUMA (A6N)
Medicine Services	WEST 1 WARD LLANDOUGH
Medicine Services	WEST 2 WARD LLANDOUGH
Surgical Services	WEST 4 ORTHOPAEDICS LLANDOUGH
Surgical Services	WEST 5 WARD, LLANDOUGH
Medicine Services	WEST 6 WARD LLANDOUGH

eTR live	63
Not live	38
Out of Scope	2

Wards not live with eTR

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Clinical Board	Ward	Comment
Surgical Services	ANWEN WARD LLANDOUGH	Engagement Required to deploy e-TR
Specialist Services	ARTHUR BLOOM DAY UNIT (Outpatients)	Unit does not currently want to use e-TR
Medicine & Specialist Services	CARDIOTHORACIC ITU (Ward T3)	Engagement Required to deploy e-TR
Medicine Services	DAY UNIT ROOKWOOD (Outpatients)	Engagement Required to deploy e-TR
Medicine, Children & Women Services	DELIVERY SUITE UHW (No discharges)	Engagement Required to deploy e-TR
Dental Services	DENTAL HOSPITAL	Engagement Required to deploy e-TR
Medicine Services	DERMATOLOGY DAY CASES LLANDOUGH (Outpatients)	Engagement Required to deploy e-TR
Medicine Services	DERMATOLOGY TREATMENT CENTRE UHW	Engagement Required to deploy e-TR
Medicine Services	ECAS ASSESSMENT WARD ROOKWOOD (Outpatients)	Engagement Required to deploy e-TR
Medicine Services	ENDOSCOPY SUITE LLANDOUGH	Engagement Required to deploy e-TR
Medicine & Surgical Services	ENDOSCOPY UNIT UHW	Engagement Required to deploy e-TR
Medicine Services	EMERGENCY UNIT	Engagement Required to deploy e-TR
Children & Women Services	FIRST FLOOR MATERNITY UHW (North, East & West)	Engagement Required to deploy e-TR
Children & Women, Specialist & Surgical Services	GWDIHW WARD - INPATIENT UHW PAEDIATRIC SHORT STAY UNIT (OWL WARD)	Pathology issue with analyser - awaiting resolution
Children & Women Services & Surgical Services	GWDIHW Ward DAYCASE	Pathology issue with analyser - awaiting resolution
Children & Women Services	GYNAE FERTILITY DAY CASES (Outpatients)	Engagement Required to deploy e-TR
Children & Women Services	GYNAECOLOGY DAY CASES LLANDOUGH (This unit is part of Surgical Day Unit)	Engagement Required to deploy e-TR
Specialist Services	HAEMATOLOGY DAY CASES LLANDOUGH	Engagement Required to deploy e-TR
Specialist Services	HOME VISIT HAEMATOLOGY (Outpatients)	Engagement Required to deploy e-TR
Medicine Services	INFUSION ROOM LLANDOUGH (IBD)	Engagement Required to deploy e-TR
Children & Women Services	ISLAND WARD, CHILDREN'S HOSP	Pathology issue with analyser - awaiting resolution
Children & Women & Surgical Services	JUNGLE WARD, CHILDREN'S HOSP	Pathology issue with analyser - awaiting resolution
Medicine Services	MEDICAL ASSESSMENT UNIT	Engagement Required to deploy e-TR
Medicine Services	MEDICAL DECISIONS UNIT	Engagement Required to deploy e-TR
Children & Women Services	MIDWIFERY LED UNIT UHW (Part of First Floor Maternity)	Engagement Required to deploy e-TR
Children & Women Services	PAEDIATRIC CLINICAL INVESTIGATIONS UNIT (PCIU)	Pathology issue with analyser - awaiting resolution
Children & Women Services	PAEDIATRIC CRITICAL CARE UNIT (PCCU High Dep)	Pathology issue with analyser - awaiting resolution
Children & Women Services	PAEDIATRIC CRITICAL CARE INTENSIVE CARE UHW (PICU)	Pathology issue with analyser - awaiting resolution
Children & Women Services	PELICAN WARD, CHILDREN'S HOSP	Pathology issue with analyser - awaiting resolution
Children & Women Services	RAINBOW WARD, CHILDREN'S HOSP	Pathology issue with analyser - awaiting resolution
Medicine Services	RHEUMATOLOGY DAY UNIT UHW	Engagement Required to deploy e-TR
Surgical Services	SHORT STAY SURGICAL UNIT (SSSU)	Engagement Required to deploy e-TR
Children & Women & Specialist Services	SPECIAL CARE BABY UNIT (SCBU)	Engagement Required to deploy e-TR
Surgical, Children & Women Services	SURGICAL DAY UNIT LLANDOUGH	Engagement Required to deploy e-TR
Surgical Services	THEATRE ADMISSIONS LOUNGE (No discharges)	Engagement Required to deploy e-TR
Surgical Services	THEATRE DEATHS WARD (No discharges)	Engagement Required to deploy e-TR
Surgical & Medicine Services	WARD T2 (Winter Pressures ward)	Engagement Required to deploy e-TR
Medicine Services	WEST 3 (DENYS) WARD (Winter Pressures)	Engagement Required to deploy e-TR

eTR - Wards Out of Scope

Clinical Board	Wards Not In Scope	Comments
Medicine Services	B7 ENDOCRINOLOGY (Not used)	Ward inactive
Medicine Services	C7 ENDOCRINOLOGY (not used - Non-MTeD Ward)	Ward inactive

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WCP Programme Highlight Report

Pro	Welsh Clinical Portal	Report End Period :	01/09/2018	Status / Trend :	↔
	12/5/2012	Project End :	Ongoing	Sponsor :	Fiona Jenkins
		Clinical Lead :	Allan Wardhaugh	Programme Manager	Jo Brooks
		Finance Lead :	Chris Lewis		

Project Summary

The purpose of this dashboard is to set out the milestones associated with the implementation of the Welsh Clinical Portal in Cardiff and Vale UHB. WCP was first implemented on 5th December 2012 when the Medicines Transcribing and E-Discharge was introduced to the health board. MTED was jointly developed by the UHB and NWIS. Further modules have followed. The programme is ongoing with new functionality being introduced in approximately 3 releases per year.

NOTES:

• Specialities in black text on the Milestone Summary are confirmed, specialties in red are planned. As the below is a high level plan for full roll out, the order in which specialities go live may be subject to change.

Recent Achievements:	Next steps and activities:	Project Status: AMBER
1) WPRS - Overall - 65/68 = 95.6% . Phase 1 PMS specialties (51/54) - 94.4% complete. Phase 2 D&T specialties (14/14) - 100% complete. 2) MTED - Phase 1 100% complete - 72 In Patient wards are live. Phase 2 36% complete with 6 wards/day units live (incl Marie Curie hospice). Phase 3 Mental Health wards post PARIS/WCP integration 3) Electronic Pathology Test Requesting - (59 inpatient Ward and 18 Inpatient Clinics (not every clinic is using e-TR there are small pilots in progress) 4) Live with Welsh Results and Reports Service - across the whole HB 5) Live with Welsh Care Record Service - across the whole HB 6) Live with Welsh GP Record - across the whole HB	WPRS - Work with health visitors to allow them to generate e-refs using e-Ad&Comm into WPRS. Work with PARIS teams to allow them access to WAP to enable them to pick up referrals electronically. MTED - Continue rollout to Day Case Units and Assessment Units. Roll out to Mental Health wards once WCP to PARIS integration is in place ETR - Considering soft mandation approach while waiting for system improvements. Also assessing UI, business continuity arrangements and any technical obstacles to mandation. WGPR - Rollout to community and therapies staff, OOH clinicians	**Cause** (if project status is amber or red, please detail the reason): N/A **Mitigation** (if project status is amber or red, please detail planned mitigations/recovery plans): N/A

Milestone / Significant Task	Expected milestone start date	Actual milestone start date	Completion date	Actual Delivery Dates (RAG rated)																	
				Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19
Alerts & Results Notifications Pilot	Nov-18																				
Alerts & Results Notifications Sign Off	TBC																				
Cardiology Requesting	TBC																				
CAV Convergence Plan developments		Apr-17																			
CAV Radiology Results	Nov-18																				
eForms (Hep C Form Pilot)	Jul-17	Jul-17	Mar-18																		
eTR - Pilot	Nov-15	Nov-15	May-16																		
eTR - InPatient Wards Phase 1	May-16	May-16	Jun-18																		
eTR - InPatient Wards Phase 2 (Paeds, Maternity, A&E)	Jul-18	Jul-18																			
e-TR -Outpatient Patient - proof of concept	Oct-17	Oct-17	Dec-17																		
eTR - Outpatients UHL	Jul-18	Jul-18																			
eTR - Outpatients UHW pilot	Mar-18	Mar-18																			
eTR eform Transfer and redesign	May-19																				
GPTR Pilot	Nov-18																				
GPTR	April -19																				
MTED BETA	Jan-12	Dec-12	Aug-13																		
MTED Phase 1 - Pilot	Jul-12	Aug-13	Sep-14																		
MTED Phase 1 - In Patient Wards	Apr-15	Apr-15	Mar-17																		
MTED Phase 2 - Day & Assessment Unts	Apr-17	May-17																			
MTED DAL on Demand	May-17	May-18	May-18																		
PACS Viewing	TBC																				
Phlebotomy module	TBC																				
Radiology eRequesting - Phase 1	TBC																				

Radiology eRequesting - Phase 2	TBC																					
WCP Core Module & Results Reporting	Jul-12	Mar-17	Complete																			
WCRS Backload	May-16	Dec-16	Complete																			
WCRS Document Upload and Notify to GP	Aug-19																					
WCRS Live	Dec-16	Dec-17	Complete																			
Welsh GP Record Pilot	Feb-14	Oct-16	Complete																			
Welsh GP Record live	Dec-17	Dec-17	Complete																			
WPRS phase 1 - Pilot - PMS	Mar-15	Mar-15	Complete																			
WPRS phase 1 - PMS Specialties	Nov-15	Nov-15	3 to complete																			
WPRS phase 2 - D&T Specialties	Jun-17	Jun-17	Sep-17																			
WPRS phase 2 - Pilot - D&T	May-17	Jun-17	Complete																			
WPRS phase 3 - Pilot - Hospital 2 Hospital (H2H)	Dec-18																					
WPRS phase 3 - Hospital 2 Hospital (H2H)	Apr-19																					
Wristband Printing Integration Service	Mar-19																					
WRRS Backload	Jan-15	Jan 16	Complete																			
WRRS Live	Feb-17	Mar-17	Mar-17																			

