Bundle Informatics and Information Governance Committee 9 May 2019

0 Agenda

agenda_IGIC_9_May_2019.docx

1 09:30 - IG19/14 Chair's opening remarks

2 IG19/15 Apologies

3 IG19/16 Declarations of Interest

4 09:30 - IG19/17 Draft minutes of the previous meeting held on 14.2.19, matters arising and summary action plan

IG19.17a Minutes IGIC 14.2.19 v0.1.docx

IG19.17b Summary Action Log.doc

6 09:35 - IG19/18 NWIS update

Mr Andrew Griffiths Director NWIS in attendance

6 Informatics

6.1 09:55 - IG19/19 Informatics operational plan 2018/19 year end report

Dr Evan Moore
Mr Dylan Williams in attendance
Recommendation:
The Committee is asked to note the report.

IG19.19a Operational Plan performance update_Year end Coversheet.docx

IG19.19b 2018 2019 End Of Year Report FINAL.pdf

6.2 10:25 - IG19/20 Informatics quarterly assurance report

Dr Evan Moore
Mr Dylan Williams and Mr Sion Jones (Information security update) in attendance
Recommendation
The IGI Committee is asked to note compliance with legislative and regulatory responsibilities which relate to the Informatics Services and to advise the service of any additional metrics required to improve assurance.

IG19.20 Informatics Quarterly Assurance Report.docx

6.2.1 10:45 - Comfort break

6.3 10:55 - IG19/21 Welsh Community Care Information System (WCCIS) status report

Dr Evan Moore
Christine Couchman in attendance
Recommendation
The Committee is asked to receive the update on delivery of the roll out of WCCIS - one of the core National IT systems

IG19.21 WCCIS update.docx

6.3.1 11:10 - IG19/22 Single Cancer Pathway and Eye Care Measure Data Compliance

Dr Evan Moore
Mr Dylan Williams in attendance
Recommendation:
The Committee is asked to note the approach to meeting both the Single Cancer Pathway and Eye Care Measure data compliance

IG19.22 Single Cancer Pathway and Eye Care Measure Data Compliance.docx

6.4 11:15 - IG19/23 IT Change management Policy

Dr Evan Moore
Mr Dylan WIlliams in attendance
Recommendation:
The Committee is asked to ratify the IT Systems Change Management Policy

IG19.23 IT Systems Change Management Policy.docx

6.5 11:25 - IG19/24 Development of BCUHB Digital Strategy - verbal update

Dr Evan Moore
Mr Dylan Williams in attendance

7 Information Governance

7.1 11:30 - IG19/25 Information Governance Strategy

Mrs Grace Lewis-Parry
Mrs Justine Parry in attendance
Recommendation:
The Committee is asked to ratify the IG Strategy

IG19.25a IG Strategy coversheet.docx

IG19.25b IG1 BCUHB Information Governance Strategy V4.4 draft.docx

IG19.25c IG Strategy Appendix A_EqIA IG Strategy 2019.pdf

IG19.25d IG Strategy Appendix B_ToR IGG.pdf

IG19.25e IG Strategy Appendix C_IGI ToR.pdf

IG19.25f IG Strategy Appendix D_IG Accountability Framework.pdf

7.2 11:50 - IG19/26 Chair Assurance report : Information Governance Group

Mrs Grace Lewis-Parry
Mrs Justine Parry in attendance
Recommendation:
The Committee is asked to note the report

IG19.26 IGG Chair's Assurance Report Apr2019-draft.docx

8.1 12:05 - IG19/28 Draft Committee annual report 2018/19

Dr Evan Moore
Recommendations:
The Committee is asked to:
1. Review the draft Annual Report for 2018-19
2. Provide comments and feedback as necessary
3. Review Terms of Reference (Appendix 1)
4. Review and approve Cycle of Business 2019/20 (Appendix 2)
5. Approve that Chair's Action can be taken to agree the final version for submission to Audit Committee

IG19.28a Committee Annual Report_coversheet.docx

IG19.28b Committee Annual Report IGIC 2018-19 v.02 draft.docx

IG19.28c App1 IGI ToR V1.0.docx

IG19.28d App2 IGI Cycle of Business 2019_20 v.02 Draft to be considered May IGIC meeting.docx

8.2 12:15 - IG19/27 Review of Corporate risks assigned to the Committee

Dr Evan Moore
Recommendation:
The Committee is asked to approve 10a, 10b & 10c for inclusion on the Corporate Risk Register, consider the relevance of the current controls, review the actions in place and consider whether the risk scores remain appropriate.

IG19.27a IGI Risk Register coversheet.docx

IG19.27b IGI Risk Register CRR10A.pdf

IG19.27c IGI Risk Register CRR10B.pdf

IG19.27d IGI Risk Register CRR10C.pdf

10 IG19/29 Issues to inform the Chair's Assurance report

11 IG19/30 Summary of In-Committee business to be reported in public

IG19.30 InCommitte items reported in public.docx

12 12:30 - IG19/31 Date of next meeting

15 August 2019

13 12:30 - Exclusion of the Press and Public

Resolution to Exclude the Press and Public
"That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960."

Agenda Informatics and Information Governance Committee

Date	09/05/2019
Time	9:30 - 12:55
Location	Boardroom, Carlton Court, St Asaph LL17 0JG
Chair	Mr John Cunliffe
Description	

	Agenda
9:30	**IG19/14 Chair's opening remarks**
	IG19/15 Apologies
	IG19/16 Declarations of Interest
9:30	**IG19/17 Draft minutes of the previous meeting held on 14.2.19, matters arising and summary action plan**
9:35	**IG19/18 NWIS update** Mr Andrew Griffiths Director NWIS in attendance
	Informatics
9:55	**IG19/19 Informatics operational plan 2018/19 year end report** Dr Evan Moore Mr Dylan Williams in attendance Recommendation: The Committee is asked to note the report.
10:25	**IG19/20 Informatics quarterly assurance report** Dr Evan Moore Mr Dylan Williams and Mr Sion Jones (Information security update) in attendance Recommendation The IGI Committee is asked to note compliance with legislative and regulatory responsibilities which relate to the Informatics Services and to advise the service of any additional metrics required to improve

assurance.

10:45 **Comfort break**

10:55 **IG19/21 Welsh Community Care Information System (WCCIS) status report**

Dr Evan Moore

Christine Couchman in attendance

Recommendation

The Committee is asked to receive the update on delivery of the roll out of WCCIS - one of the core National IT systems

11:10 **IG19/22 Single Cancer Pathway and Eye Care Measure Data Compliance**

Dr Evan Moore

Mr Dylan Williams in attendance

Recommendation:

The Committee is asked to note the approach to meeting both the Single Cancer Pathway and Eye Care Measure data compliance

11:15 **IG19/23 IT Change management Policy**

Dr Evan Moore

Mr Dylan WIlliams in attendance

Recommendation:

The Committee is asked to ratify the IT Systems Change Management Policy

11:25 **IG19/24 Development of BCUHB Digital Strategy - verbal update**

Dr Evan Moore

Mr Dylan Williams in attendance

Information Governance

11:30 **IG19/25 Information Governance Strategy**

Mrs Grace Lewis-Parry

Mrs Justine Parry in attendance

Recommendation:

The Committee is asked to ratify the IG Strategy

11:50 **IG19/26 Chair Assurance report : Information Governance Group**

Mrs Grace Lewis-Parry

Mrs Justine Parry in attendance

Recommendation:

The Committee is asked to note the report

12:05 **IG19/28 Draft Committee annual report 2018/19**

Dr Evan Moore

Recommendations:

The Committee is asked to:

1. Review the draft Annual Report for 2018-19
2. Provide comments and feedback as necessary
3. Review Terms of Reference (Appendix 1)
4. Review and approve Cycle of Business 2019/20 (Appendix 2)
5. Approve that Chair's Action can be taken to agree the final version for submission to Audit Committee

12:15 **IG19/27 Review of Corporate risks assigned to the Committee**

Dr Evan Moore

Recommendation:

The Committee is asked to approve 10a, 10b & 10c for inclusion on the Corporate Risk Register, consider the relevance of the current controls, review the actions in place and consider whether the risk scores remain appropriate.

IG19/29 Issues to inform the Chair's Assurance report

IG19/30 Summary of In-Committee business to be reported in public

Recommendation:

The Committee is asked to note the report

12:30 **IG19/31 Date of next meeting**

15 August 2019

12:30 **Exclusion of the Press and Public**

Resolution to Exclude the Press and Public

"That representatives of the press and other members of the public be excluded from the remainder of this

meeting having regard to the confidential nature of the business to be

transacted, publicity on which would

be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings)

Act 1960."

Information Governance and Informatics Committee
Draft minutes of the meeting held on 14.2.19
in the Boardroom, Carlton Court, St Asaph

Present:

Mr John Cunliffe	Independent Member– Committee Chair
Ms Lucy Reid	Independent Member
Cllr Cheryl Carlisle	Independent Member

In Attendance:

Mrs Kate Dunn	Head of Corporate Affairs
Mrs Grace Lewis-Parry	Board Secretary
Dr Melanie Maxwell	Caldicott Guardian
Dr Evan Moore	Executive Medical Director
Mrs Justine Parry	Assistant Director Information Governance and Assurance
Mr Andrew Strong	Wales Audit Office Observer
Mr Dylan Williams	Chief Information Officer

Agenda Item Discussed	Action By
IG19/1 Chair's Opening Remarks The Chairman welcomed everyone to the meeting.	
IG19/2 Apologies for Absence Apologies were received from Prof Jo Rycroft-Malone.	
IG19/3 Declarations of Interest None were received.	
IG19/4 Draft Minutes of the Previous Meeting Held on 13.11.18 and Summary Action Log The minutes were approved as an accurate record. No matters arising were raised. Updates were noted to the summary action log.	
IG19/5 Review of Corporate Risks Assigned to the Information Governance and Informatics Committee **IG19/5.1** The Committee Chair outlined some confusion amongst the members in that they had expected to have seen three separate risks around health records, local infrastructure and national issues eg; NHS Wales Informatics Services (NWIS). The Assistant Director Information Governance & Assurance clarified the escalation process	

for any new risks and that the national NWIS risk had been discussed at the Executive Management Group (EMG) but now required further work. The Committee Chair reiterated that the Committee would wish to see reference within the Corporate Risk Assurance Framework that NWIS was a significant risk in terms of BCUHB's ability to deliver the IMT&IT agenda. **IG19/5.2** In terms of CRR10a the comment was made that some of the detail from the original CRR10 had been lost and that the new risk did not reflect primary care elements. It was also suggested that the risk needed to be widened to include assets, capacity and capability. The Chief Information Officer undertook to further review and amend this risk including firming up the sources of assurance. **IG19/5.3** With regards to CRR10b the Chief Information Officer was asked to refresh the narrative to better define whether the risk related to all health records or just some aspects, and to clarify where other known risk areas were being appropriately managed. He would also firm up the sources of assurance. **IG19/5.4 It was resolved that** the Committee receive the amended risks in due at the next meeting	DW DW
IG19/6 Informatics Operational Plan Objectives 2018/19 Quarter 3 Performance Update **IG19/6.1** The Chief Information Officer presented the report and indicated that he was looking to reflect on the format and style for future meetings to enable the reports to better identify where there had been change of note or exceptions. He highlighted that the Paediatric Mobile Nursing Application (known as CHAI) which should have been delivered within Quarter 3 was now being progressed. In terms of the Results Management project, a Welsh Clinical Portal pilot due to commence would be instrumental in informing the way forward. The Welsh Patient Administration System (WPAS) was on target to go live during the first week in March. It was noted that appointed Project Manager for the Welsh Emergency Department System (WEDS) had withdrawn. In terms of significant events to report, the Chief Information Officer drew members' attention approved pilots commencing in support of the Welsh Community Care Information System (WCCIS) project. He also noted there were resource constraints within the Patient Management Status Boards (PMSB) but it remained a positive project. Finally he confirmed that capital had been secured for upgrading the IPT Telephony project. **IG19/6.2** A Committee member raised some general points regarding the completion of coversheets and ensuring that the relevant information was included within the appropriate sections and that where the accompanying narrative report identified risks or concerns that these are also highlighted on the coversheet. The Chief Information Officer would feed this back to authors of papers to the Committee and it would also be brought to the attention of the Board Secretary. **IG19/6.3** A comment was made that it was difficult for the reader to reconcile the narrative with the data in Table 1 regarding progress against objectives. The Chief Information Officer accepted that the presentation of this data from an internal planning tool did not fully work and he would reflect and amend. In terms of paragraph 1 "Objective Status" it was noted this stated that a range of projects would "no longer be reported". It was requested that if this meant they were being reported elsewhere other	DW KD DW