Key Delivery Risks / Issues	Mitigating Actions	Likelihood (1-5)	Impact (1-5)	RAG
UHB IM&T Dept Resource- There is a significant risk that funding will not be available to support the WCP programme going forward. Background: Significant resource is required to support the implementation of the Welsh Clinical Portal into Cardiff and Vale UHB - resource is required from the development team, project management, business change and implementation, testing, training helpdesk, server team, IG, PARIS team. The implementation of WCP impacts the whole department. The UHB has over the years secured external funding for the implementation of WCP and contributed local resource to ensure WCP modules can be rolled out as soon as they are available to us. However there is an ongoing risk that funding - both local and national - will not be available to the project in coming years. The WCP programme is ongoing and requires continuing support. More than half the implementation team are on fixed term contracts or secondments which are due to end in March 2019. If these staff are lost it will impact the pace at which the coming modules of WCP can be rolled out and our work in new areas such as Outpatients and Mental Health.	> Identify opportunities for continued funding - WG, UHB, Other. There is no identified funding to date to extend fixed term staff contracts beyond 31st March 2019.	4	5	20
NWIS Resource - There is a risk that NWIS cannot provide the support required. CAV UHB relies on NWIS to support our WCP Programme. NWIS is the lead developer of the WCP and supplies the modules as they become available to health boards for testing and implementation. The development team and other teams at NWIS have been hampered by resource issues which has impacted the pace at which WCP enhancements can be made available. The WCP is NWIS' flagship product but NWIS also support many other national applications e.g. WLIMS,Radis2, CYPRIS, primary care systems, WCCG, etc. The number of major incidents associated with infrastructure and applications has increased significantly in the last 12 months.	> NWIS to be appropriately resourced for the number of applications which it supports > The number of new developments to be decreased/prioritised.	3	5	15
UHB Business change/clinical resource in local departments - There is a risk that individual departments/wards/clinics/etc do not have personnel available to support the introduction of the WCP into their area due to other work pressures. Other priorities impact the amount of time that UHB staff have available to work with the team to contribute to the design, testing and implementation of the WCP. The project requires 'champions' to ensure the WCP is adopted and used and staff do not return to old ways of working.	> Staff to be identifed in each local area to work with the project team and champion the product. Work as SME's and local trainers for their department/specialty. One or more staff required per discipline eg Super user Dr and SuperUser Nurse	3	4	12
Ongoing hardware cost of implementing WCP across the UHB Ongoing resource will be required for PCs, printers, Wi-Fi, Networks, Power, Media (e.g. bags and labels for ETR).	> Decision required as to funding streams for WCP support. Clinical boards have raised concerns about the ongoing cost of replacement hardware and increased cost of media (ETR bags and labels). Project does not have a budget but there is an expectation that it does. This can be a barrier when discussing local implementations. e.g. who pays for the printers in clinic areas?	4	4	16

Delay to Integration with Paris - dependency for completion WCP implementation The UHB has 2 PAS systems, PMS and Paris. The original scope of the MTED implementation was with wards using PMS, but this excluded Mental Health Wards. Work has been undertaken to highlight this gap and meetings have been held between IT, NWIS and Civica to find a way forward once funding became available to progress the work. However with the procurement of WCCIS (replacement for Paris) this work has not progressed.	> Add to agenda for ISEC agenda. Invite MH representative (potentially Dr Neil Jones). >Revise PID and present to ISEC for discussion with NWIS.	5	5	25
The issue is that WCP UAT environment does not mirror Live environment therefore can't replicate test issues The issue is that the knock on affect of improperly configured UAT environment increases HB resources required for testing.	> Request addition to WCP Service Management Board for discussion with NWIS.			0

Name of Project dependency	Description of dependency
CAV UHB does not have a Concordat/WCP Convergence Plan agreed with NWIS.	The NWIS WCP Development Team have an increasingly challenging programme of development to fulfill. Some Health Boards have Concordats/Convergence Plans in place with can result in acceleration of these health boards' priorities. CAV UHB has a draft Concordat and convergence plan which is being discussed at Executive level.
CAV UHB IT Dept Development Resource	CAV UHB Development Team are required to contribute to the development required before WCP modules can be implemented. This development work has to be completed around other UHB priorities.
WCP Integration with Paris	The UHB has requested that NWIS work with the UHB on the integration of WCP with Paris in order to complete the implementation of existing WCP modules in Mental Health Wards and clinics. This has not progressed due to NWIS focusing on the WCCIS implementation.
Funding for CAV WCP Implementation Team Resource	The majority of the WCP implementation team are on fixed term contracts. The continuation of the implementation of the WCP at pace is dependent on securing further funding for these posts.
Speciality Resource & Engagement	Full commitment and engagement is required from Wards to prepare them to start using WCP MTeD. This requires a certain level of Clinical and Management team resource commitment from within the Speciality.
Clinical and Management Team agreement to go live dates	The dates in the roll out plan are dependent on Clinical and Management Teams agreeing to go live on the proposed date

DIGITISATION OF MEDICAL RECORDS: TOWARDS A PAPERLESS OUTPATIENTS

Executive Lead: Executive Director of Therapies & Health Science
Author: Directorate Manager, Patient Administration and Outpatients
Caring for People, Keeping People Well : This report primarily underpins the 'Sustainability' element of the Health Board's Strategy
Financial impact : seeks to expand digitisation, whilst ensuring the resources required are synchronised with the UHB's cost reduction programmes
Quality, Safety, Patient Experience impact: The developments outlined are designed to achieve optimum value from the resources available, and through targeted accessibility to clinical information, lead to improvements in the quality of inputs and outputs, which ultimately deliver enhanced and timely patient care
Health and Care Standard Number: 3.5 and 3.4 **CRAF Reference Number:** 6.8. 6.8.2, 8.1.5
Equality Impact Assessment Completed: Not Applicable

RECOMMENDATION

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

- **NOTE** the contents of the paper

SITUATION

Long-standing efforts to ensure a digital platform, now include a focus on accelerated delivery of a paperless outpatient environment. In order to achieve this, enhancement to the existing UHB infrastructure must be effectively coordinated with local, as well as national strategies & programmes, thus avoiding unnecessary duplication, delay and waste.

BACKGROUND

Thoughts of a paperless outpatient setting often centre on the creation of a single Electronic Patient Record (EPR). In one respect this has been partially achieved through the PARIS application. However, this is a system used predominantly for mental health and community activity and as such does not cater for acute outpatient care; the focus of this paper.

Organisational experience and learning from external public sector ventures, highlight the complexity in delivering an all-encompassing EPR. With this in mind and in recognition of the myriad of applications presently available to clinicians, the direction of thought has shifted towards effective interoperability (as outlined in the Informatics Strategic Outline Programme). Such an exercise needs to be coupled with enhancements to existing local and national products. In doing so, outlay is minimised and more importantly, clinical uptake is maximised.

However, adopting this approach brings significant prioritisation and synchronisation challenges, principally in relation to clinical need and strategic alignment. There is a requirement for careful consideration as to how it integrates accordingly with national visions such as, 'A Healthier Wales' and 'Once for Wales', as well as the UHB's Transformation programme and its adaptation of the Canterbury model.

ASSESSMENT

Whilst the UHB has made significant progress in the delivery of digitised records through the use of portal technology, there remains a reliance on paper for recording clinical information.

However, in recent years there has been a marked uptake in the use of digital mechanisms within the acute outpatient setting. A spectrum exists, ranging from simple scanning of the medical record, to the complete electronic capture of patient information. Despite the clear progress and the ability to 'go paperless', the tipping point has yet to be reached where the use of digital information and digital capture is considered the norm.

Consolidation of the various stand-alone, UHB and national systems, remains key. A flexible approach is required and must be clinically driven to ensure digital entry becomes custom and practice; built on enhancing the structure that is already in place. Interoperability is vital, as is the continued use of portal technology to provide the necessary foundation.

The outpatient digital agenda is a wide one and a combination of circumstances and operational learning has led to adaptive strategies. Latterly these have become more blended. The following demonstrates how:

- The UHB's Transformation Programme hinges much of its delivery around digital platforms, specifically outlined in its focus on a digitally enabled workforce (Management Executive Sep 2018)

- The Transformation Programme's outpatient workstream also recognises the use of technology. As part of this, a 'blueprint for outpatients' is being created, which maps existing, developing and soon to be implemented digital technologies. Engagement exercises with senior clinicians, along with administrative and managerial colleagues and a broad spectrum of the IM&T

team, has been pivotal. Cataloguing the wide variety of tools and processes available (or soon to be), is key to creating alignment, prioritisation and importantly, clinical steer as to the best ways in which to move to digital

- Sitting neatly within the above is the delivery of the medical record for the acute outpatient setting. The scanning of records continues, however, clinical feedback has prompted a switch to a more personalised and pragmatic approach. The Clinical Information Triage (CIT) programme gives each clinician the opportunity to request the conversion of all or part of the record to a digital format (scanned). Where it is deemed there is already sufficient digital information available, no record will be provided. As roll-out increases and supporting technology improves, the default position of providing no paper record can be applied

- Key to the effective delivery of the non-paper element of CIT, is the enhancement of the Clinical Outcome Module (COM). As a PMS based product, the IM&T team have recently taken the main components and developed a product that aims to serve clinical requirements first. A guiding principle is ensuring interoperability, effectively providing a front end which acts as a seamless route to other platforms. Importantly it enables the capture of the clinical record in a structured way (it includes the use of SnoMed-CT). Whilst clinical information is vital, the outcome of consultations and other administrative elements will also be recorded e.g. functionality to support new requirements associated with the national Eye Care Measures, at the same time doing away with Clinical Outcome Forms (COFs)

- Whilst all of elements outlined focus on local delivery, they very much consider the national agenda also. An array of 'W' products from the NHS Wales Informatics Service (NWIS), is already widely available in the outpatient setting and any drive to reduce the use of paper will require close alignment and collaboration with its work programmes and strategists. The UHB and NWIS have recently signed-up to a joint scheme specifically aimed at delivering a paperless outpatient. A UHB wide survey has been undertaken asking for the top 5 priorities which will enable this. The results are being used to collectively target areas of improvement

The very nature of delivering fit for purpose and flexible digital platforms requires a similarly adaptive approach to the strategies that underpin them. The UHB'S digital evolution is reflective of this. The collective insight amassed, along with the footing the Transformation programme provides, will achieve the clinical outputs desired. It ensures progression at operational levels are allied to native technological developments and objectives; likewise those at national level. This coordinated approach is providing traction for the user base, in turn propelling targeted UHB enhancements, and indeed, giving opportunity for national augmentation. These maturing arrangements allow for the flow of improvement to be switched, thereby engendering a greater level of agility, avoiding duplication of efforts and accelerating the delivery of change.

Welsh Community Clinical Information System (WCCIS)	
Name of Meeting : IT&G Sub Committee	**Date of Meeting** 31st October 2018

Executive Lead : Executive Director of Therapies & Health Science
Author : WCCIS Programme Manager
Caring for People, Keeping People Well : This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy.
Financial impact : Agreed ICF budget and WG capital for 2018/19 only
Quality, Safety, Patient Experience impact :
Health and Care Standard Number 3 & 4.2
CRAF Reference Number N/A
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Continued monitoring of progress both Nationally and regionally

The Committee is asked to:

- **NOTE** the contents of this update

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, foundational work to support the UHB's progression towards 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 5.2.10 testing defects and CareDirector 5.2.13 developments;
- Alignment of scoped services to nationally agreed forms and assessments, where agreed.

BACKGROUND

REGION

The regional WCCIS team and local MHCS team 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 within the Vale of Glamorgan and local contribution into national use cases to support functional development of WCCIS from Cardiff Council and the UHB. The region has taken a unique approach within Wales by ensuring the design 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 is 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 loss of the national integration lead is now having secondary impacts; aside from delaying integration of WCCIS with other national 'W' products, work to ensure integration with the next version of the WCCIS product 5.2.12 has also delayed this release.

The subsequent anticipated release of the WCCIS product will be version 5.2.13, which includes numerous developments to support the ABHB implementation of WCCIS into Mental Health services. Reviews of these developments continue to feed into the UHB's gap analysis, and experience from the MHCS team is informing national use cases and system developments.

Many of the concerns raised by the UHB, and nationally by Directors of Therapies in June 2018 still stand:

- The mobile app suffers from some fundamental defects and is not in use in any 'live' site;
- The contractual model doesn't allow for a partial-scope implementation, and requires commitment to a timescale for full implementation and payment of the full maintenance costs;
- Concerns regarding the governance structure of the national programme have not been addressed;
- The balance of financial and contractual risk remains heavily weighted against Health Boards and Local Authorities;
- Health standards work is incomplete; work to standardise some local authority assessments is initialising.

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 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 case is being brought forwards to the Regional Partnership Board to secure funding for 2019/20 supporting the sharing of patient/client records across organisation boundaries in the region, and retaining an active stake in the national programme.

WORK PROGRAMME HIGHLIGHT REPORT - WLIMS	
Name of Meeting : IT&G Sub Committee	**Date of Meeting** 31st October 2018

Executive Lead : Executive Director of Therapies & Health Science
Author: Deputy Director of Therapies & Health Science
Caring for People, Keeping People Well: Periods of unplanned unavailability of the WLIMS system have a direct impact on the ability to provide timely care for patients. This is an issue both locally and nationally and the more services that are on the WLIMS system the greater the risk to patient care.
Financial impact: To be determined
Quality, Safety, Patient Experience impact: A resilient legacy Laboratory Information Management System is required for blood transfusion service business continuity planning to mitigate the risks associated with further delays to the implementation of the WLIMS blood transfusion module.
Health and Care Standard Number Standard 2.8 Blood Management, Standard 2.9 Medical Devices, Equipment and Diagnostic Systems, Standard 3.1 Safe and Clinically Effective Care
CRAF Reference Number 1.2, 5.1, 5.1.2, 5.1.4, 6.8, 6.9.1
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by: Existing server cluster design, limited hardware maintenance cover, limited software maintenance cover until March 2019 and in house expertise.

The Committee is asked to:

- **NOTE** the conclusion of the Extraordinary National Pathology IT Programme Board held on 5th October 2018.

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 Cadwaladr UHB, Hywel Dda UHB and Cwm Taf UHB

Abertawe Bro Morgannwg UHB and Aneurin Bevan UHB use MasterLab LIMS as a platform to deliver its blood transfusion services.

Masterlab is resilient and stable and will provide a robust business continuity plan to address any further delays in implementation of WLIMS blood transfusion module. Aneurin Bevan had 2 legacy systems, TPATH and Masterlab. They have recently consolidated onto Masterlab to address the risks currently faced by Health Boards who do not have any other LIMS apart from TPATH.

BACKGROUND

WLIMS is currently not sufficiently stable or performant 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.

CSC currently provides hardware and software support to the version of TPATH currently used by NHS Wales as part of a national contract managed by NWIS. CSC have served notice that the TPATH contract will expire at the end of that term (i.e. the end of March 2019) unless we refresh both the hardware and the software and provide them with a formal notification that the upgrade is being procured. At this point CSC will continue to support the older version of TPATH until the upgrade is fully deployed.

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 to 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 AND ASSURANCE

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.

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					Director of Therapies	
E- Advice					Director of Therapies	
E – IT Training					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
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	Continue to monitor progress – due to be complete Dec 2018
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.	Continue to monitor progress

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. Due to be delivered next financial year 2019.

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.	**October 2018** Development currently in Test environment and due to switch to live Dec 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.	**Partial Complete** **October 2018 – update** The supplier has recently agreed (3rd October 2018) to undertake the testing. Timescale to be agreed within the next month.

INFORMATION COMMISSIONERS OFFICE VISIT
Name of Meeting : Information Technology and Governance Sub Committee **Date of Meeting:** 31 October 2018

Executive Lead : Executive Director of TIIC/Deputy CEO
Author : Senior Manager Performance and Compliance
Caring for People, Keeping People Well : This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy.
Financial impact : The Information Commissioner has powers to fine organisations that are in breach of the law and through their acts or omissions materially harm or damage individual. The levels of fine can now reach a maximum of 20 million Euros. The ICO now has the right to undertake mandatory audits on NHS organisations. This does not exclude the ability for individuals to take legal action against the organisation in respect or harm or damage both as a result of physical or psychological harm or reputational harm.
Quality, Safety, Patient Experience impact : The content of this report impacts on the quality, safety and experience of our patients and their families. It also has the potential to impact adversely on the reputational standing of Cardiff and Vale University Health Board and the confidence our community has in us if we are not honest with patients and families when things go wrong or fail in our opportunity to learn and put things right. The management of data and personal information is fundamental to providing a quality service and exemplary patient experience.
Health and Care Standard Number 3.4 & 3.5
CRAF Reference Number 8
Equality and Health Impact Assessment Completed: There are no equality and diversity implications; equality and diversity is a standard being self- assessed as part of this process.

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Reports detailing compliance against legislative requirements.

The Information Technology and Governance Sub Committee is asked to:

- **NOTE** this update in relation to action following the audit by the Information Commissioner Office of UHB compliance of the Data Protection Act 1998 carried out in May 2016
- **NOTE** that significant progress was made in delivering actions under the original action plan agreed with ICO. This work has continued and been subsumed within the new DPA 2018/ICO action plan.
- **AGREE** that going forward the ITGSC will receive a combined GDPR/ICO action plan

SITUATION

This report gives ITGSC details of steps being taken in response to the audit by the Information Commissioners Office (ICO) of compliance with the Data Protection Act (DPA) 1998.

BACKGROUND

On the invitation of the UHB the ICO carried out a detailed audit of UHB compliance with DPA 1998. The ICO gave the UHB a "limited assurance" rating. A comprehensive action plan was agreed. The ICO carried out a desk based audit approx. 12 months afterwards that essentially reaffirmed its original audit rating.

Implementation of the action plan has been monitored by the former IGSC and ITGSC on a regular basis.

ASSESSMENT

Since the above audit, the most far reaching changes in information governance legislation have been introduced, specifically the implementation of the General Data Protection Regulation (GDPR) on 25 May 2018 as the enabler for the DPA 2018 being enacted. The net effect of the above is that the IG "landscape" has changed considerably since the above ICO audits. This has had a knock on effect on the content of some of the recommendations. To streamline arrangements it is **RECOMMENDED** that, going forward, the ITGSC receives a combined GDPR/ICO audit action plan. This is intended to give assurance that the UHB is making progress in terms of implementing the recommendations agreed with ICO updated to reflect the requirements of GDPR/DPA 2018.

COMBINED ICO/GDPR ACTION PLAN
Name of Meeting : Information Technology and Governance Sub Committee **Date of Meeting:** 31 October 2018

Executive Lead : Executive Director of TIIC/Deputy CEO
Author : Senior Manager Performance and Compliance
Caring for People, Keeping People Well : This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy.
Financial impact : The Information Commissioner has powers to fine organisations that are in breach of the law and through their acts or omissions materially harm or damage individual. The levels of fine can now reach a maximum of 20 million Euros. The ICO now has the right to undertake mandatory audits on NHS organisations. This does not exclude the ability for individuals to take legal action against the organisation in respect or harm or damage both as a result of physical or psychological harm or reputational harm.
Quality, Safety, Patient Experience impact: The content of this report impacts on the quality, safety and experience of our patients and their families. It also has the potential to impact adversely on the reputational standing of Cardiff and Vale University Health Board and the confidence our community has in us if we are not honest with patients and families when things go wrong or fail in our opportunity to learn and put things right. The management of data and personal information is fundamental to providing a quality service and exemplary patient experience.
Health and Care Standard Number 3.4 & 3.5
CRAF Reference Number 8
Equality and Health Impact Assessment Completed: There are no equality and diversity implications; equality and diversity is a standard being self- assessed as part of this process.

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Reports detailing compliance against legislative requirements.

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.

- **NOTE** actions taken to strengthen governance arrangements in a series of specific areas to consolidate the action plan

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. The action plan originally agreed with ICO has therefore been updated to align it to GDPR/DPA 2018.

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, a combined ICO/GDPR action plan will be presented to ITGSC going forward. In this way ITGSC be able to track progress via a single reference document.

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 combined ICO/GDPR action plan is attached as Addendum 1.

ITGSC's attention is also drawn to the following specific actions taken to consolidate the action plan. For space reasons it would not have been practical to include these details in the plan itself.

Data Processing Contracts

GDPR requires Data Controllers to enter into formal written contracts with organisations that process personal data on their behalf (Data Processors). These contracts essentially need to set out the instructions of the Data Controller and the key roles and responsibilities of both parties. The UHB's own Data Processing Contract (DPC), written by its lawyers, goes beyond this by including provision for an indemnity from Data Processors, in the event of personal data being compromised for reasons that the Data Processor is solely responsible for, of minimum £5 million per annum. The DPC requires Data Processors to carry suitable insurance to meet such liability.

This raises the following issues:

- Because of the nature of UHB activities, it is frequently the case that pseudonymised data is processed i.e. personal details are not immediately apparent but can be identified via a suitable key. This is because identification of individual data subjects is usually essential to achieve the purpose of the exercise. For this reason the UHB in principle regards pseudonymised data is personal data and therefore requires its Data Processors to enter into a DPC as above.
- This can give rise to problems insofar as some Data Processors are reluctant to give an indemnity of minimum £5 million per annum, particularly if this is manifestly disproportionate to the likely risk in the event that the data is compromised. For this reason it is sometimes the case that, following a risk assessment by users, the indemnity limit may be scaled down on the express prior authorization of an Executive Director (usually the Executive Director of Informatics).
- There are sometimes instances where the UHB is a Data Processor. Typically this occurs in a research setting where the Data Controller is the Research Sponsor. It is the norm for such arrangements to be formalised via the standard UK model non-commercial trial agreement. This covers GDPR requirements in terms of formalizing the Data Controller/Data Processor relationship. The UHB would therefore not enter into a DPC unless this was specifically required by the Data Controller. In this case the DPC would normally be provided by the Research Sponsor. Its use would therefore need to be sanctioned by an Executive Director (usually the Executive Director of Informatics).