than the IGI Committee, then the narrative needed to confirm where they were being reported. **IG19/6.4** With regards to the CHAI project a question was asked why this was not wider than paediatrics. The Chief Information Officer reported that a range of departments went through a bidding process to trial the project with paediatrics being the successful department. He agreed that it was a more wider generic solution which had potential for rollout to other departments, particularly if the national solution for mobile nursing records did not work out. **IG19/6.5** With regards to the IPT telephony project it was accepted that the statement "these issues are now suggested to be resolved" was poorly worded and the Chief Information Officer would amend to more clearly demonstrate that the issues were resolved. He was also asked to provide a statement to explain the issues that were being experienced with the "My Ping" solution and restrictions being placed on the Health Board by NWIS. The Chief Information Officer added that the intention was to evaluate "My Ping" properly. Members also asked that clarity be provided on what the WCCIS pilots were meant to deliver. **IG19/6.6** The Committee Chair was keen to understand by how much the capital limit would be missed and the reasons for this. The Chief Information Officer indicated this would not be known until closer to year-end. **IG19/6.7 It was resolved that** the Committee note the report and the amendments to the 2018-19 Operational Plan as highlighted.	DW DW DW DW
IG19/7 Digital Strategy Development Update **IG19/7.1** The Chief Information Officer presented the paper, confirming that this was not a new strategy but was a high level document set in the context of the national plan and was being further developed to incorporate a more detailed costed plan. He drew attention to Figure 1 which aimed to illustrate how the demand for digital technologies was identified and flowed from demand to delivery. A number of digital enablers were also set out on pages 6-9 which would require prioritisation, and the Chief Information Officer highlighted Figure 4 which set out how acute systems could be harmonised to support Excellent Hospital Care. The paper also aimed to demonstrate a strong commitment to working across the region with partners being on the same system, however, it was apparent that the model for integrating services would be at risk if national developments were not delivered. Finally the Chief Information Officer indicated that the Strategy Partnerships & Population Health Committee had received the paper on the 5.2.19 but did not formally approve as members had queries and questions which were not able to be answered at the meeting. **IG19/7.2** A Committee member welcomed the paper which she found clear and easy to follow and that it more helpfully defined what were local and what were national projects. She did however feel that given the public nature of the paper it should more clearly define what is meant by primary care – ie GPs alone or other primary care contractors. The Chief Information Officer confirmed it related primarily to General Medical Services systems and undertook to reflect this more clearly within the scope of the document. **IG19/7.3** The question was asked as to who would be assessing and prioritising the potential digital enablers and it was confirmed this would primarily be the Digital Strategy	DW

Group. The Board Secretary also confirmed that a new governance structure to oversee the delivery of the Three Year Plan and Annual Operational Plan had been signed off at Executive Team on the 13.2.19. **IG19/7.4 It was resolved that the** Committee note the report.	
IG19/8 Review and Approval of Informatics Operational Plan 2019-20 **IG19/8.1** The Chief Information Officer presented the paper which set out the focus for Informatics over the next year, in line with the broader organisational plans for 2019-2022. He alluded to a significant challenge to delivery as workforce related, although this was a challenge shared by other Health Boards. **IG19/8.2** A question was asked around the digital mobile workforce and the Chief Information Officer recognised the need for a cohesive national plan and that there would have to be detailed profiling of the needs of each area or team of healthcare professionals as they would have differing requirements. He reported that there had been a recent appointment within BCUHB of an individual to focus on mobile devices specifically. He also mentioned an initiative to improve connectivity with Local Authorities but that a major sticking point was primary care as their systems did not fall either within health nor social care networks. A member enquired about broadband rollout and the effect on informatics plans, and the Chief Information Officer state there was a joint North Wales document on future investment into infrastructure which he would circulate. A member also suggested that the date for the rollout of Office 365 seemed too generous; it was reported that there were migration issues which created challenges in compatibility which would require resolution **IG19/8.3** The Chair noted that the Committee was being asked to approve the plan however there were elements yet to be finalised. The Chief Information Officer confirmed that at the time of writing best estimates had been included around budget and capital. **IG19/8.4 It was resolved that** the Committee approve the Informatics Operational Plan 2019-20 subject to there being no significant changes once the budget and capital details were confirmed.	DW
IG19/9 Chair's Assurance Report – Digital Transformation Group **IG19/9.1** The Chief Information Officer highlighted continuing issues with low attendance at the Group and that this had been escalated, and a communication sent directly to the membership to stress the importance of their engagement and attendance. He also drew members' attention to an interesting presentation by "Patient Knows Best" (PKB) regarding a digital patient portal. The Group had also reviewed informatics related risks, and the Assistant Director Information Governance & Risk reported that training for systems owners (in terms of the GDPR risk) was being very well received by staff attending. A Committee member noted her concern at the lack of engagement and issues around skillsets with systems owners, and the Chief Information Officer confirmed that action had been taken to check/ensure that they had been correctly identified as a system owner and to offer support and training. The Committee Chair noted reference to the Eye Care Business Case which had a national commitment to deliver but did not appear to be fully structured from a financial perspective; the Chief Information Officer accepted there were caveats around the resource to deliver.	

IG19/9.2 It was resolved that the Committee note the issues of significance from the Digital Transformation Group.	
IG19/10 Information Governance Summary Key Performance Indicator (KPI) Report for Quarter 3 2018-19 **IG19/10.1** The Assistant Director Information Governance & Risk presented the paper, and noted that the last meeting of the Information Governance Group (IGG) had been stood down due to the number of apologies received. A summary KPI report had been prepared for sharing with the IGI Committee. The Assistant Director Information Governance & Risk highlighted key points including the reduction in responding to Freedom of Information (FOI) requests and non-clinical subject access requests which she explained related predominantly to delays in obtaining responses from departments and line managers. She was pleased to report an increase in responding to Health Records requests and that mandatory training compliance levels had been maintained. In addition, near misses were now also being reported in line with the Information Commissioner's Office comment last year. **IG19/10.2** A Committee member asked whether the full KPI report could not have been provided as the summary was difficult to follow and did not allow for comparison of trends or lessons learnt. The Board Secretary set out the challenges in ensuring the level of detail was meaningful but also was appropriate for the public domain, and suggested that the report would need to evolve as the IGI Committee matured. Following discussion the Committee were content that the full Quarter 4 report be provided in-committee to the next meeting to allow work to commence on revising the format as from Quarter 1 of 2019-20. A copy of the full KPI Quarter 3 report would be circulated to members via email for their information. **IG19/10.3** The Assistant Director Information Governance & Risk provided a verbal update against the two Level 2 incidents which related to an allegation of altering of a patient record and to missing community records. She undertook to circulate further information on IG incidents in terms of actual numbers and performance. The Caldicott Guardian noted that ideally there should be a good level of reporting of incidents categorised as low harm which would indicate that people were open and willing to report. In terms of FOIs a conversation took place regarding the context and scale of the request which it was felt was important when looking at performance levels.	JP JP JP
IG19/11 Issues of Significance to Inform the Chair's Assurance Report To be agreed outside of the meeting but to include summary of discussions around corporate risks, barriers to CHAI project, the development of the digital strategy and the Information Governance KPI report.	
IG19/12 Date of next meeting 9.30am on 9th May 2019 in the Carlton Court Boardroom	
Resolution to Exclude the Press and Public That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960."	

BCUHB Information Governance and Informatics Committee Summary Action Log – arising from meetings held in public				
Officer	**Minute Reference and Action Agreed**	**Original Timescale**	**Latest Update Position**	**Revised Timescale**
13.11.18				
Evan Moore	**IG18/4 Committee Terms of Reference** Feedback a recommendation on whom should be 'in attendance' on a regular and also adhoc basis, following consideration at Executive Team	1.2.19	14.12.19 The Executive Medical Director reported back to the Committee that he and the rest of the Executive Team were content with the membership as set out in the terms of reference.	Action to be closed
Evan Moore Dylan Williams	**IG18/5 Committee Cycle of Business** The Executive Medical Director and Chief Information Officer to feedback a recommendation on the content and frequency of Health Records reports to be included within the COB.	1.2.19	14.12.19 The Chief Information Office reported that Health Records will be a standing item at each quarterly meeting of the Committee	Action to be closed
Justine Parry	**IG18/12 Information Governance Policies** • Information Security Policy – a new policy to replace the Health Board's IG05 IM&T Security Policy. The Assistant Director Information Governance and Assurance agreed to address the queries raised in respect of encryption (5.2) and concern regarding email storage in records management (5.5)	~~1.2.19~~ 5.5.19	This is an issue which require involvement of NWIS due to national policy and will be raised at the next national IG management advisory group to be held on 6.3.19 14.12.19 The Committee were informed that a senior representative of NWIS would be attending the May meeting of the Committee. It was agreed this should be an annual invitation.	 May
14.2.19				
Dylan Williams	**IG19/5.2 Corporate Risks** Further review and amend CRR10a	TBA	Completed – Three corporate risks developed and on the agenda for May.	Action to be closed
Dylan Williams	**IG19/5.3 Corporate Risks**	TBA	Completed – Three corporate risks developed and on the	Action to

	Further review and amend CRR10b		agenda for May.	be closed
Dylan Williams	**IG19/6.2** Take on board comments regarding completion of coversheets	May	Completed	Action to be closed
Kate Dunn	**IG19/6.2** Share comments re coversheets within Office of Board Secretary to help support authors	March	Completed	Action to be closed
Dylan Williams	**IG19/6.3 Informatics Operational Plan** Take on board and reflect range of comments made on the format, narrative and presentation of this report.	May	Completed	Action to be closed
Dylan Williams	**IG19/7.2 Digital Strategy Development** Clarify within document the scope in terms of primary care	March	Further engagement undertaken on the digital strategy to ensure care closer to home and primary care scope is clear. In addition, the Strategy is being amended to reflect the newly agreed Estates and Workforce Strategies. Further work will be required once the outcome of the national Informatics Governance and National Architecture Reviews are known.	Action to be closed
Dylan Williams	**IG19/8.2 Informatics Operational Plan** Circulate copy of North Wales document regarding investment into infrastructure (inc broadband rollout)	March	Circulated for information.	Action to be closed.
Justine Parry	**IG19/10.2 Information Governance KPI Summary** Circulate copy of full KPI report for Q3 via email	February	Circulated 14.2.19	Action to be closed
Justine Parry	**IG19/10.2 Information Governance KPI Summary** Revise full KPI report to work towards submitting in public session from Q1 onwards	August	In progress	

Justine Parry	**IG19/10.3 Information Governance KPI Summary** Circulate details of IG incidents numbers and performance	February	Circulated 14.2.19	Action to be closed

Information Governance and Informatics Committee **9.5.19**	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board ***To improve health and provide excellent care***

Report Title:	**Operational Plan performance update 2018/2019 Informatics End of Year Report**
Report Author:	Mrs Tracy Williams, Head of Informatics Performance & Improvement
Responsible Director:	Dr Evan Moore, Executive Medical Director
Public or In Committee	Public
Purpose of Report:	This paper aims to provide the IGI Committee with a high level report summarising:- • Informatics deliverables against objectives that were outlined within the 2018 2019 operational plan, • Challenges not met within year which are risks to the delivery of objectives and services going forwards (Tier 1 risks), • 2018 2019 Capital and revenue expenditure. This report has been provided to support the committees work in overseeing the direction and the delivery of the Health Boards Informatics strategies and plans.
Approval / Scrutiny Route Prior to Presentation:	This is a summary of deliverables that have previously been reported as part of quarterly progress reports against the operational plan. Reports were formally to the F& P committee and latterly to the IGIC. The composite report has received scrutiny and approval from the Informatics Senior Management Team.
Governance issues / risks:	This report details challenges not met within year, which are risks to the delivery of objectives, plans and service delivery going forward. These risks have been captured on Datix as “tier 1” risks and have been subject to previous discussions at this committee. Note – these risks have recently been updated. - Risks are fully detailed in IGIC risk report.
Financial Implications:	The End of Year report highlights “deliberate” and approved brokerage of All Wales Capital within the Informatics discretionary capital programme for 2018 2019. The £225k brokered will require re-provision to the WPAS project in 2019 2020. Increased recruitment activities during the last two quarters of 2018 2019 and recruitment plans for 2019 2020 are projected (and are evidenced) to increase Informatics staffing costs to the cost envelope

	allocated. This is likely to affect support that can be provided for the Health Boards underlying financial position going forward.
Recommendation:	The Committee is asked to note the report.