Use of Data Security and Confidentiality Agreements (DSCAs)

Delivery of UHB activities frequently requires non-UHB employees to have access to UHB IT systems. It is essential that such access is formalized to the extent that the UHB can take appropriate sanctions in the event that such

access is abused. The normal process for this is to give such parties UHB honorary contracts via which they agree to comply with relevant policies and procedures to the same extent as substantive employees. However, this is not always practical given the large numbers of people involved, the duration that access is required etc. This is particularly relevant in relation to students undergoing clinical training who need to access UHB IT systems. For this reason the normal practice is to ensure that such people complete a DSCA before such access is given.

Use of Transport Layer Security (TLS)

Electronic transmission of personal data between the UHB and partner organisations is integral to delivery of UHB core business activities. This can create a problem insofar as, up till fairly recently, such transmission could only be regarded as secure it was made between two organisations who were both on the NHS Wales e-mail network (e.g. not between the UHB and non-NHS partner organisations such as Local Authorities). Secure alternative third party arrangements such as the NWIS secure portal are available but these need to be arranged via the IT Help Desk. In addition they are cumbersome in terms of sending short e-mails, such as patient correspondence including PID. A secure alternative arrangement called TLS is now available which allows users to transmit personal data between participating organisations (most Councils and some police and fire services in Wales) in the same way as they would send e-mails across the NHS Wales e-mail network. NWIS has agreed proof of concept for TLS so the UHB has now asked for it to "go live" at the UHB. A major advantage of TLS will be that if users use this to transmit/receive clinical corres containing PID it will not be blocked even if the UHB elects in future to block all corres with PID sent via the main NHS Wales e-mail network.

Other Actions

In the same vein the following actions are also highlighted:

- Ongoing development of Information Asset Registers (IARs). Specifically an IAR has been produced covering major IT systems covering key areas such as legal basis for processing personal data, business continuity arrangements and roles of Information Asset Owner/Administrator roles.
- Reinforcement of requirement to undertake Data Protection Impact Assessments (DPIAs), in accordance with GDPR criteria, to ensure that any potential risks associated with the introduction of new arrangements for the processing of personal data are considered and mitigated prior to implementation.
- Professional development of senior IG managers
- Updating of UHB Information Governance Policy. This is covered in more detail in the paper "Controlled Documents Framework".

Addendum 1

Information Commissioner's Office Data Protection Audit May 2016

Cardiff and Vale University Health Board

Appendix A

Detailed findings and action plan

Action plan and progress

Recommendation	Agreed action, date and owner		Progress at October 2018 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 4 - All are actively performing their roles **Responsibility:** Deputy SIROs/SIRO **Date for implementation:** Immediate – completion March 2017		**Partially Complete** **Evidence:** Awareness, Training and development initiatives were ramped up prior to GDPR coming into force in May and have continued to maximise awareness of relevant legal issues amongst all staff. This programme, to which Legal and Risk solicitors contribute, will continue. A podcast is also available for all staff with intranet access to view. This is based on "12 IG commandments" shared with staff in a series of presentations to promote awareness of GDPR which are intended to stimulate awareness of key IG concepts via relating them to operational issues they will encounter in their roles for the UHB.

			The UHB has revisited its earlier “one size fits all” approach whereby staff were appointed as IAOs/IAAs by default by virtue of their job titles. It now targets relevant individuals to “champion” IG in their work settings by virtue of their individual skill sets, specialist knowledge and operational responsibilities for systems / assets. These individuals should be regarded as the ”go to” people for IG matters and designated points of contact with the corporate IG dept. The success of this approach can be seen by the following • The number of area specific Information Asset Registers (IARs) in place (see A37) • Take up of the role of system managers as set out in the Information Asset Register for corporate/large scale IT systems (see A37) The UHB has also made progress by tying in business continuity and the information asset register together in an aligned process.
A5. Ensure role specific training is completed by all current IAOs and IAAs and that a process is in place to ensure this training is completed by staff who are appointed to be a deputy SIRO, IAO or IAA in future within reasonable timescales.	**Management Response:** Recommendation accepted The UHB will ensure that: 1 - All IAOs and IAAs complete training by March 2017. 2 - All IAOs will be trained 4th November 2016 3 - All IAAs will be trained by		**Partially Complete** **Evidence** As per A4.

	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** See A16 – 19 – updating of Information Governance policy. The UHB Information Governance intranet pages have been significantly expanded.
A9. Consider the requirement for a relevant member of each CHB to attend the IGSC to ensure a speedy and adequate	**Management Response:** Recommendation accepted The UHB will ensure that consideration is given to: 1 - The appropriate		**Partially Complete** **Evidence** As per A4

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.	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 CHB 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
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 • 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 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. • 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. 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. • 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. • 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 • 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.
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. 2 An updated IG policy has been prepared and will be presented to the IGTSC at the earliest opportunity. 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 is presently being updated to align it to GDPR and should have received legal opinion by the end of November.

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,	**Management Response:** Recommendation approved The UHB will ensure that all risk		**Incomplete** **Evidence**

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 controlled documents are updated with specific reference to the information governance framework. **Responsibility:** SIRO/ **Date for implementation:** March 2017		
A32. Conduct a review to ensure all teams/ departments are maintaining an adequate up to date risk register in line with Health Board Policy and that all risk registers are reviewed on a regular basis.	**Management Response:** Recommendation approved. The UHB will ensure that: 1 - A review of risk registers is undertaken 2 -An annual review is undertaken **Responsibility:** Deputy SIROs/SIRO/ **Date for implementation:** Immediate – completion March 2017		**Partially Complete** **Evidence** 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		**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.

	Date for implementation: Immediate – completion March 2017		
A35. Review all policies and procedures outlining the information risk structure within the Health Board ensuring each role is clearly outlined and has a role description. Communicate the structure to staff throughout 2016 to ensure awareness is raised to facilitate full implementation.	**Management Response:** Recommendation approved The UHB will ensure that the Information Governance Policy and supporting procedures will be updated at the end of its first full year to reflect the evolving nature of the IG management framework, the information risk structure and the completion of the high level controlled documents framework. **Responsibility:** SIRO/ **Date for implementation:** Immediate March 2017		**Partially Complete** **Evidence** See item A16 - 19
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	**Management Response:** Approve recommendation.		**Partially Complete** **Evidence**

completed as soon as possible, reviewed regularly and updated where necessary. Consider if these registers will feed into a Health Board wide IAR or who will have oversight of all Information Assets across the organisation. Review the contents of each IAR to ensure they include all manual records, smaller databases and medical devices that may hold personal data.	The UHB will ensure that: 1 - All IARs for clinical boards will be completed as soon as possible and include all information assets. 2 - The corporate risk register arrangements will include a separate register for all information risks. **Responsibility:** Deputy SIROs/SIRO **Date for implementation:** December 2016		IARs are in place as follows: Clinical Boards Corporate Depts An IAR has been produced setting out the following in relation to large scale IT systems: • IAO/IAA • System manager • Description of data processing undertaken • 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
A39. Provide enhanced access to Datix to relevant members of the IG team to ensure they are able to view all IG related incidents	**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		**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

reported across the Health Board.	the UHB **Responsibility:** Head of Information Governance **Date for implementation:** Immediate – completion March 2017		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	**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.

be sent to the IG team and relevant directorate managers.			
A42. Conduct a review of incidents reported across the organisation to ensure directorates do not have backlogs of incidents that have not been adequately investigated or closed when actions have been completed.	**Management Response:** Recommendation approved The UHB will ensure that: 1 - A comprehensive review is undertaken 2 - A report is brought to the 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		**Partially Complete** **Evidence** 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. Work has been undertaken by the Patient Safety Team to eliminate backlog across all incident categories to ensure there are minimal numbers outstanding.
A43. Update the incident reporting policies and procedures to ensure they reflect the current process followed within the Health Board. Information incidents	**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		**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

should be defined as a specific type of incident with a specific procedure staff should follow in the event of such an incident occurring.	is updated to include comprehensive reference to information governance. **Responsibility:** Director of Nursing **Date for implementation:** December 2016		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** 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	**Management Response:** Recommendation **Responsibility:** Head of Information Governance		**Partially Complete** **Evidence** See A44

this template mandatory as part of the project approval process.	**Date for implementation:** December 2016		
A46. All PIAs should be authorised by a relevant member of the IG team, reported through the IGSC and a log of all PIAs completed should be held by IG.	**Management Response:** Recommendation approved **Responsibility:** Head of Information Governance **Date for implementation:** December 2016		**Complete** **Evidence** A central log 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) 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. NB reference to BCU IAR.

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

	Responsibility: Deputy SIROs/SIRO **Date for implementation:** Immediate – March 2017		
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 plans are in place covering corporate and some local IT systems

	-The plans will be tested routinely **Responsibility:** /SIRO/Deputy SIRO **Date for implementation:** Immediate – completion March 2017		2. Business continuity plans need to be developed in all settings 3. 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.
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)		**Partially 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		**Partially Complete** **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……

CALDICOTT GUARDIAN REPORT
Name of Meeting : Information Technology and Governance Sub Committee **Date of Meeting**: 31 October 2018

Executive Lead : Medical Director/Caldicott Guardian
Author : Information Governance Manager and Coding
Caring for People, Keeping People Well: This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy.
Financial impact: There are significant potential financial implications in relation to this work. The Information Commissioner has powers to fine organisations that are in breach of the law and through their acts or omissions materially harm or damage individual. The levels of fine can reach 20 million Euros and the ICO now has the right to undertake mandatory audits on NHS organisations. This does not exclude the ability for individuals to take legal action against the organisation in respect or harm or damage both as a result of physical or psychological harm or reputational harm.
Quality, Safety, Patient Experience impact : The content of this report directly impacts significantly on the quality, safety and experience of our patients and their families.
Health and Care Standard Number 3.4 & 3.5 **CRAF Reference Number** 8
Equality and Health Impact Assessment Completed: There are no equality and diversity implications; equality and diversity is a standard being self- assessed as part of this process.

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Reports detailing updated actions.

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
  - 2017/8 Caldicott Principles in Practice (CPiP) Assessment – Reconciliation with ICO Audit of Compliance with Data Protection Act 1998

SITUATION

As with previous reports the bulk of the matters presented below have been drawn from meetings at the Medical Records Management Group 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

ASSESSMENT

i) Digitisation of the health record

This is covered under agenda item 9.1 and accompanying paper regarding Outpatient Digitisation

ii) Records Destruction

It is important to note that the destruction of paper records will be significantly impacted by the recent launch of the Infected Blood Enquiry. Decision has been taken at Management Executive (15.10.18), to immediately suspend any such destruction until the completion of the enquiry. The anticipated duration is at least two years. Alternative measures including a wider scanning exercise or increased use of off-site storage are being considered.

iii) Restricted Access to Central Medical Records Libraries

The Medical Records Dept has restricted access to its UHL libraries (bar limited periods for access to file documents in records only). A trial in library 3 at UHW commenced the end of August. Early assessment points to significant benefits for storage management and for services, who are largely embracing the new “click and collect” service. A more formal review due November will quantify the outcomes. If the success seen to date is reflected further, then resource realignment options will be put forward in order to sustain and expand restricted access.

iv) Medical Records Library

A significant stock reduction exercise has now been completed, resulting in the removal of 12000 boxes from on-site filing areas. The department has subsequently been able to partially introduce a new stock management process, greatly increasing efficiency. The impact of both has largely

eradicated long standing risks to health and safety. This is reflected in recent workplace inspections, including by the Medical Director as Caldicott Guardian, which indicate a vastly improved position from the year prior. The efforts of the Filing Library team have been recognised by CD&T Clinical Board through a special staff recognition award.

v) Decommissioning of Whitchurch Hospital

There continue to be problems with the secure storage of records at Whitchurch hospital. These are covered in a separate paper submitted to the private meeting.