Health Board's Well-being Objectives *(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)*		**WFGA Sustainable Development Principle** *(Indicate how the paper/proposal has embedded and prioritised the sustainable development principle in its development. Describe how within the main body of the report or if not indicate the reasons for this.)*	
1.To improve physical, emotional and mental health and well-being for all		1.Balancing short term need with long term planning for the future	√
2.To target our resources to those with the greatest needs and reduce inequalities		2.Working together with other partners to deliver objectives	√
3.To support children to have the best start in life		3. Involving those with an interest and seeking their views	√
4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being		4.Putting resources into preventing problems occurring or getting worse	√
5.To improve the safety and quality of all services	√	5.Considering impact on all well-being goals together and on other bodies	
6.To respect people and their dignity			
7.To listen to people and learn from their experiences			
Special Measures Improvement Framework Theme/Expectation addressed by this paper http://www.wales.nhs.uk/sitesplus/861/page/81806			
Equality Impact Assessment *No EqIA has been carried out as a change of policy or direction is not envisaged*			

Disclosure: Betsi Cadwaladr University Health Board is the operational name of Betsi Cadwaladr University Local Health Board

2018/2019 INFORMATICS END OF YEAR REPORT

OUR STRATEGIC OBJECTIVES

DIGITAL ROADMAP

The building blocks of a single patient view which those receiving, providing or supporting patient care can access. This includes adopting a digital by default principal, capturing data once and reusing it. Minimising the use of paper and working towards "paper free at the point of care"

DATA DRIVEN DECISION MAKING

Providing tools to put data from a variety of sources at the heart of decision making in a timely and user friendly manner. Providing insights to inform effective decisions through synthesising information from a variety of sources

UNDERPINNING SERVICE TRANSFORMATION

Supporting Services to combine technological opportunities with new business processes, that enable us to meet our Local and National responsibilities

DIGITAL MOBILE WORKFORCE

Providing digital tools to support staff to undertake duties, work together and communicate effectively from a variety of locations. Reducing overheads, supporting strategies and enabling "time to care"

2018 HIGHLIGHTS *How we performed and what we delivered*

We moved closer to rationalising core systems by upgrading the Welsh Patient Administration System (WPAS) in the East. This completed phase two of the WPAS programme supporting the delivery of strategic objectives

Additional Benefits : - Cost savings circa £140k per annum will be realised once we have achieved a single instance of the WPAS . Standardisation of processes will also follow in future phases improving staff processes / experiences

Phase one of BCU Digital Health Record (DHR) project was completed , producing an Outline Business Case to procure a system to provide a single digital view of the acute patient record; improve patient safety, support sharing, provide greater compliance with Data Protection legislation, streamlining working practices to deliver cashable savings.

The implementation of the new data warehouse has continued, with a number of data sets passing the rigorous testing process. Work has also begun to enabled governed access to data by other departments.

Development of dashboards and reports in Power BI has also begun, including the use of visually innovate Emergency Department floorplans and mobile dashboards.

To support BCU in meeting General Data Protection Regulations, a Patient Records Transition Programme was established . This programme will be developed further in 2019 2020 to review the management arrangements for supporting good record keeping across all patient record types.

A pilot to support patient flow and bed management by displaying data to support ward rounds in Central has been undertaken (known locally as stream/flow). Project evaluation and recommendations are awaited benefits are anticipated for Patients and Staff

700
Corporate phones supported (400 replacements within year)

400
personal devices enabled to ultalise a BCU email account

40 Ipads
10 Ipods
Additional Pilots; Facilities, community nursing & nursing e-docs

1
Mobile Device Technician Appointed

700
new SKYPE Users

2018/2019 INFORMATICS END OF YEAR REPORT

OUR STRATEGIC OBJECTIVES

MANAGING INNOVATION & EMERGING TECHNLOGIES

Learning and Innovating by providing accelerators of digital transformation. Collaborating with innovators and entrepreneurs and suppliers to encourage innovation

DIGITAL INFRASTRUCTURE

Providing, developing and maintaining a secure, flexible and robust infrastructure to enable a digital future. Getting the "basics right" and building an Infrastructure to support transformation

WORKFORCE DEVELOPMENT, TRANSAPRENCY, SUSTAINABILITY & STANDARDS

Nurturing a digital culture throughout the organisation so that our workforce can envisage and inform how they want to work. Supporting staff to develop and provide services that meet the efficiency, quality and sustainability challenges that we face. Adopting evidence based best practice and meeting our legislative requirements

2018 HIGHLIGHTS *How we performed and what we delivered*

- **Completion of a pilot to automate clinical coding (phase 2 Small Business Research Initiative Project) resulting in accurate automated coding for appropriate test specialties. Draft Business case completed for future phases.**
- **We entered into an agreement with the Welsh Government to host a centre of excellence for Small Business Research Initiatives (SBRI) within Health on behalf of Wales and established the Centre.**

- **46 Health Board sites were migrated to Public Sector Broadband enabling faster access to Health Board systems**
- **10 Gigabyte links were installed between acute data centres increasing bandwidth , processing capacity and improving business continuity (Note works to be fully completed by end of April 2019)**
- **1582 IP telephones installed (2600 total) completing installation in 55 sites and supporting core infrastructure**
- **Data centre expansion completed in the East to accommodate new equipment and enhance business continuity**
- **Delivery of services in challenging circumstance. Enacting Business Continuity Plans for Health Records as a result of Library infrastructure failings in Central.**

17 WTE **Increase to budget ***

20% reduction in fixed term staffing* **

28% * ** Improvement against compliance rates for clinical coding

Sound Financial Management: Pages 4 and 5

Workforce, Learning and Development

2 Clinical Coding Accreditation awards attained

7 Management (ILM)Accreditation awards attained

6 PRINCE2 Foundation Awards

3 PRINCE2 Practitioner Awards attained

93% Mandatory Training Compliance

83% PADR Rate

* This will reduce risks to continuity of services & support retention of essential knowledge & skills to support service delivery
**Data from March 2018 to Nov 2018.
***Apr 2018 Clinical Coding compliance rate was 63.4%. Apr 2019 compliance rate is 92%. Compliance rate is required to be 95%

2018/2019 Challenges not met within Year / Going Forward

2018 2019 Tier 1 Informatics Corporate Risks

Informatics Resource:- There is a risk that digital services within the Health Board are not fit for purpose. This may be due to: (a) A lack of capacity and resource to deliver services / guide the organisation. (b) Increasing demand (internally from users e.g. for devices/ training and externally from the public, government and regulators e.g. growing need for digital services.) (c) the moving pace of technology. This could lead to failures in clinical and management systems, and a failure to support the delivery of the Health boards strategy / plans impacting negatively on patient safety/outcomes. It may also pose a greater risk to the Health board of infrastructure failures and cyber attack.

National Infrastructure and Products:- There is a risk that the national infrastructure, technical architecture and products are not fit for purpose and do not allow the organisation to deliver benefits as planned. This is caused by a) a one size fits all approach b) products which are not delivered as specified (e.g. time, functionality and quality) . c) the approach of the National Programme to mandate/design systems rather than standards. d) poor resilience and a "lack of focus on routine maintenance". e) Supplier capacity leading to commitment or delivery delays. f) Historic pricing models that are difficult to influence / may not be equitable. This may result in negative impacts in several key areas including:- Patient outcomes. An inability to support the strategic direction of the Health Board. Delays to delivery of transformational change. Inefficient work flows, poor system usage. Increased costs as we maintain multiple systems / pay inequitable prices. Delays with the delivery of cost saving

Health Records:- There is a risk that patient information is not available when are where required. This is caused by a lack of suitable storage space, uncertain retention periods, and the logistical challenges with sharing and maintaining standards associated with the paper record. This may result in substandard care, patient harm and an inability to meet our legislative duties.

2018/2019 Capital and Revenue Expenditure

Capital funding and spend may be summarised as follows:

Funding	Group	Sum of Brokerage	Approved Budget	Expenditure to date	Budget less spend
All Wales	All Wales	-225,000	507,400	462,123	45,277
Discretionary	Original discretionary programme	225,000	2,791,058	3,042,126	-251,068
	Additional WG schemes		1,732,000	2,162,294	-430,294
	Total Discretionary		4,523,058	5,204,420	-681362
	Grand Total	0	5,030,458	5,666,543	-636,085

All Wales Capital funding allocations were fixed at M6 with reductions (for WPAS) or return (for WEDS) to reflect project status (WPAS) and or product availability (WEDS).

WPAS project underspends on staffing from M6 resulted in an agreed "brokering" of funds (£225k) within hardware allocations at M11 and M12. Resultant deliberate overspend of 225k against the original discretionary capital programme (to enable brokerage).

Total discretionary capital expenditure (£5,204,420) reported includes "additional" schemes authorised following the Health Boards receipt of supplementary funding (£1,732,000) from the Welsh Government . This was utilised to fund Omincell and Telepath. Exclusion of these schemes provides an "Informatics only" scheme total of £3,042,126 with a "deliberate" overspend of £251,068 at year end.

Figure 1, provides a summary of spend mapped to strategic objectives which were outlined with the operational plan. As indicated, over 98 percent of spends were made against digital infrastructure schemes. These schemes are designed to "get the basics right" by providing, developing and maintaining a secure, flexible and robust infrastructure to enable a digital future.

Figure 1: 2018 2019 Discretionary Capital Spends

Discretionary Capital Programme	
Scheme	**Expenditure £**
DIGITAL ROADMAP	£11,400
UNDERPINNING SERVICE TRANSFORMATION	£36,065
DIGITAL INFRASTRUCTURE	£2,994,373
WORKFORCE DEVELOPMENT TRANSPARENCY SUSTAINABILITY & STANDARDS	£17,575
Additional IT discretionary	
- Omnicell (WG Add Funds)	£1,681,672
- Telepath (WG Add Funds)	£480,622
Credits	£17,287
Total	£5,204,420

Circa £1.1million of this was spent to support the replacement of obsolete desktop hardware and provide tools e.g. laptops to access, store and process data. This included the £225k brokerage.

£570k was spent on products that would support or enhance security. This spend comprised of projects to upgrade perimeter security (£416k), procure web filtering software to replace an out of contract solution (£95k) and procure 'safend' licences that control and encrypt ports i.e. Memory sticks and flash drives (£57k).

The remainder was primarily allocated to improving business continuity or user experience e.g. speed of access. This includes works relating to data centres and server upgrades (£330k) and Core Telephony Switch Upgrades (176k) which also feature in future year plans.

	ANNUAL	WTE	WTE	CUMULATIVE		
	BUDGET	BUDGET	ACTUAL	BUDGET	ACTUAL	VARIANCE
Income Total	-138,906	0	0	-138,906	-303,891	-164,985
Total Pay	12,844,349	424.66	379.92	12,844,349	11,944,332	-900,017
Total Non Pay	4,477,629	0	0	4,477,629	4,473,279	-4,350
Report Total	17,183,072	424.66	379.92	17,183,072	16,113,720	-1,069,352

2018/2019 Capital and Revenue Expenditure

The annual budget is inflated from its standard position of £17,125,237 due to funds from the Welsh Government to fund the SBRI centre of Excellence. A three year proposal to secure longer term funding for the Centre is currently being discussed. Outcome of discussions are anticipated by the end of quarter 1 of 2019 2020.

As indicated in figure 2, in Financial Year ending 2018 2019, Informatics contributed £1,069k towards the health boards underlying deficit. The underspend was generally attributable to:-

- delays to the WCCIS project, resultant pay and non-pay savings circa £432k.
- An increased budget of £1.482m from the 2017 2018 position awarded to increase resources and the full year effect of this when recruitment plans and activities were required.
- Delays in enacting or delivering plans to leverage the benefits of the funding, including BCU wide recruitment controls imposed in the final quarter of 2018 2019 requiring appointments after 01.04.19.

Increased recruitment activities during the last two quarters of 2018 2019 and recruitment plans for 2019 2020 are projected to increase staffing costs to the cost envelope allocated.