Planning, Estates and Operational Services have commissioned a specialised company to undertake a wholescale clearance exercise of the Whitchurch site. Whist the predominate function will be to remove any residual equipment and furnishings, any documentation found will be corralled within a secure on-site location. Terms of service include on-site destruction, which will proceed at the end of the operation; anticipated to be mid November. Destruction will only take place after the correct assessment is undertaken by related departments, to include Medical Records.

This exercise commenced 5th October and is preceded by several similar exercises undertaken by Medical Records to locate and remove medical documentation. The Medical Director also visited the site. Whilst severely hampered by the estate condition and other significant safety concerns, this assignment was exhaustive. As such the remaining exercise acts purely as a contingency should remaining documentation be located.

It is recognised that a more comprehensive approach to document transfer and disposal should have ensued prior to the decommissioning of services. Planning and Estates are in the process of formulating a decommissioning procedure which will in the future assign clear ownership of areas, ensure joint on-site assessments are conducted and obtain sign-off signifying no documentation remains unchecked.

vi) 2017/8 Caldicott Principles in Practice (CPiP) Assessment / Reconciliation with Data Protection Act 1998

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 was not possible to complete the 2017/8 CPIP assessment. It was therefore decided at the June ITGSC meeting that the 70% score (assessment undertaken in February 2018) reported to the March 2018 meeting should be regarded as the 2017/8 full year score as there appeared to have been no subsequent material deviation either way in those areas where the UHB had assessed its performance to be less than 100%.

Concern has been expressed in earlier meetings that reported 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.

To address this concern the attached spreadsheet maps the following:

- Individual areas assessed under CPiP in 2017/8 as scored at less than 100%.
- The ICO's 2016 assessment of DPA compliance in the above areas
- Summary of current arrangements in the above areas.
- Planned remedial action (further details of these are set out in the paper "Combined ICO/GDPR Action Plan"

An update on the completion of CPiP in 2018/9 will be submitted to the next meeting of the Committee.

CALDICOTT PRINCIPLES IN PRACTICE – FEBRUARY 2018 – SCORES OF LESS THAN 100%

CPiP Question No	Question summary	Current Position	ICO Action Plan Section	ICO Assessment in May 2016	Planned remedial action
G6	Do mechanisms and guidelines exist to ensure that any decision taken by a patient or service user to restrict the disclosure of their personal information are appropriately respected?	Privacy notice (posters in patient/public facing areas signpost this on UHB internet site) direct users to the UHB DPO (contact details given)	n/a	n/a	Ongoing IG training – Shared Services Legal to repeat course delivered recently to corporate depts..
G7	Is information risk management included in the organisation's wider risk assessment and management framework?		A29 A32	Incomplete Partially complete	To be covered in updated UHB risk management policy.
G9	Does the organization have formal contractual arrangements with all contractors and support organisations that include their responsibilities in respect of information security and confidentiality?	These arrangements are set out mainly in Data Processor Agreements (Contracts). UHB DPA template should be sent	A14	Partially complete	DPA regime to be Consolidated.

		out by Procurement with documentation before letting any contract involving the processing of PID			
G10	Does the organisation ensure that all new services, projects, processes, software and hardware comply with information, security, confidentiality and data protection requirements?	UHB has Data Protection Impact Procedures. The IG Dept asks users to complete a DPIA where proposed activities involving processing of PID raise material IG issues.	A44 A45 A46	Partially complete Partially complete Complete	Arrangements to be consolidated through ongoing training etc
M7	Does the organization have a Business Continuity and Disaster Recovery Plan?	Corporate and area specific plans exist but are not routinely tested	B22 (re business critical records)	Partially complete	Arrangements to be consolidated through ongoing training etc
IP 2	Do you tell patients and service uses about the ways in which their information will, or may, be used?	A privacy notice has been produced in line with GDPR. It is	A14	Partially complete	Arrangements to be Consolidated.

		widely available in public/facing areas			
TA 1	Does your organization have a mechanism for addressing Information Governance for new staff as induction?	“Face to face” IG training on induction withdrawn for resource reasons. All staff required to do on line mandatory IG training	n/a	n/a	Consideration to be given to reinstating “face to face” IG training on induction if resources allow this in future.
TA 2	Have you conducted an analysis of information governance training needs?	No corporate analysis undertaken. Individual needs considered via PADR process	n/a	n/a	n/a
TA 3	Do you provide information governance training to staff, other than at induction?	Refresher training every 2 years	n/a	n/a	n/a
TA 4	What percentage of your staff have undertaken an Information Governance training session?	68.49% as at end August 2017	n/a	n/a	Ongoing reinforcement of Mandatory requirement to do IG training.
IM 1	Have information flows been comprehensively	Information asset registers	A36	Partially complete	Ongoing reinforcement of Importance of mapping

		mapped and has ownership for information assets been established?	existing in some but not all settings. IAR for major IG systems has high level of detail			data flows. This will be picked up in DPIAs.
. IM 4		Is there awareness of the organisation's responsibilities when transferring personal data outside of the EEA?	Issue covered in UHB Data Processor Contract	n/a	n/a	n/a
IM 5		Does the organization have a strategy to ensure the correct NHS number is recorded for each active patient and service user, and that is used routinely in clinical communication? Does the organization have documented procedures on the identification and resolution of duplicate or confused paper and electronic records for patients and service users	The UHB provides access for staff to cross reference Welsh Demographics Service (WDS). UHB also sends a weekly trace to WDS to validate NHS number. Current compliance above NWIS data validity standards	n/a	n/a	
IM 8		Does the organization have processes and	SOP HR011 "Missing	B20 B36	Partially complete Partially complete	Ongoing reinforcement of Importance of adhering to

		procedures in place to enable it to regularly, monitor, measure and trace paper health records	Health Records" followed			SOP HR011.
CA 3		Is there a Confidentiality Code of Conduct (or equivalent) which provides staff with clear guidance on the disclosure of patient/service user identifiable information?	TBA			
CA 3		Has the information made progress with encryption of devices containing personal identifiable information (PII) in line with the Encryption Code of Practice for NHS Wales Organisations (2009)?	TBA			
CA 4		What controls are in place to restrict staff access to patient/service user identifiable information?	Procedures exist but are not rigorously applied	C24	Partially complete	Ongoing reinforcement of Procedures.
CA 5		Are there physical access controls in place for relevant buildings?	POD for "Restricted Access to Health Records Libraries and	B32 B16	Partially complete Partially complete	Bid for funding to be pursued

		Assurance in Locating Health Records" not yet funded			
CA 6	What password management controls are in place for information systems that hold patient/service user information?	IT to advise re systems other than Good	C6 (Re Good App)	Complete	n/a
CA 7	Has the organization established appropriate confidentiality audit procedures to monitor access to person identifiable information?	Cav Web – Break glass procedure requires people responsible for relevant specialties to acknowledge such access, investigating where they consider it necessary WCP – NIIAS reports highlight cases where records have been accessed inappropriately.	A51	Partially complete	Arrangements to be Consolidated.

		Relevant staff are contacted.			
CA 8	Does the organization have appropriate policies in place to cover risks associated with off-site working using electronic and manual records containing person identifiable information PII?	TBA	n/a	n/a	

INFORMATION GOVERNANCE INTEGRATED REPORT
Name of Meeting : Information Technology and Governance Sub Committee **Date of Meeting:** 31 October 2018

Executive Lead : Deputy CEO, Executive director of TIIC
Author : Senior Manager Performance and Compliance
Caring for People, Keeping People Well : This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy.
Financial impact : The Information Commissioner has powers to fine organisations that are in breach of the law and through their acts or omissions materially harm or damage individual. The levels of fine can now reach a maximum of 20 million Euros. The ICO now has the right to undertake mandatory audits on NHS organisations. This does not exclude the ability for individuals to take legal action against the organisation in respect or harm or damage both as a result of physical or psychological harm or reputational harm.
Quality, Safety, Patient Experience impact : The content of this report impacts on the quality, safety and experience of our patients and their families. It also has the potential to impact adversely on the reputational standing of Cardiff and Vale University Health Board and the confidence our community has in us if we are not honest with patients and families when things go wrong or fail in our opportunity to learn and put things right. The management of data and personal information is fundamental to providing a quality service and exemplary patient experience.
Health and Care Standard Number 3.4 & 3.5
CRAF Reference Number 8
Equality and Health Impact Assessment Completed: There are no equality and diversity implications; equality and diversity is a standard being self- assessed as part of this process.

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Reports detailing compliance against legislative requirements.

The Information Technology and Governance Sub Committee is asked to:

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

SITUATION

This report 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:

- The newly appointed Director of Digital and Intelligence will, once in post, take over the role of Senior Information Risk Owner (SIRO).
- Paul Rothwell will continue to provide the role of 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
- The corporate governance department has successfully recruited to two posts, following an internal skill mix review. At the end of November the establishment of the team will have increased to 4.8WTE, although operates below this level due to sickness.

2. **Data Protection Act – Serious Incident Report**

Date reported: 1 June 2018 to 30 September 2018

During this period 377 incidents were reviewed of which 123 were identified as relating to an IG issue. These were assessed using a risk rating scale.

0 were considered serious incidents.
3 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 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 quarter 1 and 2 was 39.4%. This can be broken down as follows:

Table 1: Q1

Total received	164	
Response <=20 days	48	29.3%
Response >20 days	98	59.8%
Withdrawn / awaiting clarification		1.8%
Response outstanding	15	9.1%

Table 2: Q2

Total received	156	
Response <=20 days	78	50%
Response >20 days	30	19.2%
Withdrawn / awaiting clarification	0	0
Response outstanding	48	30.8

FOI compliance figures are an ongoing concern for the department. However, an increase in Q2 from Q1 demonstrates a commitment to working towards full compliance. Since March 2018 the department has been operating without the FOI lead. This has clearly had an impact on our ability to respond within the statutory timeframe. From mid November the department will be bolstered by 1.8 WTE who, as a priority start work to improve our FOI response compliance, this also includes updating the FOI disclosure log.