Information Governance and Informatics Committee **9.5.19**	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board ***To improve health and provide excellent care***

Report Title:	**Informatics Quarterly Assurance Report**
Report Author:	Tracy Williams, Head of Informatics Performance & Improvement Sion Jones, Head of ICT
Responsible Director:	Dr Evan Moore, Executive Medical Director
Public or In Committee	Public
Purpose of Report:	The purpose of this report is to provide the Information Governance and Informatics Committee with a mechanism to gain assurance on behalf of the Health Board that legislative and regulatory responsibilities are being met which relate to Informatics services. This report also provides key performance indicators that relate to the quality and effectiveness of information and information systems against which the Health Boards performance may be regularly assessed. This is the first version of the Informatics Quarterly Assurance Report and this report will be developed further to meet the requirements of the committee as required. The report summarises 1. The Welsh Audit Office review of progress made against 2014 clinical coding recommendations. Reviewed in December 2018 2. Our compliance measure against mandated national targets and our compliance measure against adopted benchmarked targets. It also highlights where key performance indicators are required and suggest the use of initial metrics (ICT security).
Approval / Scrutiny Route Prior to Presentation:	Chief Information Officer
Governance issues / risks:	The report is the first Informatics Quarterly Assurance Report and highlights
Financial Implications:	*N/A*
Recommendation:	The IGI Committee is asked to note compliance with legislative and regulatory responsibilities which relate to the Informatics Services and to advise the service of any additional metrics required to improve assurance.

Health Board's Well-being Objectives *(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)*	√	**WFGA Sustainable Development Principle** *(Indicate how the paper/proposal has embedded and prioritised the sustainable development principle in its development. Describe how within the main body of the report or if not indicate the reasons for this.)*	√
1.To improve physical, emotional and mental health and well-being for all		1.Balancing short term need with long term planning for the future	√
2.To target our resources to those with the greatest needs and reduce inequalities		2.Working together with other partners to deliver objectives	√
3.To support children to have the best start in life		3. Involving those with an interest and seeking their views	√
4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being		4.Putting resources into preventing problems occurring or getting worse	√
5.To improve the safety and quality of all services	√	5.Considering impact on all well-being goals together and on other bodies	
6.To respect people and their dignity			
7.To listen to people and learn from their experiences			
Special Measures Improvement Framework Theme/Expectation addressed by this paper *http://www.wales.nhs.uk/sitesplus/861/page/81806*			
Equality Impact Assessment *EqIA is not required as a change of policy or direction is not envisaged and/or budgets are not being reduced.*			

Disclosure: Betsi Cadwaladr University Health Board is the operational name of Betsi Cadwaladr University Local Health Board

Informatics

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Informatics Quarterly Assurance Report – 2019/20 Quarter 1

The purpose of this report is to provide the Information Governance and Informatics Committee with a mechanism to gain assurance on behalf of the Health Board that legislative and regulatory responsibilities are being met which relate to Informatics services.

This report will also provide key performance indicators that relate to the quality and effectiveness of information and information systems against which the Health Boards performance may be regularly assessed.

This report will evolve in the coming quarters to meet the requirements of the committee based upon direction provided.

Contents

1. National Audit Office Reports

In December 2018 the Wales Audit Office examined the progress made in addressing recommendations set out in the **2014 Review of Clinical Coding** and any resulting improvements in clinical coding performance.
It reviewed progress against recommendations which focused on :-

- raising the profile and awareness of clinical coding across the Health Board;
- developing a single coding policy and procedure to ensure consistent practices and processes;
- strengthening clinical engagement with medical staff; and
- improving the quality of medical records across the Health Board.

Findings; In its draft Report issued in March 2019, the WAO concluded that *"the Health Board has improved its coding performance significantly, but has not yet realised the full potential of clinical coding and more work is needed to engage with clinicians and improve medical records*"

Whilst clinical coding was noted to have improved significantly we are not above the WG target for coding completeness. Data within the report highlights that we are above the National Average and as at 17.04.19 the current coding position for BCULHB is 94% against the 95% target.

The Health Boards accuracy of coding was also evidenced to have improved by 5.45% in its latest assessment.

The report noted that some progress had been achieved in implementing the 15 recommendations that had been made, and highlighted that addressing the coding backlog has meant that many

actions still need to be completed fully. Figure 1 provides the status of recommendations.

Figure 1; Status of 2014 recommendations:-

Total number of recommendations	Implemented	In progress	Overdue	Superseded
15	3	12	0	

Further discussions of summary of progress against recommendations are planned with WAO before the report is formally accepted to agree the status of the recommendations based upon evidence available.

We have suggested that 1 of the "in progress" recommendations is superseded and 3 of the "in progress" recommendations should now be closed. An action plan for remaining recommendations has been developed and will be monitored.

In addition to the recommendations for the 2014 report. The WAO have made some further recommendations:-

2019 Recommendations	
Board Awareness	
R1	Ensure that performance on coding is reporting into the newly formed information governance informatics committee to ensure that monitoring performance against WG target is maintained
Clinical engagement	
R2	Revisit training materials and standardise across the Health Board, ensuring that the materials reflect the totality of the Health Boards coding not just site based.

Section 2 of this report and quarterly reports that will follow will enable the closure of R1. R2 is scheduled for completion by the end of quarter one.

2. Compliance

2.1 Clinical Coding. National Coding Targets exist for clinical coding completeness and clinical coding accuracy and form part of the Welsh Government NHS delivery framework.

There are several reasons as to why clinical coding completion in a timely manner is vital, examples provided by Welsh Government include to allow monitoring of treatment effectiveness and clinical governance, to monitor public health trends and to enable assessment and scrutiny in delivering the condition specific Annual Quality Plans and Tier 1 measures.

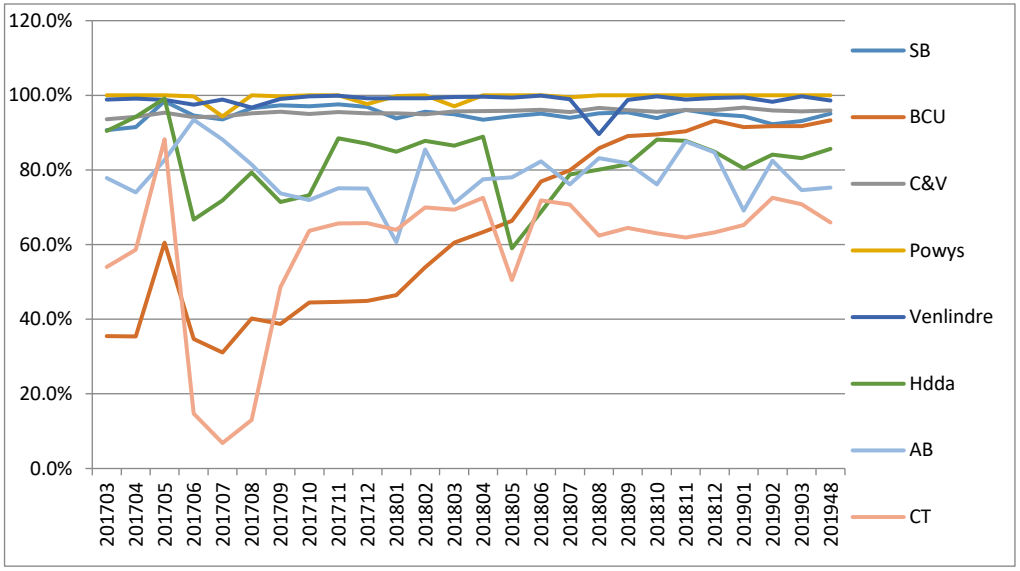
The coding completeness in BCU for April 2019 was 93.3% against the National target of 95%. (This target measures the percentage of clinically coded episodes within 1 month of episode end date).

The Health Board is showing continued improvement against this target although progress has slowed over recent months. The improvement in coding completeness enables the Health Board to work with timely data in regards to Freedom of information requests, Costings, Mortality data and Internal Audit.

The second National Target of Coding Compliance requires an improvement in the accuracy score attained in the annual National Clinical Audit Program.

The 2018/19 National Audit result of 89.6% accuracy attained demonstrated a 5.4% improvement of accuracy in clinical coding from the previous 2017/18 audit.

The following graph shows BCU's coding completeness against the target compared to other Welsh Health Boards.



2.2.ICT Security; is the ability to protect the confidentiality, integrity and availability of digital information assets. A range of tools and processes has and are being adopted within the Health board to support ICT security. **Appendix 1** provides a detailed security position update, and highlights the range of tools that are being or are planning to be utilised within the Health Board for ICT security.

Whilst ICT security is essential as the Health board is reliant upon its information assets to improve and support the delivery of care, **targets** for measuring compliance against the use of tools or process that are required for ICT security **are not mandated or monitored** Nationally e.g. as part of delivery frameworks.

Appendix 1 provides a table that highlights measurements of our adoption of available security and software updates. In the absence of mandated targets, it is recommended that targets (circa 93% / 96%) are applied to these to aid monitoring and assurance.

2.3 ICT Service Support Report. A total of 90,716 calls were logged with the Informatics department this past year, this was a 7% reduction on the previous year's total of 97,541.

The average length of time service users wait before their call is answered has been reduced by 12.3 % and callers are now waiting on average 2 minutes 8 seconds before their call is answered.

Top 10 call classifications 2018/19

	Number of Calls
Password Reset (NADEX)	6965
User Profile	4454
Printing	2936
Software Deployment	2732
Corrupt Software	2267
Internet Explorer	1092
E Mail	871
Shared Drive Access	730
Request for Advice	582
Reset Password (WPAS)	561
Grand Total	**23190**

Benefits of additional training has resulted in the ICT Service Desk Support Officers resolving 87.96% of calls at first point of contact. The average length of time a Support Officer is on a call has also reduced to 5 minutes 30 seconds, which can be partially attributed to the service maturing due to enhanced skill sharing sessions.

The implementation of Live Chat for support queries and advice has proven successful across a number of the informatics teams and we

have received 8,593 contacts in the last 12 months. Similarly, 28% of support calls were logged via the Informatics web portal.

2.4 National and Local System Availability

National Systems; During the last 12 months, there have been 57-recorded incidents of national system failures that have directly impacted clinical services.

- 42 WCP Outages. *WCP has been unavailable for a total of 176 hours and 54 minutes approx.*
  *This equates to **97.97%** of WCP system availability/uptime*

- 15 WPAS Outages. WPAS has been unavailable for a total of 69 hours and 5 minutes approx.
  This equates to **99.21%** of WPAS system availability/uptime

Note: Due to the increased regularity of unplanned outages emanating from nationally hosted systems, extra data is now being collected to better measure the wider impact on services and quantify any associated cost for future reporting.

Local Systems; With the advent of the NIS Regulations, the way in which we record unplanned outages has changed and been adapted to assist with mandatory reporting under these regulations. Therefore, there is only data available for the last quarter of 2018/19.

***Note:** The Security of Network & Information Systems Regulations (NIS Regulations) provide legal measures aimed at boosting the overall level of security (both cyber and physical resilience) of network and information systems for the provision of essential services and digital services*

In the last 3 months, there have been 11 incidents of unplanned outages.

- 4 Network connectivity incidents
- 1 Telecoms incident
- 4 Server related incidents
- 2 Environmental incidents (power loss)

Further detail of the above events is available on request.

2.5 Availability of case notes for Outpatient Appointments

The percentage of acute patient records that were available for outpatient clinics in BCU during March was 99.95%; this remains the same as the previous month.

This remains above the benchmarked target of 97.4%. During March a total of 35,641 patients attended outpatient clinics within BCU and were "arrived" and "outcomed" by Health Records Staff.

	Current Month	Previous Month	Within Tolerance
% casenotes available for outpatient clinic	99.95%	99.90%	

Work on the pruning of case notes of patients last seen for treatment in 2015 from the main file libraries has commenced on each site, however due the destruction embargo space is limited and notes are being stored in boxes on the floor. Work on the retention or destruction of case notes from secondary file libraries has ceased across the Organisation as an embargo has been put in place due to the National Infected Blood Inquiry.

Appendix 1; ICT Security Position Update for IGIC

Our security appliances continue to detect and block an ever-increasing number of malware related events attempting to exploit known software vulnerabilities.

In the period Jan – Mar this year, we have detected circa 53,000 threats, which range from outdated malware, phishing attempts to false positives.

Firewalls and Intrusion Prevention Systems employed by NWIS provide the first line of defence against external threats that come via the Internet. A recent report highlighting a typical week (15-22 Apr 19) detailed 273 malware incidents from 209 sources.

Together with our anti-virus solution, web content filtering and distributed firewalls, we further mitigate from such vulnerabilities by way of continuously rolling-out vendor software updates and security patches to all networked devices on the Health Boards ICT infrastructure, which currently stands at circa 14,000 devices.

The table below details the patch management position as of March 19.

	% Compliant
Windows 7	92
Windows 10	96
Office 2007	76
Office 2010	99
Office 2013	85
Office 2016	82
Server Operating Systems	96
Average Desktop OS	94
Average Office apps	85
Average Server OS	96
Average all platforms	90

Further investment has been focused in a number of areas with the purpose of strengthening and raising the Health Boards overall Cyber-Security posture and threat defence.