4. Subject Access Requests Processed

4.1 Health Records requests June to September 2018

	Jul	Aug	Sep	
Total Requests	260	228	206	Open and Closed requests received in that month
Requests Closed over 28 Days	105	153	72	All records closed in the month greater than 28 days
Average Close Time	43	38	33	Average closed in month. Not all requests opened in month will be closed by end of month.
% age of Requests Closed within 28 Days	60%	33%	65%	All records closed in that month 28 days or less

Compliance on par with pre-GDPR levels but below the position reported in Q2 of 2017. It should be noted that under GDPR for all SARs received on or after 25 May 2018, the processing time limit has reduced to one month.

Compliance expecting to improve with the internal utilization of 'Move it'.

4 .2 Non Health Records

There were a total of 13 subject access request submitted for non-health records June 208 to September 2018. 12 responses were issued within the statutory one month day time limit and 1 was extended.

5. Compliance Monitoring/NIIAS

The UHB continues to audit the appropriate use of systems, adopting both routine monitoring reporting and targeted review.

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

This subject is also covered in the paper on "Sensitive Incidents" in the private part of the meeting.

CONTROLLED DOCUMENTS FRAMEWORK
Name of Meeting : Information Technology and Governance Sub Committee **Date of Meeting:** 31 October 2018

Executive Lead : Executive Director of TIIC/Deputy CEO
Author : Senior Manager Performance and Compliance
Caring for People, Keeping People Well : This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy.
Financial impact : Well documented systems of work improve and maintain efficiency, reduce risk and the potential for legal action.
Quality, Safety, Patient Experience impact : Well trained staff following well documented systems of work provide services that reduces risk and improves the patient experience.
Health and Care Standard Number 3.4 & 3.5 **CRAF Reference Number** 8
Equality and Health Impact Assessment Completed: There are no equality and diversity implications; equality and diversity is a standard being self- assessed as part of this process.

ASSURANCE AND RECOMMENDATION

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.

The Information Technology and Governance Sub Committee is asked to:

- **NOTE** that UHB Controlled Document Framework is being strengthened and rationalised via the updating of the UHB Information Governance (IG) policy. The new policy will 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).
- **NOTE** that an updated Subject Access Requests Procedure has been submitted to the UHB's lawyers for review.
- **NOTE** that Version 5 of the Wales Accord on the Sharing of Personal Information (WASPI) has been issued.

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.

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.

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), IG Toolkit and to improve future audits that may be undertaken.

Background

CDF - 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.

Assessment

Current IG staffing constraints and the prioritization of work to evidence progress in implementing GDPR have impacted significantly on the updating of the CDF. To allow for this, and as discussed at the June 2018 ITGSC meeting, the UHB is seeking to adapt policy documentation developed at a national level by the Information Governance Managers Advisory Group (IGMAG) for use in a UHB setting

The NHS Wales Information Governance Policy developed by IGMAG has now been formally approved by the Welsh Information Governance Board which has mandated health bodies in NHS Wales to adopt. The policy has now been updated to reflect the needs and environment of the UHB and consolidates into a single policy the following documents also developed by IGMAG.

- Information Governance policy
- Secure transmission of data via e-mail.
- Internet access
- IT security

Work has commenced to enable the draft policy to go through the UHB's ratification and engagement processes, to include discussion at the Information Governance Executive Team prior to consideration at ITGSC and onward transmission to the Strategy and Delivery Committee for approval.

ITGSC's attention is also drawn to the following

Subject Access Requests Procedure

The UHB has also updated its Subject Access Requests procedure to align it to GDPR/Data Protection Act 2018. This has been submitted to the UHB's lawyers for review.

WASPI

Although not a policy-related development, the attention of ITGSC members is drawn to the fact that Version 5 of the Wales Accord for the Sharing of Personal Information has now been issued to the UHB. This is an important development in terms of strengthening governance arrangements for the sharing of personal information between participating public sector bodies.

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NHS WALES INFORMATICS MANAGEMENT BOARD

Minutes of the meeting
Thursday 16 August 2018 – 14:00-16:30

Attendees:

Frances Duffy (FD)	Welsh Government
Frank Atherton (FA)	Welsh Government
Peter Jones (PJ)	Welsh Government
Matthew Jenkins (MJ)	Welsh Government
Bradley Kearney (Secretariat)	Welsh Government
Nicola Prygodzicz (NP)	Aneurin Bevan University Health Board
Sharon Hopkins (SH)	Cardiff and Vale University Health Board
John Peters (JP)	Cardiff and Vale University Health Board
Anthony Tracey (AT)	Hywel Dda University Health Board
Andrew Griffiths (AG)	NHS Wales Informatics Service
Liz Waites (LW)	NHS Wales Informatics Service
Helen Thomas (HT)	NHS Wales Informatics Service
Neil Frow (NF)	NHS Wales Shared Services Partnership
Phil Walters (PW)	Public Health Wales
Mark Osland (MO)	Velindre NHS Trust
Daniel Phillips (DP)	Velindre NHS Trust
Chris Turley (CT)	Welsh Ambulance Service Trust
Claire Bevan (CB)	Welsh Ambulance Service Trust

Apologies:

Julie James AM	Leader of the House and Chief Whip
Andrew Goodall	Welsh Government
Caren Fullerton	Welsh Government
Matthew John	Abertawe Bro Morgannwg University Health Board
Evan Moore	Betsi Cadwaladr University Health Board
Dylan Williams	Betsi Cadwaladr University Health Board
Fiona Jenkins	Cardiff and Vale University Health Board
John Palmer	Cwm Taf University Health Board
Karen Miles	Hywel Dda University Health Board
Eifion Williams	Powys Teaching Health Board
Huw George	Public Health Wales
Steve Ham	Velindre University NHS Trust
Mark Osland	Velindre University NHS Trust

1. Welcome, introductions and apologies

FD welcomed members to the meeting, and apologies were noted. FD also explained that in Andrew Goodall's absence, she would chair the meeting.

FD noted that Claire Bevan had joined the Board as the permanent representative for nursing.

FD acknowledged that there had been some pressure on colleagues in recent weeks due to system outages, and she thanked those who worked to resolve them.

2. Detailed update from Welsh Ambulance Service Trust (WAST)

CT gave a presentation to the Board about the recent developments and plans for IM&T in WAST.

The following key points were made:

- CT is supported by Aled Williams, Head of ICT; and Nicki Maher, Head of Health Informatics and Business Intelligence.
- The ICT and HI team in WAST is responsible for delivering three of the strategic actions set out in the organisation's IMTP:
    - Development of clinical information sharing arrangements;
    - Pursuance of an agile working model through the use of staff mobile devices; and
    - Expansion of a robust information framework with appropriate governance, to allow stakeholders to get the information required, in a timely manner and to make the most effective decisions.
    - A further 21 strategic actions will require the team's support in some form.
- The organisation implemented a new Computer Aided Dispatch (CAD) system in November 2017 with the support of £4.5m funding from Welsh Government.
- Staff use digipens to capture patient information digitally, to feed into the patient care record (PCR). The contract to provide these was recently extended.
- WAST will continue to support the roll-out of 111 into additional pathfinder areas, while also supporting the procurement of an integrated 111 system.
- A staff mobility pilot has commenced with devices issued to an initial cohort of 150 staff, as well as the roll-out of Wi-Fi-enabled equipment that can be used to access information systems securely when away from base.
- The organisation's draft Long Term Strategy to 2030 recognised the importance of technology as a key enabler, with Embracing Technology as one of the four strategic themes. The organisation will also be revising its Digital Strategic Outline Programme (SOP).

CB said that working with digipens helped give the organisation more clinical information. She also said that the organisation had been trying to meet with each of the other Health organisations over the past 12 months to discuss opportunities to improve outcomes.

SH said that she had not heard of the web-enabled patient booking system, and asked whether it was linked to partial booking. CT said they were separate systems, but would look into any opportunities to link them. FD noted that there had been workshop sessions with other health boards run by WAST to engage, and said that the more conversations such as those that took place, the more likely it was that those types of links and connections were made.

3. A Healthier Wales – the role of informatics

FD said she was conscious that since A Healthier Wales had been launched, NIMB had not had an opportunity to comment on and discuss it. FD asked members to think about how they embrace new technology and digital ways of working, and asked for any comments or thoughts about the plan.

CB said that it would be beneficial to think about how social care is embraced and truly integrated beyond the community system. She also said that WAST had been asking their clinicians what they could do if they had further access to social care systems and data. FD said that NIMB had tended to have a focus on health rather than social care, and the question for members would be how the Board organises itself to look at more of the social care issues. She also said that WCCIS was the flagship project that attempts to join health and social care together and asked if it was sufficient that A Healthier Wales mentions it as a priority area.

NP said she was keen for NIMB to review whether the current mechanisms within health boards and trusts were fit for purpose to respond effectively, in light of A Healthier Wales referring to accelerating current plans. She said she didn't think many organisations would currently be fit to respond in that sense, and suggested that a clearer vision about how we see technology helping patients and staff was needed to engage them in the agenda. She said that the agenda was still being driven from technology solution perspective, rather than the service fully driving it. She also asked how time could be made to plan how organisations think they can respond to the recommendations set out in A Healthier Wales. SH said that there was a need to rethink the conversations that we have with health and social care staff and patients that respects the technical context, but also respects conveying how digital and technology will benefit them.

AG agreed that it was important to focus on the transformation agenda and lead with that rather than with the technical agenda. He said that, in the past, he had seen projects that started with a business focus that became technical, which meant that people's engagement was not sustained throughout. He said a way to sustain stakeholders through discussions needed to be found.

NF said that engagement needed to be in a language that everyone could understand. He said there was a need to focus on how organisations respond to emerging technology, and also implementing programmes and change management.

PJ said that a governance review would be taking place shortly to look at some of these issues and also mentioned the Digital Health and Care Conference, scheduled for November, as a space to encourage some fresh thinking. He said it was important to keep focus on the business need rather than the IT products themselves. He said that the system was getting better at engaging with clinicians, but less good at engaging with the public and service users.

FD said that there was an expectation that leaders in organisations were digital leaders, and suggested there may be opportunities to work with HEIW to get

something related to digital into their programme going forward. She also said that the governance review would look at the ambitions set out in A Healthier Wales, and that it would commence in a couple of weeks time. She said it would involve external people engaging with NIMB and with organisations and would report back by Christmas. FD asked whether it would be worth thinking about having a session before the conference in November.

Action: Session with NIMB members to discuss response to digital elements in A Healthier Wales to be arranged before DHC conference in November.

4. WCCIS update

LW gave a general overview of progress on WCCIS to date, with particular reference to the recent Gateway review. She said that the review recommended that the governance around WCCIS was too complicated and that it may be limiting progress. She said that time had been spent looking at how it could be streamlined. She said the review also recommended the appointment of a programme director to engage with regional partnership boards (RPBs). LW said that moving to the new governance model would rely on an appointment to the programme director role.

FD said that in conversations with Carol Shillabeer, as the SRO on the health side of WCCIS, she had described work ongoing around positioning, in particular to pick up the resources needed for a programme director. FD said she thought Carol would wish to come to NIMB to share that work with members. She said that WCCIS was a high-profile programme with significant investment put into it, and that it was on the agenda of the Public Accounts Committee (PAC).