Smoothwall - Web Filtering

We are currently in the process of replacing our old web filtering software with a product called Smoothwall. This new filtering software will allow real-time traffic analysis based on predefined and appropriate content controls. Unlike its predecessor, Smoothwall has the added advantages of improved granular reporting on user activity and access controls in relation to social media content.

Palo Alto - Next Generation Firewalls

Following a lengthy and detailed procurement process, we have recently purchased 6x NextGen Firewalls to replace our existing at the 3 DGH sites. Work will commence early June to install and commission, with each site benefiting from 2 Firewalls for resilience in an active and standby configuration.

The new Palo Alto Firewalls will introduce many benefits that will allow us to create allow/deny rules based on users, devices and applications, whereas the existing Cisco Firewalls only allow rules to be created based on devices. The other major advantage is automated threat protection. The Firewalls will have the ability to detect and block any irregular network activity that may be associated to malware and reduce the impact of propagation resulting in reduced unplanned downtime and disruption of clinical and business services.

McAfee - Threat Intelligence Exchange (TIE)

McAfee currently provides the Health Board with anti-virus and intrusion prevention protection across a number of platforms. TIE has been purchased to strengthen the intelligence of information gathering and sharing between our McAfee suite of products. McAfee's Threat Intelligence Exchange software allows any threat that is detected on either PC, Laptop, Server or Email to be blocked automatically across all platforms.

LogRythm – Security Information & Events Management (SIEM)

This product has been procured by NWIS for use throughout NHS Wales. SIEM captures security and event log data from applications and devices connected to the corporate network. Data is monitored, collected and analysed in real-time before being transposed into meaningful reports highlighting correlation with potential malware activity and subsequent incident response. This product will be installed late July.

Nessus

Unlike SEIM, Nessus actively scans devices connected to the corporate network looking for potential vulnerabilities that may possibly be exploited. Nessus incorporates a constantly updated database of known vulnerabilities, which it uses when scanning networked devices in an attempt to uncover security weaknesses. As with LogRythm, NESSUS was also a nationally procured product.

Forward View

The main purpose of the nationally procured SIEM and NESSUS products is to provide a real-time holistic view of potential threats and vulnerabilities within the Health Boards ICT infrastructure, allowing for a more proactive approach to mitigation and protection.

With the ever-increasing threat of cyber-attacks, it is necessary to have a layered proactive approach to security, for which the above products and solutions will provide. However, such an approach demands specialised resourcing to administer and respond when the need arises. Welsh Government have acknowledged this requirement and agreed to provide funding to recruit two specialist Engineers within the BCU ICT Services for such purposes. This will be the first step in establishing a dedicated ICT Security Team supported by a Cyber Security and Compliance Manager that will also be recruited to over the coming months.

Informatics

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Information Governance and Informatics Committee **9.5.19**	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board ***To improve health and provide excellent care***

Report Title:	**Welsh Community Care Information System (WCCIS) status report**
Report Author:	Mrs Christine Couchman, Programme Manager (WCCIS)
Responsible Director:	Dr Evan Moore, Executive Medical Director
Public or In Committee	Public
Purpose of Report:	This paper aims to provide the IGI Committee with a mechanism to enable it to review the performance and delivery of the WCCIS programme. The report summarises the current position, which has been subject to several exception reports and provides the background for context. Health Board costs to date, which have also been subject to reporting via a variety of Governance structures are also included. This report has been provided to the IGI Committee to enable it to review the performance and delivery of the roll out of one of the core National IT systems. *This paper has been included at the request of the Committee.*
Approval / Scrutiny Route Prior to Presentation:	This paper is a summary of the current position, as discussed within the BCU WCCIS Programme Committee. The paper has been reviewed the Deputy Chair of the Programme Committee.
Governance issues / risks:	This paper details the significant challenges faced by this programme to date and highlights a risk that planned pilots to progress this project may not be feasible within year. These pilots were included within the 2019 2020 operational plan (which remains subject to final approvals following finance allocations). As noted within the paper, the Programme committee have requested assurances around delivery before considering approval to proceed This may affect the delivery of benefits outlined within the business case
Financial Implications:	The programme has incurred a number of costs to date with are detailed within the paper. Functional availability remains an issue.
Recommendation:	The Committee is asked to receive the update on delivery of the roll out of WCCIS - one of the core National IT systems

Health Board's Well-being Objectives *(indicate how this paper proposes alignment with*		**WFGA Sustainable Development Principle**	

the Health Board's Well Being objectives. Tick all that apply and expand within main report)		*(Indicate how the paper/proposal has embedded and prioritised the sustainable development principle in its development. Describe how within the main body of the report or if not indicate the reasons for this.)*	
1.To improve physical, emotional and mental health and well-being for all		1.Balancing short term need with long term planning for the future	√
2.To target our resources to those with the greatest needs and reduce inequalities		2.Working together with other partners to deliver objectives	√
3.To support children to have the best start in life		3. Involving those with an interest and seeking their views	√
4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being		4.Putting resources into preventing problems occurring or getting worse	√
5.To improve the safety and quality of all services	√	5.Considering impact on all well-being goals together and on other bodies	
6.To respect people and their dignity			
7.To listen to people and learn from their experiences			
Special Measures Improvement Framework Theme/Expectation addressed by this paper *http://www.wales.nhs.uk/sitesplus/861/page/81806*			
Equality Impact Assessment *No EqIA has been carried out as a change of policy or direction is not envisaged*			

Disclosure: Betsi Cadwaladr University Health Board is the operational name of Betsi Cadwaladr University Local Health Board

Welsh Community Care Information System (WCCIS) status report

Executive Summary

Contract
BCU were one of the first Health Boards in Wales to sign up for the new Welsh Community Care Information System (WCCIS) in March 2016, with a plan to implement over a 3 year period beginning in April 2017.

Testing and Concerns
The implementation was always expected to be challenging, but issues were identified in September 2016 during early data migration work, and resulted in a delay notice being received from the supplier in March 2017.

A correction plan has not yet been received from the supplier, and significant additional defects were uncovered following local testing against the Statement of Requirements in July 2017. Key concerns included:

- De-duplication of client records
- Lack of Interfaces to national systems e.g. the Master Patient Index (MPI)
- Lack of integration with Microsoft Outlook
- Diary functionality within the Mobile app
- Security and connectivity of the Mobile solution
- Audit functionality
- Re-allocation of cases and associated tasks

These additional issues were considered and agreed with representatives from Health and Social Care organisations across Wales in October 2017, and the results were raised to the suppliers. Two Show and Tell sessions followed in May and July 2018 where each requirement was considered in detail. The sessions attempted to categorise and prioritise issues for resolution, with some being agreed as defects, and others argued as enhancements by the supplier.

Discussions are still ongoing nationally to reach agreement on a Functional Roadmap which should provide certainty over deliverables and timescales. The Roadmap was due for release in August 2018, having been identified as a requirement following the National OCG Gateway 0 Review in November 2017.

From a BCU Programme perspective, the lack of timely progress in addressing defects has been a major concern.

Some hope of action was raised when Aneurin Bevan (AB) Health Board signed a deployment order in March 2018. The project teams from BCU, AB and Powys engaged closely to ensure requirements and priorities were aligned. AB's timescales for implementation were driven by a requirement to move from an obsolete system, and significant work was undertaken to identify and communicate pre-requisites. A high level of confidence was expressed by the supplier and the National team, which provided a level of assurance to BCU that the product would be fit for purpose (specifically for a Mental Health implementation), by June, and later July, 2019.

AB subsequently received a delay notice from CareWorks early in 2019, removing integration from the scope of their go LIVE release. AB made the decision not to go LIVE without the integration functionality being available and therefore delayed their go-live date. Work is being undertaken to develop a correction plan and issue a new go-live date for AB. It is understood that key interfaces are being targeted for the next release, 5.2.14, currently scheduled for testing at the end of October 2019, although the functional roadmap to detail release content and timescales remains outstanding.
A Gateway Review into the National Programme in November 2017 noted the supplier assertion that 100% of the functionality outlined in the Statement of Requirements (SoR) had been delivered; conversely, it was stated that while Local Authorities have accepted that the product would develop over time, Health Boards require 100% of functionality to be in place before making a significant investment.

The Way forward
An Options Appraisal was produced for consideration by the Programme Committee, chaired by the SRO Russ Favager, in November 2017. A number of options were considered which reflect the issues raised during the testing phase, and described above.

The Committee concluded that BCU should progress implementation despite the gaps in functionality, once key prerequisites were met. The decision was ratified by the Executive Management Team on 31st Jan 2018, with the caveat that BCU should seek to renegotiate the terms of the Deployment Order.

Since that time, work has continued with the National team to press for defect resolution, with the National Commercial Group to seek an alternative contractual agreement, and in engagement with BCU Community Nursing and Mental Health teams to plan for a small scale implementation.

Commercial discussions
Commercial discussions have resulted in an offer that BCU could move to a new type of Deployment Order, subject to a minimum commitment of around 400-500 users. While this would provide a lower risk for the Organisation than the existing contract, scaling up to this number of users without key interfaces and functionality would not be feasible, and the Programme Committee have requested further assurance. An approach to the Commercial Group has been made, but an initial response expressed concerns that requesting further concessions might undermine agreements in other places. Further discussions have been requested.

Current position
At the time of writing, 12 Local Authorities have implemented the system, while Wrexham Local Authority has been delayed, with plans to implement in November 2019. Powys are the only Health Board to have implemented to date, using limited community functionality. Aneurin Bevan and BCU Health Boards are subject to correction planning.

Detailed Analysis

Procurement and Approval
The Welsh Community Care Information System (WCCIS) is a once-for-Wales solution, procured in March 2015 to facilitate joint case management and more effective sharing of care records across health and local authorities. The extensive tender exercise included a detailed Statement of Requirements (SoR), agreed by all key stakeholders (through Welsh Systems Consortium [WSC], Clinical Reference Groups and LHB Technical Leads), and signed off at the Community Stakeholder Board in August 2013.

The CareDirector solution from CareWorks was eventually selected as the preferred option in November 2014. CareWorks were the existing supplier of the Raise product to several Local Authorities through the WSC, and had developed their proposal with Advanced Health and Care and Certus Technology Group as sub-contractors for the development of Health requirements. The Health & Social Care Roadmap at the time of the procurement outlined a Health and Integration release to be delivered in October 2015 which would include Mental Health Act and Measure, Community Health, Scheduling, Medication Recording, Clinical Coding and Inpatient bed management functionality.

The Master Services Agreement (MSA) for the product was signed by Bridgend Local Authority, and runs for a period of 8 years, up to 31st March 2023 with an option to extend on an annual basis for a further four years. Individual Deployment Orders are signed by Authority Parties for an initial 8 year period from go-live, and again can be extended to a maximum of 12 years. Further clarity has been sought on the implications of individual deployment orders running beyond the period of the MSA.

The BCU Business Case was taken to the Board in January 2016 for approval, and a Deployment Order was subsequently signed in March 2016.

National Governance & Gateway Review
National Governance is currently under review following the appointment in November 2018 of a National Programme Director. The Programme is led by joint Senior Responsible Officers (SROs), Carol Shillabeer and Dave Street, who represent Health and Social Care interests.

An OGC Gateway Review (Gateway 0) into the Project was delivered in November 2017. At the time of the Review, eight Local Authorities and one Health Board (Powys) had implemented the system and BCU had already received a Delay Notice.

Assessing the likelihood of success of the National WCCIS programme, the review has concluded a confidence assessment of Amber, suggesting that overall the programme will recover. Locally however the programme was assessed as Red, given the lack clear timescales for resolving identified functionality issues.

Nine Critical and Essential recommendations were made in the report, which included a refreshed and focused vision statement for WCCIS to be commissioned;

progression of Benefits realisation work; resourcing of a communications lead and refreshing the communications plan; an agreed definition of what will constitute successful completion of the programme; strengthened Governance; an Information Governance strategy; a new role for overall national programme direction and oversight; a functional road map.

The review had noted the supplier assertion that 100% of the functionality outlined in the Statement of Requirements (SoR) has now been delivered; conversely, it was stated that while Local Authorities have accepted that the product will develop over time, Health Boards require 100% of functionality to be in place before making a significant investment. This dichotomy was seen as central to the issues experienced by BCU.

The North Wales Regional position
Three Local Authorities in North Wales (Anglesey, Gwynedd and Wrexham) were already using the Raise product, and therefore planned to upgrade to WCCIS as their existing product became obsolete.

Discussions with Health and Local Authorities across North Wales had identified benefits, aligned with the requirements of closer Integrated Working, which would be best served by a Regional approach, and a Regional Programme Board was therefore formed to steer a strategic approach to integrated service delivery.

While Anglesey and Gwynedd implemented the product in the summer of 2017, Wrexham have delayed their implementation. Conwy Local Authority have recently signed a deployment order and are keen to align their implementation with BCU.

The BCU Programme
BCU Signed a Deployment Order in March 2016, with an initial on-boarding plan including testing and data migration to be carried out in advance of a planned go-live in April 2017. The plan was broadly aligned to Local Authority plans in order to derive the benefits of integration.

Testing
It was during early testing and data migration work that defects were identified, with key data fields and relationships omitted from the database design meaning that the product did not meet requirements for statutory recording and reporting in line with defined Minimum Data Sets.

Having attempted and failed to resolve the requirements, CareWorks issued BCU with a delay notification in March 2017, citing both lack of MPI (Master Patient Index) integration and a lack of compliance with minimum data set requirements as impeding progress. Subject matter experts from Health Boards across Wales and the National Team worked with the supplier to develop use-cases outlining the required changes for compliance, and the fixes were scheduled to be developed for release in version 5.2.9, to be released in November 2017. This again failed testing.

Further Concerns
In the meantime, the fact that issues had been identified through data migration work raised concerns that testing had not been sufficiently robust. As a result, the BCU

project team carried out targeted local testing against the “MUST” requirements within the original SoR. This work identified some significant failings which would impact on BCU’s ability to go-live in a manner which improved service delivery for staff and patients. Some of the key concerns noted were:

- **De-duplication** of client records; previous Local Authority implementations had resulted in a significant number of duplicate records in the system which need to be fully addressed in advance of go-live.
- **Interfaces**, particularly the Master Patient Index (MPI), required to ensure data quality of patient records and avoid further instances of duplication
- Lack of **integration with Microsoft Outlook**, meaning practitioners will need to manage separate electronic diaries
- **Security and connectivity of the Mobile solution** is currently via VPN, which will be onerous for users and has hindered testing
- **Diary functionality** within the Mobile app does not allow booking of appointments more than 2 days in advance, meaning staff would revert to paper diaries
- **Audit functionality** not applied fully across the system, meaning that some activity is not currently recorded
- **Re-allocation of cases and associated** tasks is not currently automated and requires multiple searches, which could result in risks to follow-up

Governance and Escalation

The issues were raised at both the BCU Programme Committee, and at the Regional Programme Board, where the Local Authorities shared many of the identified concerns. It was anticipated that these issues would impact on all other health boards, and that many would also impede Local Authorities as they move from the current usage (upgrade to the raise system) and start to move towards new ways of working. The issues were fully documented and escalated to a National (health and social care) work stream, where they were debated at a meeting in October 2017. Further Issues have subsequently been escalated by ABHB over the lack of national arrangements for Service Management or Ways of Working.

An agreed list of defects was subsequently prioritised and raised with the supplier and the National Team for action. At this stage, there was disagreement from the supplier, meaning that further negotiation would be needed. The list was finally explored at ‘Show and Tell’ meetings the following May and July (2018), with each requirement considered in detail, and attempts were made to categorise and prioritise issues for resolution. Some of the issues were ultimately agreed as defects, and others argued as enhancements. From the final output, a Functional Roadmap was due to be outlined by 31st August 2018. This is still outstanding.

The Way Forward

As the level of concern over functionality became clear, an Options Appraisal was carried out by the project team, and considered by an extraordinary meeting of the WCCIS Programme Committee on 3rd November 2017. The Committee concluded that BCU should not withdraw from the project, but should instead explore the options for progressing implementation despite the gaps in functionality, once key

prerequisites were met. This was anticipated to mean a small scale pilot on office-based PCs which would allow the limited sharing of information in integrated teams to begin. The decision was ratified by the Executive Management Team on 31st Jan 2018, with a caveat that BCU should seek to renegotiate the terms of the Deployment Order.

Pilot Proposal
Options for this pilot were explored with a number of clinical areas, and an initial plan for a pilot implementation was agreed in May 2018. To meet requirements and capacity of the West Area Team and the Regional Programme Board, the pilot was centred on the Anglesey area to facilitate an exploration of integration with the Local Authority (who are already using the system).

The National Team were approached for support in renegotiating the terms of BCU's DO to support the reduced requirements of a small scale pilot, as specified by the Programme Committee and the Executive Management Team. The Commercial Group had already opened discussions with the supplier, and therefore further negotiations were aligned with this work. A "menu" of three alternative contract types has now been agreed.

- BCU's **original Deployment Order** requires payment for the full cohort of 3600 users on implementation. This was the sole, nationally negotiated contract up until a Phased Agreement was renegotiated in advance of the Aneurin Bevan commitment.
- The new **Phased approach** still requires payment for the full cohort within 2 years of implementation, but payments can begin at 62.5% of the full contract value.
- A third contract type, the **Community Nursing proposal**, was agreed in the autumn of 2018. This allows organisations to sign up for a smaller cohort of users, with a minimum number of around 400-500 required to make the agreement viable to the supplier.

Following National agreement on the Community Nursing contract, formal discussions were arranged between BCU, The National Commercial Group and the Supplier, with the Community Nursing proposal offered as a replacement for the existing BCU deployment order. This would require BCU to withdraw from their existing Deployment Order, with a revised business case and appropriate approvals.

On consideration, a minimum number of around 500 users had been identified as a reasonable commitment if the expected functionality (promised for the ABHB implementation) was in place to allow the project to scale up. Evaluation of the pilot implementations would have provided an evidence base to plan for scale up to priority areas. The subsequent announcement of delays to required interfaces, and the ongoing issues with de-duplication of patient records however mean that scaling up within the required 12 months is unlikely to be viable, and the Programme Committee have therefore requested further assurances around delivery before considering approval to proceed.

BCU Finance

The programme costs to date have been largely supplemented by Integrated Care Funds (ICF). The ICF is a mechanism to support delivery requirements of the Social Services and Well-being (Wales) Act 2014, and is managed through Regional Partnership Boards.

Over the 3 year period 2016 – 2019, a total of £1,030,991 in ICF money was awarded as directed expenditures through the BCU allocation from Welsh Government, with approved allocations distributed to Local Authorities. This onwards distribution is shown as Non-pay Services from Local Authorities, within the BCU WCCIS budget.

Allocations were determined proportionally according to requirements, managed through the Regional Programme Board, with larger allocations made to organisations with live projects. The funding to date has supported management of the Regional Programme of work, implementation and business change requirements for Anglesey and Gwynedd Local Authorities, preparatory work for Wrexham Local Authority and BCUHB, and business case development for the remaining Authorities.

The provision of funding for Informatics staff costs has enabled BCU to support the WCCIS Programme at a National, Regional and Local level. Nationally, this has meant engagement with a range of work streams including Testing, Configuration, Integration, Change Control, Technical Assurance, Reporting and Business Change. Regionally, the focus has remained on the Integration Agenda, seeking to support the Regional Programme through engagement with Local Authority partners and clinical groups, to understand and progress the requirements for new ways of working and information sharing.

At a local level, the first year of the BCU project was heavily focussed on readiness activities for go-live, including engagement, process mapping, business change, data quality and migration, reporting, configuration and testing. Following on from the delay notice in March 2017, emphasis shifted slightly to first support the National Team and the Supplier in the development of use cases to address identified defects, and then to carry out more targeted testing.

With no clear timescales for delivery, the team was down-scaled in the following months to mitigate risk. Engagement however continued at a National Level, raising issues and seeking to challenge and shape requirements. In recent months, with the Programme Committee decision to pursue implementation, a small number of posts have been re-recruited to. This has enabled progress in engagement with the CRT agenda, and close working with BCU staff and Local Authority partners to shape the system configuration.

Annual Statements show that the total expenditure on the BCU programme for the three year period 01/04/2016 to 31/03/2019 was £1,349,670. This expenditure includes £534,850 paid out to the Local Authorities from recharged ICF Allocations. Total grants in the region of £1,030,991 in ICF funding were received by the Health Board over this period, meaning that the net total contributed by BCU was £318,679*.

No payments have yet been made to the supplier.

WCCIS Budget 2016 – 2019

	2016-17	2017-18	2018-19
BCU Staff (Projects/ ICT / Information)	245,885	252,657	163,457
Agency Staff (Business Change)	58,437	63,902	0
BCU Non-Pay	7,177	14,936	8,369
Services from Local Authorities	141,172	228,568	165,110*
Total Costs	**452,671**	**560,063**	**336,936**
Received Directed Expenditures - ICF	345,000	342,991	343,000

* A further £72,890 claim for Services from Local Authorities is anticipated

Conclusion
The implementation of the WCCIS solution has proved challenging.

Significant defects have been identified with the product and escalated nationally for resolution, but a correction plan and revised implementation date for BCU remain outstanding. Agreement on a functional roadmap to provide assurance on the delivery timescales for key functionality is urgently required.

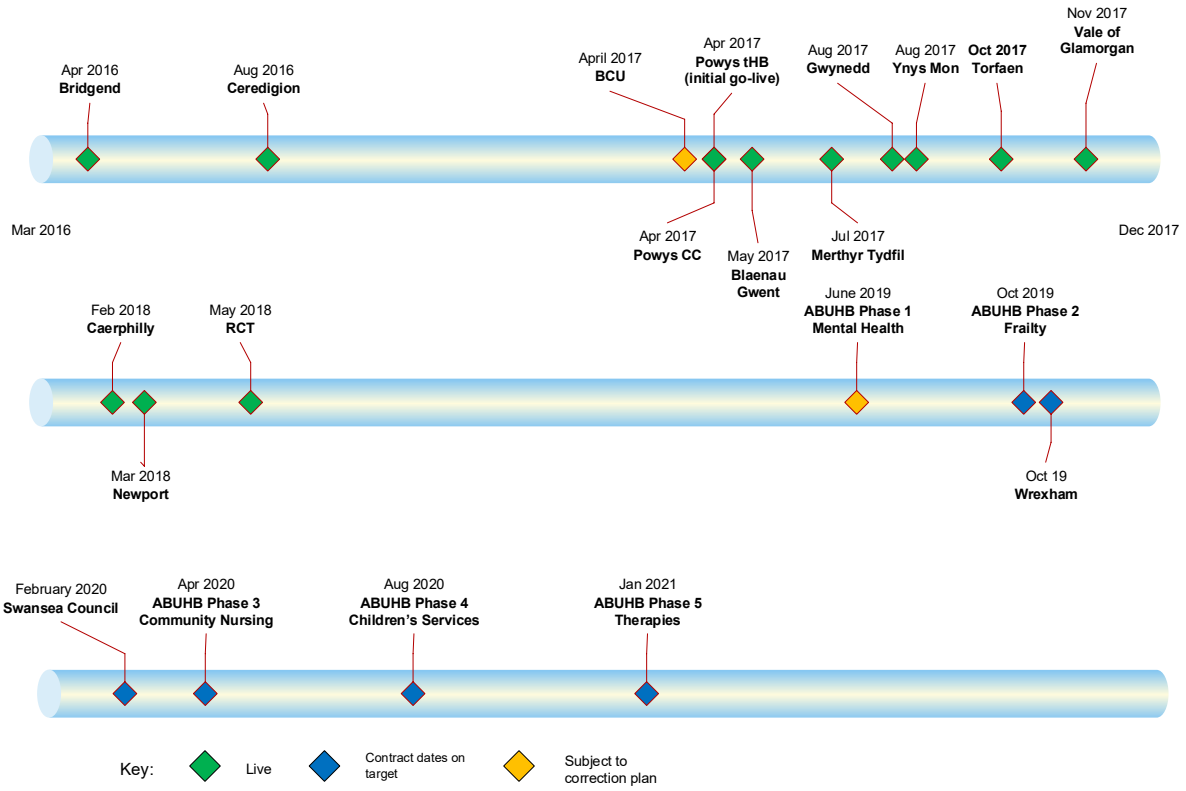
In the meantime, the Health Board's Executive Team have supported the decision to explore a small scale implementation with available functionality, provided a commercial arrangement can be agreed.

BCU remain committed to delivering an IT solution that will support community and social care services in delivering joined-up care closer to home.