NP asked whether NIMB should be signing off the new governance approach and structure in October. She also said she was concerned that the challenges around WCCIS weren't described in the current documentation. She said it was important not to measure success by the number of organisations that have gone live with WCCIS and recognise that changing whole systems in organisations is a large undertaking. NP said that her board had committed to a business change process, and that they could not afford for the project to fail with the significant investment they had already put in. She also said that there were big risks around delivering to Aneurin Bevan UHB's implementation date, and that swift help and support was needed to get their project on track. SH said a conversation to understand the context around the challenges of implementing the system would be useful.

FD said that there were still issues that needed to be sorted through that Andrew Goodall was aware of. She said it was important to refer back to the SROs to give them the chance to outline the actions they need to take.

Action: Carol Shillabeer to be invited to the next NIMB meeting to share progress on WCCIS.

5. Statement of Intent update

JP gave a presentation to update members on the progress against the priority areas for actions outlined in last year's Statement of Intent.

The following key points were made:

- Information Governance framework – a project group was established, and stakeholder sessions took place in January and February, which led to a paper setting out the current Welsh IG framework. An options paper in June set out four options, and option 4 around the 'data promise' was recommended. It was noted however that there was some objection to this, and option 2 of following the English opt-out approach was also suggested. Therefore, next steps are to look at better understanding the impact, resource, technical and legal ramifications of both options 2 and 4. JP praised NHS, NWIS and Welsh Government colleagues for their efforts in progressing this work over the past twelve months.
- National Data Resource (NDR) – there is an ongoing process of engaging with stakeholders taking place, recognising that there were many different sets of priorities for an NDR. Feedback so far helped produce a rough draft outline for the process and a steering group had been formed. There was a wish to collaborate with academia on this, and support from NIMB for this approach was requested. The need to be involved in any initiative to improve the data warehouse was also made clear.
- Skills and resources – A needs assessment required a skills survey of staff to establish baseline information. Members were asked to support the skills survey, which would take place in September.
- Quality – Data standards developments through WISB would enhance the national data sets and identify new areas of improvement. IQII also had a portfolio of improvements to be made in data quality, and WTSB will perform the same function as WISB but for technical standards, after agreement of their forward plan. The next key priority is to implement SNOMED CT, which could ultimately give capacity to interpret information in new ways to drive forward research and health policy.

SH said that it was important to agree some firm deadline around agreeing an approach to an information governance framework, as the work had the potential to take a long time due to the large number of parties involved. PJ said that after England's announcement of an opt-out, there was the potential for confusion with what the approach was in Wales. He said that a lot of work had been done to get to two options that had been fairly well tested and that it was important to get this over the line in the next couple of months. FD acknowledged that the information governance framework was a complex piece of work and said it would be useful to have an update at the October meeting to get some firm timescales agreed.

FD thanked JP and HT for the update and asked members if they were having conversations in their own organisations about this work. SH said that the paper was helpful in translating the conversation into something that was more readily understood. NP said that articulating what this work means for organisations and determining where it sits in the bigger picture will help engage people into the wider agenda.

NP also said that a guide to SNOMED CT would be really helpful to engage people and to help people understand it. SH said that organisations need leaders to

understand why people need this work to happen. HT said that her team had pulled together a range of educational material, and that she would be happy to circulate to members.

CB asked who the target audience was for the skills survey, referencing the fact that the NHS staff survey had just taken place. HT said that the survey would prioritise anyone whose role related to data or analytics, and that the survey would be simple but still provide the rich information that was needed to establish a baseline.

Action: Update to be provided on information governance framework options under the Statement of Intent.

Action: HT to circulate informative material on SNOMED CT to members.

6. WAO recommendations

FD presented a paper to show the progress that had been made against each of the recommendations from the WAO's report into health informatics in Wales. She said that PAC will be producing a report with more recommendations before the end of the year. She also said that work would soon be starting on the governance and system architecture reviews, which were the two key short term items.

NP said it was good to have the updates on the recommendations coming through NIMB, as she said it was the right forum for them. She said it was important to monitor the actions closely to make sure that they were being sufficiently addressed. AT said that some thinking on timescales for completion of some of the actions would be helpful for internal purposes, but acknowledged the complexity of the issues.

7. Risks and issues

AG gave an update on the critical risks in the risk log. Related to the risk around CaNISC, he said that since the last meeting the Welsh Patient Administration System (WPAS) business case had been approved by Welsh Government and that the business case for the remaining patient record functionality was being drafted.

AG said that deployment orders were ready to be signed for WEDS and that the risk rating would be reviewed after a project board meeting scheduled for Friday 17 August.

AG also said that a bid had been submitted to Welsh Government for £200k to fund a vulnerability-testing platform. PJ said that an attempted cyber attack had been reported to Welsh Government two weeks ago, showing that there had been significant changes in the reporting of such incidents as a result of investment in a new monitoring system.

Speaking in regards to CaNISC, PJ said that there had been instances where business cases submitted to Welsh Government had to be sent back with comments and changes. He asked that the business case being drafted around CaNISC be capable of being supported when it is submitted.

FD noted that the level of risk against many of the items in the log is still the same as the inherent level, despite the mitigating measures in place. There is work to be done on the log, acknowledging that she didn't expect changes to every item every two months, but noting that more discipline in developing the log is necessary. She said that a number of times, answers at PAC have referred to scrutiny of the risks at NIMB, highlighting the importance of ensuring robust and consistent consideration of risks, including assessment of effectiveness of mitigation measures. She asked if IPAD could look at the risk log again and decide whether the risks, scores, measures and timescales are correct.

Action: AG and IPAD to review the risks, scores, mitigating measures and timescales of the current risk log.

8. CCIO Update

FD noted Rhidian Hurle's absence, but asked members for any comments on the written update he had submitted.

CB said that there was informal assurance of the funding for chief nursing information officer roles for a set time and then it would be expected that health boards take over the funding. She also said she was pleased to see that WAST now having access to WCP was mentioned and said that clinicians in the organisation were becoming more confident in using it.

FD asked members whether organisations had been able to appoint chief clinical information officers since the CCIO launch event. AT said that Hywel Dda had recruited, but noted Betsi Cadwaladr UHB's approach in appointing regional CCIOs was something they were looking at. He also welcomed the addition of CNIOs, but said the organisation needed more of their time.

SH said that more thinking was needed into the model being suggested for CCIOs and its fit with individual organisations. She said that Betsi Cadwaladr UHB's approach looked promising and said that CCIOs was an example of a good idea that needs a better conversation with organisations; otherwise it won't achieve what it's meant to.

9. Capital for IM&T

DP presented a paper that explained the breakdown of the £5.1m of capital funding recently approved by the Cabinet Secretary for Health and Social Services. DP said that letters to confirm the funding allocations for each organisation would be sent out shortly. He said that it was important to be clear about priorities.

PJ said that one of the things that could be improved on is the scrutiny of business cases. He acknowledged that it might mean more work for organisations and Welsh Government, but it would contribute to a better result.

LW said that it was good to see funding agreed at an earlier stage to last year, but noted that it was already nearly five months into the financial year. She said that a lot

of the funding was to recruit staff and there was already a limited amount of time to get people in post. She said it was important to get quicker and smarter at agreeing funding to put organisations in a better position. FD said that the process had still taken some time; she acknowledged that input from various stakeholders slows the process down but agreed that the process needed to be quicker. DP said that discussions around the three-year plan for informatics will start to solve these issues.

NP said there was a need to look back to see whether money was spent on what it was meant to be spent on, and whether the funding delivered or not. She said that if there was more funding available next year then planning should start sooner. She also said she had mentioned unallocated capital in the past, and said there may be opportunities to pitch for some of that funding. She noted, however, that there would need to be confidence that any further funding would deliver certain projects and deliver against certain risks. PJ said that his team was working on options should any further funding become available.

DP said that he would circulate the appendix to his paper following the meeting.

Action: DP to circulate appendix to paper on the allocation of capital funding.

10. Papers to note

PJ said that he had received some feedback on the terms of reference for the Strategy Assurance and Advisory Group, and had reflected that the document was not meeting expectations. He said he would revise and reissue.

AT said that more information was needed in relation to the NIS directive, and said there was a need to develop a stronger position going forward. PJ said that his team have been engaged with NCSC whilst working on the NIS directive, and acknowledged there was more work to be done internally. He said he would bring a further update to NIMB in October.

Action: PJ to revise terms of reference for the Strategy Assurance and Advisory Group, and reissue to NIMB in October.

Action: Update on position regarding the NIS directive to be brought to the next meeting.

11. Minutes and actions from the previous meeting

The minutes of the June NIMB meeting were agreed.

12. AOB.

FD said that Public Health Wales were due to present their developments and plans for IM&T at the next NIMB meeting in October.

CAPITAL MANAGEMENT GROUP MEETING
20TH AUGUST 2018 AT 11:30AM
CORPORATE MEETING ROOM, HQ, UHW

Present:

Marie Davies, Deputy Director of Strategic Planning (Chair)
Fiona Jenkins, Executive Director of Therapies & Health Standards
Clive Morgan, Assistant Director of Therapies
Richard Hurton, Assistant Finance Director
Steve Curry, Chief Operating Officer
Geoff Walsh, Director of Capital, Estates and Facilities
Nigel Mason Business Manager, Capital, Estates & Facilities
Tony Ward, Head of Discretionary Capital
Jeremy Holifield, Head of Capital Planning

In attendance: Zoe Riden

		ACTION
1.	**APOLOGIES FOR ABSENCE** Apologies were received from Abigail Harris, Mike Bourne	
2.	**NOTES FROM THE PREVIOUS MEETING** Notes of the meeting held on 16th July were taken as a true and accurate record	
3.	**MATTERS ARISING** **Rookwood Relocation** AH had been in discussion with WHSSC regarding a letter of support for the Business Case. A letter had subsequently being issued confirming the discussions and responding to concerns/clarifications required by WHSSC. A letter of support had been received which enabled the responses to the Business Case scrutiny questions to be returned to WG. MD confirmed that the scrutiny document had been issued to WG. **Critical Care** MD advised the group that she had attended a Critical Care meeting with WG at which the additional revenue funding had been discussed, which was to support an expansion of the service. MD and SC confirmed that no capital funding was available to support the expansion plan and that it was expected that the	

	additional capacity could be accommodated in the existing footprint.	
4.	**EXECUTIVE SUMMARY** GW presented the Capital Report and confirmed little change to the CRL. GW formally reported that the Tesco/Woodland House acquisition had completed on Tuesday 6th August and that discussions were ongoing to confirm all the departments that would be relocated. However, the priority was to vacate Iowerth Jones by the end of the calendar year requiring IT to relocate to Woodland House and Podiatry to CRI. The later requiring PCIC CB to relocate to Woodland House. GW confirmed that the funding to support the acquisition necessitated the disposal of Iowerth Jones within the current financial year. The site had been offered under the WG land transfer protocol and the LA had confirmed their intention to acquire the site. A joint valuation process was progressing. The CMG were also advised that the receipt from the disposal of Lansdowne Hospital was also required to support the acquisition of Woodland House and that the WG had brokered the expected receipt to support the deal. Consequently, when the site is disposed of any receipt will be given back to WG. GW confirmed that a small project team had been established to plan and manage the relocation of the staff, which included Capital, Estates, Facilities and IM&T representatives. It was envisaged that when all staff relocating had been identified a HR rep may be required. FJ advised the group that GB had raised concerns with regards the IT staff resource to support the programme. GW confirmed this issue had been discussed at the project team meetings and it had been agreed that no funding had been identified from discretionary capital to support any additional resource. GW had advised GB to produce a paper for consideration by ME. MD proposed that FJ raise the issue at the next ME meeting. Property disposal: Further funding to support the capital programme would be generated through the disposal of the following UHB assets. • Amy Evans is progressing with the Local Authority / Social Housing • Colcott tentative discussions were ongoing with the Local Authority for a joint valuation.	FJ
5.	**MAJOR CAPITAL PLANNING REPORT**	

Neonatal Project

JH reported that the next phases of the scheme were on programme with Obstetrics ward/theatre due to complete on 16th November and Neonatal Phase 2a on 19th November 2018. MD requested clarification of commissioning dates for both areas, JH confirmed the additional Obstetrics capacity would be commissioned early December 2018, and the additional cots in Neonatal by mid December 2018.