Recommendation
The committee is asked to use this paper to receive an update on delivery of the roll out of WCCIS - one of the core National IT systems

Appendix A – Timelines

WCCIS – National Milestone Programme Plan March 2019



WCCIS – BCU Key Milestones

Information Governance and Informatics Committee **9.5.19**	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board ***To improve health and provide excellent care***

Report Title:	**Single Cancer Pathway and Eye Care Measure Data Compliance**
Report Author:	Mr Richard Walker, Head of Information
Responsible Director:	Dr Evan Moore, Executive Medical Director
Public or In Committee	Public
Purpose of Report:	The Executive Management Group has requested that the the IGI Committee to be updated on the new Single Cancer Pathway and Eye Care Measures Data Set Compliance Notices and how compliance with the data requirements will be achieved until BCUHB is on the latest version of the Welsh Patient Administration System (WPAS). WPAS had been updated to deliver the technical and data elements of both Data Set notices; however the health board will not be on a single version of WPAS for two years.
Approval / Scrutiny Route Prior to Presentation:	Chief Information Officer
Governance issues / risks:	The paper highlights • the technical approach for data compliance during our phased implementation of WPAS and the need to provide interim in-house systems which are compliant with national data requirements. • there is a service impact to the changes in the data collection and booking process that requires support by the organisation.
Financial Implications:	None
Recommendation:	The Committee is asked to note the approach to meeting both the Single Cancer Pathway and Eye Care Measure data compliance.

Health Board's Well-being Objectives *(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)*		**WFGA Sustainable Development Principle** *(Indicate how the paper/proposal has embedded and prioritised the sustainable development principle in its development. Describe how within the main body of the report or if not indicate the reasons for this.)*	
1.To improve physical, emotional and mental health and well-being for all		1.Balancing short term need with long term planning for the future	√
2.To target our resources to those with the greatest needs and reduce inequalities		2.Working together with other partners to deliver objectives	√
3.To support children to have the best start in life		3. Involving those with an interest and seeking their views	
4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being		4.Putting resources into preventing problems occurring or getting worse	√
5.To improve the safety and quality of all services	√	5.Considering impact on all well-being goals together and on other bodies	
6.To respect people and their dignity			
7.To listen to people and learn from their experiences			
Special Measures Improvement Framework Theme/Expectation addressed by this paper http://www.wales.nhs.uk/sitesplus/861/page/81806			
Equality Impact Assessment *No EqIA has been carried out as a change of policy or direction is not envisaged*			

Disclosure: Betsi Cadwaladr University Health Board is the operational name of Betsi Cadwaladr University Local Health Board

Single Cancer Pathway and Eye Care Measure Data Compliance

Situation

Data Standards Change Notifications (DSCN) 2018/07 (AMD) and 2019/01 set out data and waiting list management requirements in relation to the Eye Care Measure (ECM) and Single Cancer Pathway (SCP).

WPAS version 19.2 will provide the functionality to report and manage the ECM and SCP but formal reporting of these measures will commence before WPAS upgrades are completed. The purpose of this paper is to inform IGIC of BCU's processes for reporting, outline any limitations and from an Information service perspective, provide an assessment of our ability to comply with national requirements.

Background

Version 18.1 of WPAS is in place in the Centre and East areas of BCU. Whilst version 18.1 provides the facility to collect data items relating to the ECM it does not support pathway management and booking. WPAS 18.1 does not support data collection or tracking in relation to the Single Cancer Pathway.

PIMS in the West, offers the ability to collect the relevant data to support the monitoring of the ECM, it does not support SCP. WPAS is not scheduled for implementation in the West until 2020.

WPAS upgrades to version 19.2 are scheduled for late July (Centre) and August 2019 (East). The upgrade will provide the sites with the personalised target waiting list (PTL) to manage the ECM and Tracker 7 to support the tracking of the SCP. Due to capacity limitations within the service and a July implementation date potentially impacting upon the ability to provide the first formal submission of the SCP, the testing and Go Live of Tracker 7 will be delayed until September 2019.

Assessment

Eye Care Measure

The following table outlines current and future compliance with DSCN 2018/07 (AMD).

		Data Collection	Booking / Patient Pathway Mgmt.	Reporting
Current	West (PIMS)	✓	X	✓
	Centre (WPAS 18.1)	✓	X	✓
	East (WPAS 18.1)	✓	X	✓
Future	West (PIMS)	✓	✓ with External PTL solution	✓
	Centre (WPAS 19.2)	✓	✓ (Jul 2019)	✓
	East (WPAS 19.2)	✓	✓ (Aug 2019)	✓

BCU has been reporting against the ECM since early 2018. Whilst some data quality issues exist, the systems currently in place support the relevant data capture. From a reporting perspective, BCU will be compliant with DSCN 2018/07 (AMD) when formal reporting commences in May 2019 (relating to April's position).

Patients are currently booked in accordance with RTT rules and the service will not be able to comply with the waiting list management requirements of DSCN 2018/07 until the implementation of WPAS version 19.2 in July and August 2019 and the development of an external PTL solution for the West.

A PTL solution (outside of PIMS) will need to be developed and maintained until WPAS is implemented in the West. All of the relevant data for this is available via the data warehouse.

The DSCN implementation and WPAS upgrade dates are not aligned. The PTL solution that will be developed for the West area could be implemented for the Centre and East however there is concern that due to development time an interim solution would only be in place for a short period before the WPAS upgrade. This would mean that staff would very quickly need to re-learn a booking process and of greater concern, that the interim solution would act as a barrier to the move to using WPAS to operationally manage patients and in effect become a 'workaround' outside of the core system. The Information service are able to support the development of a PTL solution but operational ownership is key to this area of work.

Single Cancer Pathway

The following table summarises current and future compliance with the DSCN 2019/01.

		Data Collection	SCP Tracker / Management	Reporting
Current	West (PIMS)	X	X	✓
	Centre (WPAS 18.1)	X	X	✓
	East (WPAS 18.1)	x	X	✓
Future	West (SharePoint)	✓*	✓ with External PTL solution	✓*
	Centre (WPAS 19.2)	✓*	✓ (Sep 2019)*	✓*
	East (WPAS 19.2)	✓*	✓ (Sep 2019)*	✓*

**Compliance is dependent upon staffing resource for patient tracking and data entry*

The current PAS systems do not support the tracking and reporting of the single cancer pathway. Shadow reporting of the SCP to date has included indicators that specifically relate to the total patients treated in month and the proportion of those treated within target. Data has been sourced from the current cancer tracker SharePoint (this relates to urgent suspected cancer referrals and so is only part of the total SCP), CANISC and various datasets manually extracted from PAS and RADIS. This process applies to all sites and whilst it has enabled the service to comply with the key requirements of shadow reporting it does not support the formal measurement of the SCP as outlined in DSCN 2019/01.

To assist the service in meeting the reporting requirements of DSCN 2019/01, a second SharePoint list is in development. This will enable tracking of the single cancer pathway across three sites until Tracker 7 becomes operational in Centre and East in September. This solution will remain in place for the West until WPAS is implemented there in 2020. This second SharePoint will capture the additions to the cancer pathway from other waiting lists i.e. the non USC patients, picked up from referrals for imaging (RadIS) and other diagnostic procedures such as endoscopies (PAS). This will enable the service to report the number of patients joining the SCP each month.

The proposed SharePoint solution will provide the opportunity for the service to be compliant with DSCN 2019/01 however the significant increase in the number of patients to track means that the

service does not have sufficient resource to capture and record all necessary data items (i.e. date of downgrade, suspension date for NUSC patients from point of suspicion of cancer) (appendix 1) therefore will not be fully compliant until additional resource is secured.

Recommendations

The committee is asked to note:

Eye care measure

- The service will move to booking in line with the ECM pathway requirements when WPAS version 19.2 is made available in the Centre and East areas in July and August 2019, avoiding the use of an interim PTL solution.
- Service leads and Information are working together to develop a PTL solution for the West area until the implementation of WPAS.

Single Cancer Pathway

- The information team are working with Cancer Services to develop a robust SharePoint solution that supports compliance until the implementation of Tracker 7 in September for East and Central. It will be used in West until WPAS is implemented.
- Cancer Services have requested additional staff resources to track the additional patient pathways and collect the necessary data to support the management and reporting of the single cancer pathway.

Appendix 1 – Provided by Cancer Services

Compliance with DSCN WISB ref: ISRN 2018 / 011

Measure	Definition	BCUHB Compliant Y/N	Explanation if N
1	**Treated by USC-nUSC**		
USC pathway	Information should be copied from the dataset used to complete the existing proforma *Monthly Cancer Target Monitoring Form - Urgent Suspected Cancer*	Y	
Treated in target with suspensions	This is the total treated in target recorded for the month in column *Number of newly diagnosed cancer patients starting first definitive treatment this month AND within 62 days from receipt of referral* - suspensions to be applied as per existing RTT and supplementary national guidance	Y	
Treated in target without suspension	This is the total treated in target recorded for the month in column *Number of newly diagnosed cancer patients starting first definitive treatment this month AND within 62 days from receipt of referral*	Y	
Total treated	This is the total recorded for the month in column *Total number of newly diagnosed cancer patients starting first definitive treatment this month*	Y	
NUSC pathway	Information should be copied from the dataset used to complete the existing proforma *Monthly Cancer Target Monitoring Form - 'Non' Urgent Suspected Cancer*	Y	

Treated in target with suspensions	This is the total treated in target recorded for the month in column *Number of newly diagnosed cancer patients starting first definitive treatment this month AND within 31 days of diagnosis* - suspensions to be applied as per existing RTT and supplementary national guidance	Y	
Treated in target without suspension	This is the total treated in target recorded for the month in column *Number of newly diagnosed cancer patients starting first definitive treatment this month AND within 31 days of diagnosis*	Y	
Total treated	This is the total recorded for the month in column *Total number of newly diagnosed cancer patients starting first definitive treatment this month*	Y	
Single Cancer Pathway			
Treated in target with suspensions	The total number of patients who began treatment **within target** in the month within 62 days from the point of suspicion. Suspensions to be applied as per existing RTT and supplementary national guidance	N	Suspensions for NUSC patients are applied from date of decision to treat only
Treated in target without suspension	The total number of patients who began treatment within target in the month within 62 days from the point of suspicion	Y	
Total treated	The total number of patients treated in the month that were referred onto the SCP including those that exceeded the 62 day target. There is not an expectation for the number of referrals to correspond with the numbers treated in any particular month.	Y	
2	**Treated by Tumour Site**		
Treated in target with suspensions	As worksheet 1 'Treated by USC NUSC' but for **SCP only** and categorised by tumour site. The sum of the tumour categories in these columns should be equal to the SCP *Numbers Treated in Target with suspensions*	N	Suspensions for NUSC patients are applied from date of decision to treat only

Treated in target without suspension	As worksheet 1 'Treated by USC NUSC' but for **SCP only** and categorised by tumour site. The sum of the tumour categories in these columns should be equal to the SCP *Numbers Treated in Target without suspensions*	Y	
Total treated	As worksheet 1 'Treated by USC NUSC' but for **SCP only** and categorised by tumour site. The sum of the tumour categories in these columns should be equal to the SCP To*tal treated figure in worksheet 1*	Y	
Percentage treated in target with suspensions	Autopopulated (Treated in target with suspensions/Total treated) x 100	N	Suspensions for NUSC patients are applied from date of decision to treat only
Percentage treated in target without suspensions	Autopopulated (Treated in target without suspensions/Total treated) x 100	Y	
3	**Entry onto Pathway**		
Entered Pathway	The total number of patients referred onto the single cancer pathway in the reporting month including those that are later downgraded or removed from the pathway, broken down by entry onto the pathway. These are patients starting from the point of suspicion as defined in Single Suspected Cancer Pathway Definitions - pathway start date http://www.walescanet.wales.nhs.uk/scp-key-documents. It is understood that all patients who are downgraded may not be captured at present until process changes are made. Until process changes are in place it is acceptable to use the date the patient record is downgraded (i.e., downgrade actioned on the system) as a proxy for the actual date of downgrade	N	Referrals from GP's (i.e., all USC's) are captured. NUSC's are captured but we are unable to split NUSC's by source at present and date of downgrade is not captured for all NUSC's as prospective tracking is not in place for this cohort. It is hoped that this will be resolved prior to live June reporting.