Generally the works had gone well with only some disruption as a result of noise being an issue. JH confirmed that a meeting was being held to discuss mitigation options.

JH confirmed that it was anticipated that Neonatal Phase 2b completion was scheduled for 3rd April 2019 with the last phase being the MRI on 5th July 2019. Meetings were being arranged with Mike Bourne to discuss the commissioning programme for the MRI.

CRI Enabling works

Scheduled to complete the 1st week of September 2018

Renal Facility UHW

JH advised the group that there had been difficulty in agreeing a date for the vacant possession of suite 19 to allow works to commence. This was as a result of a significant increase in transplants that had been undertaken had impacted on the T5 ward moving to B5. A meeting was scheduled to discuss the logistical issues and it was agreed that it would be helpful to have Lee Davies in attendance.

Vacant possession of Renal Suite 19 was required on 17th September to allow a completion of the works on 22nd March 2019.

4.1 Project Status Report

The project status reports were provided for detailed reference of the ongoing schemes. GW confirmed these are reported to WG on a monthly basis.

CM noted that an allowance for medical equipment was included on several of the projects. It was agreed that it would be beneficial for CM to have sight of any equipment schedules prior to ‘sign off’ to ensure any potential problems can be averted. Previously a piece of decontamination equipment had been ordered but the UHB could not support its use.

	4.2 Letters of Approval There were no letters of approval received for the reporting month	
5	**DISCRETIONARY CAPITAL & ESTATE COMPLIANCE REPORT** TW confirmed the discretionary capital programme reported a breakeven position overall with contingency currently at £465K and unallocated funding at £191K. However, the Paediatric South ward refurbishment tender received was circa £260k over the budget allowance and a further £89K budget pressure was identified for additional asbestos works at CRI. Consequently, given the H&S risk with the asbestos at CRI and the importance of the Paeds ward to the UHB winter plan, GW had made the decision that the statutory compliance budget would need to be reduced by £349K to support the schemes. He was naturally concerned about having to reduce this particular budget line but had little choice. MB asked how the budget costs and tendered costs were so different. GW confirmed that the construction market was growing in the area of south east Wales and the Bristol area and that this is being reflected in tender returns and in particular to the M&E sub contracts. TW advised that there scheme had a significant mechanical element with additional cooling requirements. The CMG recognised the difficult position faced by the capital team and unanimously agreed to support the decision made by GW and had acted appropriately. TW confirmed a total of £850k remained in the Statutory Compliance budget for the financial year. Following the awarding of the scheduled statutory compliance contracts only £18K would be available for any remedial works identified. MD noted that circa £0.8m remained in the unallocated and contingency budgets. TW gave a brief overview of the schemes which impacted on the bed capacity: Ward T5 refurbishment – scheduled to vacate by 24/08/2018 Commence works 28/08/2018 Completion 28/09/2018 Ward A2 North – works complete Ward A2 South – works commence 8/10/2018 Complete 18/11/2018	

	Paeds South - Completion 05/10/2018 Haulwen - Dates to be confirmed East 1 had a scheduled completion date for this week, ready for handover. **Statutory Compliance** TW advised the group that a number of statutory compliance contracts were progressing through the OJEU process including: Legionella – awaiting approval Emergency Lighting – out to tender Pools – finalising tender documentation Smoke/fire dampers – finalising documentation Fire alarms – preparing for re-tender BMS – Preparing re-tender **5.3 Regulation 18 Areas** The report identifying restricted areas was included for information.	
	MEDICAL EQUIPMENT REPORT CM reported the findings of the WG decontamination audit and confirmed that costs had been received for the Refurbishment of the Scope Cleaning Room which calculated to £146k. This included the enabling works to install AER decontamination equipment which had been purchased previously. A meeting was held with the audit team and it was recognised that the refurbishment was a matter of urgency. GW raised concerns regarding the allowance of £50K for the enabling works suggesting that following evaluation of the scope of works it was anticipated that a budget of £146K would be necessary. CM confirmed that the estimate was made by Sterile Services without seeking advice from the Capital team. GW requested that all future estimates be provided by the capital team so that we have more robust costs. Following a discussion, the group approved the shortfall be met from the Discretionary Capital contingency allocation. CM confirmed an 'Invest to Save' scheme had been submitted to WG for the introduction of UV decontamination units for £134k which included £44k of enabling works. CM reported that no response had been received to date. TW confirmed that the £44k estimated enabling works was provided by the Discretionary Capital team. CM reported two pieces of networkable kit were on trial for the UHB to continue to provide the neurophysiology regional service. CM had committed that the £86k would be made available, and	

	confirmed that Gareth Bulpin had agreed to ensure the IT works were in place. MD questioned if the UHB could provide a regional solution if put in place, it was recognised that the UHB could not provide the degree of resilience needed to provide a robust regional solution but it would provide the UHB with options to treat patients. CM confirmed a full regional Service would be in the excess of £700k to get all of the kit networkable with other HB's (£300k alone for UHB) but as the HB were unable to support the amount it was confirmed for the minimum £86k budget to be utilised. MD approved and confirmed the funding would be provided from Medical Equipment budget. CM informed the CMG that the Surgical Clinical board continued to highlight the requirement for the Theatre endoscope stack and microscope to relocate ENT surgery to UHL. The relocation o this service to UHL was a key enabler to the UHB being able to support the vascular centralisation. The cost of the equipment required was £215K which if funded from contingency would leave only £154K (£96K previously approved for decontamination) GW understood that the ENT surgical team had agreed to use theatre 5 at UHL until Black & Grey was developed but questioned whether this equipment would then be transferred. MD suggested that the group seek confirmation that if the funding was approved for the equipment that they have a firm plan to use it in this financial year. GW confirmed a meeting had been scheduled with the CE, SC, AH and GW to agree the capital priorities of the organisation we have little resource to progress all that is being requested. CM reminded the group that Cardiology currently had a decontamination facility available with no suitable equipment available which would cost approximately £50k. He advised that this was likely to be raised in the recent WG audit. A letter was submitted to WG for the request of £1.065m additional funding of those and other issues, including minimally invasive nitro valve surgery. No response has yet been received. MD suggested that CM write to GW/AH to highlight the level of risk and implication. MD suggested that the Risk Register for medical equipment be reviewed to ensure that the requests are explicitly identified.	CM CM CM
7.	**IM&T REPORT** FJ presented the IM&T report and provided an update on the priority issues around virtual servers. FJ drew the groups attention to the working being undertaken by the critical care network who were procuring an electronic solution to go paperless although it didn't include all of the HB's	

	costs. FJ reported this would need to be monitored closely to identify the costs above the allocation of the budget. MD questioned if the BC had been supported by the UHB? FJ reported the BC came through the critical care network. MD noted that the BC had not been brought to CMG or BCAG for a revenue support. MD proposed that IT and Specialist Services collectively provide a paper for the following CMG which describes what the capital requirements would be and what context was in terms of the national programme. Also it was advised to attach the NBC to the paper.	FJ
8.	**SERVICE PLANNING** MD presented the Service Planning report and highlighted that Theatres redevelopment and reconfiguration continued as an evolving scheme. MD reported there were a number of BC's which needed to be developed but that WG had requested a Strategic Overview paper which considered a range of schemes including Main Theatres refurbishment at UHW, Haematology, Radiopharmacy, Hybrid & Major Trauma Theatres and UHL theatres. MD confirmed work was ongoing with Clinical board colleagues to ensure the paper presented a clear service context. BC's were being developed for the Replacement of Orthopaedic Theatres at UHL and the upgrading of Black and Grey as a single integrated Theatre, ensuring the context for both of the developments are clear. There were Two developments which were highlighted; Remodelling of SSSU to an emergency floor for a more coherent service model for UHW Theatres and the development of theatre capacity at UHL to enable elective ambulatory/ lower routine surgery for the HB's Medium term model. It was anticipated that the Strategic overview paper would be completed the end of August / early September. **Shaping Our Future Wellbeing** There was no further update following the previous report, a delivery group meeting was scheduled for sign off on a number of stages of the project. **Radiopharmacy** GW had explored alternative options for the service to be situated off site. He was considering whether the facility could be collocated with St Mary's, or there may be an opportunity to combine a new facility for Radio Pharmacy and WEQAS. **Mortuary**	

	GW confirmed a project team had been established and the initial meeting was held approximately 2 weeks ago, work was ongoing with the mortuary team to identify all of the options of refurbishment, new build or relocation to the coroner's progress off site. MD clarified that it remained a service priority for the organisation which the HB were scoping the most proportionate proposal which would be submitted to WG for funding. MD reminded the board of a capital prioritisation workshop approaching and it would be vital to brief AH,LR&BC on the consequences of not investing in the major schemes needed for the organisation.	
9.	**CAPITAL PROJECT REQUESTS** A Summary of the capital project requests was presented at the meeting which highlighted the stages of each individual. Two additional requests had been submitted since the last meeting. PR0006 requested TDSI at HYC, the clinical board confirmed they would fund installation and also fund all breakdown and maintenance costs from their revenue budget. The request was agreed. PR0007 GW provided an overview of the request which was anticipated to be financed by charitable funds although GW noted that the area requested had not yet been assigned to the department, therefore no work was to commence at this time.	
10.	**ANY OTHER BUSINESS** GW gave his apologies for the following scheduled meeting	
11.	**DATE AND TIME OF THE NEXT MEETING** Monday 15th October 2018, 11:30am, Corporate Meeting Room, HQ	