4	**Treated by Entry onto Pathway**		
Treated in target with suspensions	This is the same cohort of patients as in worksheet 1 'Treated by USC nUSC' but for SCP only and categorised by source of entry onto the pathway. This is essential for understanding where the majority of patients are entering the pathway and which areas are problematic. For further guidance please contact the Cancer Network via the email address below: singlecancerpathway@wales.nhs.uk. The sum of the pathway categories in these columns should be equal to the SCP Numbers Treated in Target with/without suspensions figures in worksheet 1.	N	Suspensions for NUSC patients are applied from date of decision to treat only
Treated in target without suspensions		Y	
Total treated	As worksheet 1 'Treated by USC nUSC' but for SCP only and categorised by entry onto the pathway. The sum of the pathway categories in this columns should be equal to the SCP Total treated figure in worksheet 1.	Y	
Percentage treated in target with suspensions	Autopopulated (Treated in target with suspensions/Total treated) x 100	N	Suspensions for NUSC patients are applied from date of decision to treat only
Percentage treated in target without suspensions	Autopopulated (Treated in target without suspensions/Total treated) x 100	Y	
5	**Enter Pathway by Tumour Site**		

Total number of patients entering the pathway	The total number of patients referred onto the single cancer pathway in the reporting month including those that are later downgraded or removed from the pathway, broken down by tumour site. These are the same cohort of patients as Worksheet 3 'Entry onto pathway' but by tumour site. It is understood that all patients who are downgraded may not be captured at present until system changes are made. Until system changes are in place it is acceptable to use the date the patient record is downgraded (i.e. downgrade actioned on the system) as a proxy for the actual date of downgrade.	N	Recording USC & NUSC totals, but unable to split NUSC's entering the pathway by tumour site currently and date of downgrade is not captured for all NUSC's as prospective tracking is not in place for this cohort. It is hoped that this will be resolved by live June reporting.
6	**Informed Date by Tumour Site**		
Total with diagnosis informed date	This cohort consists of patients who have been informed of their confirmed diagnosis. This count is attempting to capture the date on which they were informed in the reporting month regardless of which month they entered the SCP or whether they have begun treatment or not. If current systems are unable to capture the date the patient is informed of their diagnosis then the decision to treat date or date the patient is downgraded should be used in the short term while work is progressed to make the necessary changes on systems.	N	USC's only - date of decision to treat and date downgraded used as a proxy (as per DSCN guidance as this currently is not captured on systems, including Tracker 7)
Total with diagnosis informed date within 28 days	This cohort consists of patients who have been informed of their confirmed diagnosis. This count is attempting to capture the number of patients who were informed of their diagnosis within 28 days in the reporting month regardless of which month they entered the SCP or whether they have begun treatment or not. If current systems are unable to capture the date the patient is informed of their diagnosis then the decision to treat date or date the patient is downgraded should be used in the short term while work is progressed to make the necessary changes on systems.	N	USC's only - date of decision to treat and date downgraded used as a proxy (as per DSCN guidance as this currently is not captured on systems, including Tracker 7)

Percentage with informed date within 28 days	This cohort consists of patients who have been informed of their confirmed diagnosis. This percentage is attempting to capture the number of patients who were informed of their diagnosis within 28 days in the reporting month regardless of which month they entered the SCP or whether they have begun treatment or not. Autopopulated (Total with end date within 28 days /Total with diagnosis end date) x 100	N	USC's only - date of decision to treat and date downgraded used as a proxy (as per DSCN guidance as this currently is not captured on systems, including Tracker 7)

Information Governance and Informatics Committee **9.5.19**	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board ***To improve health and provide excellent care***

Report Title:	IT Systems Change Management Policy
Report Author:	Mrs Sharon Smith Informatics Improvement Facilitator
Responsible Director:	Dr Evan Moore, Executive Medical Director
Public or In Committee	Public
Purpose of Report:	To gain approval for a BCUHB wide IT Systems Change Management Policy that has been developed following recommendations from Internal Audit on Change Management.
Approval / Scrutiny Route Prior to Presentation:	A Task and Finish group with representatives from BCU System Owners and Informatics have worked together in the development of the draft Policy. Consultation has been undertaken for these documents with affected staff (System Owners) between 12.02.2019 and 04.03.2019.Scrutiny and subsequent approval of both documents was undertaken by the Informatics Senior Management Team between 04.03.2019 and 18.03.2019. Approval requested from the Executive Management Group (EMG) at the meeting held 1st May 2019.
Governance issues / risks:	None
Financial Implications:	None
Recommendation*:*	The Committee is asked to ratify the IT Systems Change Management Policy

Health Board's Well-being Objectives *(Indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)*	√	**WFGA Sustainable Development Principle** *(Indicate how the paper/proposal has embedded and prioritised the sustainable development principle in its development. Describe how within the main body of the report or if not indicate the reasons for this.)*	√
1.To improve physical, emotional and mental health and well-being for all		1.Balancing short term need with long term planning for the future	
2.To target our resources to those with the greatest needs and reduce inequalities		2.Working together with other partners to deliver objectives	√
3.To support children to have the best start in life		3. Involving those with an interest and seeking their views	√

4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being		4.Putting resources into preventing problems occurring or getting worse	√
5.To improve the safety and quality of all services	√	5.Considering impact on all well-being goals together and on other bodies	
6.To respect people and their dignity			
7.To listen to people and learn from their experiences			
Special Measures Improvement Framework Theme/Expectation addressed by this paper *http://www.wales.nhs.uk/sitesplus/861/page/81806*			
Equality Impact Assessment An *EqIA has been undertaken during the development of this policy to ensure that the proposed policy does not adversely affect/impact upon individuals. A copy of the EqIA is included within this report in Appendix 2*			

Disclosure:
Betsi Cadwaladr University Health Board is the operational name of Betsi Cadwaladr University Local Health Board

Appendix 1

Version: Draft 0.03
Reference Number

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

IT SYSTEMS CHANGE MANAGEMENT POLICY

Date to be reviewed:		**No of pages:**	6
Author(s):	Sion Jones Sharon Smith Tracy Williams	**Author(s) title:**	Head of ICT P & I Facilitator Head of Informatics P & I
Responsible dept / director:	Informatics / Chief Information Officer		
Approved by:	Information Governance and Informatics Committee		
Date approved:			
Date activated (live):			

Date EQIA completed:	06.09.2018
Documents to be read alongside this policy:	BCMP01 - Business Contingency Management Policy IG26 Software Patch Management Procedure
Purpose of Issue/Description of current changes: Issued to provide direction and define the policy for dealing with Information Technology (IT) Change Management within BCUHB	

First operational:					
Previously reviewed:					
Changes made yes/no:					

Contents

Introduction and Policy Statement

1.1 The Betsi Cadwaladr University Health Board (BCUHB) is increasingly dependent on its Information Technology (IT) systems and infrastructure to deliver patient care, operate efficiently and account for its actions. The interdependencies of systems and infrastructure are complex, and the results of changes made to one system / part of the infrastructure may have consequences for others

1.2 Uncontrolled implementation of changes presents significant risks including those to patient care, business continuity and everyday business processing and therefore BCUHB recognises the importance of change management. Ineffective IT change management process are critical in the provision of a structured and efficient process to ensure changes to systems are undertaken with the highest possible level of quality, safety, and accountability.

1.3 The objective of this policy is to ensure appropriate change management is in place in order to minimise the risk of disruption to The BCUHB, its service users and stakeholders.

1.4 This Change Management Policy is aligned to ITIL (formally an acronym for Information Technology Infrastructure Library) best practice guidelines.

Purpose of the document

2.1 This policy and associated procedures will define the way in which change management for Information Technology (IT) Systems is undertaken throughout the organisation to mitigate associated risks with poor change control such as:-

- Information being corrupted and/or destroyed;
- Computer performance being disrupted and/or degraded;
- Productivity losses being incurred; and
- Exposure to reputational risk.

Scope

3.1 Change is defined as “the addition, modification or removal of anything that could have an effect on IT services”. Types of changes are defined as:-

- Standard Changes
- Emergency Changes
- Normal Changes

3.2 The policy and its associated procedures relate to all clinical and non-clinical IT systems, services and documentation used by the BCUHB. Changes to systems will be managed and controlled by adhering to the processes defined within this policy.

3.3 The policy and its associated procedures relates to all types of changes (which follow the ITIL guidelines and are detailed in the Informatics Change Management Process document).

3.4 This policy applies to all staff employed by or contracted to BCUHB. All systems and third party suppliers who provide systems to support clinical and operational services and includes experts who BCUHB might call upon in consultation.

Aims and Objectives

4.1 This policy and its associated procedures aim to mitigate the associated risk and / or negative impact of change whist responding to changing requirements.

4.2 It aims to minimise the risk of unnecessary changes being applied to a system without forethought, thus avoiding the introduction of faults into the system and assist with the effective use of resources as robust controls would mean that it is less likely that conflicting changes are applied. In particular processes must be in place to:-

- **Provide** a change management process that is in proportion to the scale of the change
- **Ensure** change is implemented in a standard way enabling repeat processes to be used, making the whole process easier to manage
- **Ensure** that change is assessed and approved / authorised by the appropriate change authority e.g. leadership team. This includes user requests for change
- **Ensure** that changes are recorded and evaluated prior to assessment e.g. risk assessed and documented via request for change forms
- **Ensure** that change management is documented throughout its cycle in a consistent way and shared when appropriate.
  The change life cycle is typically Log the change, set the priority of the change, categorise the change, undertake impact and resource assessment, approval, scheduling, build, test, implement, review and close.
- **Ensure** that authorised changes are prioritised, planned, tested, implemented, documented and reviewed in a controlled manner
- **Integrate** into other service management processes to allow authorised changes to be tracked, unauthorised changes to be identified and the true impact of the change understood
- **Provide notice** (with the exception of emergency changes) to any sites, services or users affected by the change
- **Ensure Staff** are trained, so that all staff are made aware of their responsibilities for change management

These processes are required to protect the live IT environment from disruption associated with unplanned or failed changes

Where third party suppliers are responsible for the provision of IT services or products, details of how changes are requested and managed MUST be documented e.g. in service level agreements

Responsibilities

Chief Executive

5.1 The Chief Executive has overall responsibility for change management within BCUHB. As Accountable Officer he/she is responsible for the management of the organisation and for ensuring appropriate mechanisms are in place to support service delivery and continuity. Change management is key to this as it will prevent disruption to the live IT environment associated with unplanned or failed changes.

Information Governance and Informatics Committee

5.2 The committee is responsible for ensuring that this policy is implemented, through the Informatics and Information Governance Strategies, and that change management systems and processes are developed, implemented and monitored.

Directorate Managers and Heads of Service

5.3 Directorate Managers and Heads of service are responsible for ensuring adherence to and implementation of the policy.

BCUHB IT System Owners

5.4 The responsibility for change management is devolved to the relevant System Owners within BCUHB, who will ensure that IT system changes within their area are managed in a way which meets the aims of the organisation's change management policy and procedures. For systems that are ISO accredited any changes made need to ensure that the relevant standards are maintained.

All Staff

5.5 All staff must ensure that they manage change and keep appropriate records in line with this policy and procedures and with any relevant clinical standards guidance.

Monitoring and Escalation Arrangements

6.1 Monitoring of this policy will be the joint responsibility of the Chief Information Officer and the Assistant Director of Information Governance and Assurance as both clinical and non-clinical IT systems are covered by the policy. The policy and supporting procedures will be disseminated throughout the organisation. Escalation of issues will be through the Information Governance and Informatics Committee to the Board as per the Health Board's Standing Orders.

This policy and associated procedures will be reviewed every 3 years. Review maybe invoked earlier if new legislation, new standards or codes of practice are introduced.

References

- Healthcare IT Skills - Change Control Procedures
- The Information Technology Infrastructure Library (ITIL®)
- West Hampshire Clinical Commissioning Group; IT Change Management Policy V 5. August 2018. Accessed https://www.westhampshireccg.nhs.uk/download.cfm?doc=docm93jijm4n1853
- ISO27001 Security, Change Management and Control Policy

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EQUALITY IMPACT ASSESSMENT FORMS

PARTS A and B: SCREENING AND OUTCOME REPORT

Introduction:
These forms have been designed to enable you to record, and provide evidence of how you have considered the needs of all people (including service users, their carers and our staff) who may be affected by what you are writing or proposing, whether this is:

- a policy, protocol, guideline or other written control document;
- a strategy or other planning document e.g. your annual operating plan;
- any change to the way we deliver services e.g. a service review;
- a decision that is related to any of the above e.g. commissioning a new service or decommissioning an existing service.

This is not optional: Equality Impact Assessment is a specific legal requirement on public sector organisations under equalities legislation and failure to comply could result in a legal challenge to a decision or strategy. More importantly, equality impact assessment helps to inform better decision-making and policy development leading to improved services for patients. **This form should not be completed by an individual alone, but should form part of a working group approach.**

The Forms:
You must complete:

- **Part A** – this is the Initial Screening that is always undertaken and consists of Forms 1 to 3; these forms are designed to enable you to make an initial assessment of the potential impact of what you are doing, and decide whether or not you will need to proceed to a Full Impact Assessment (Part C);

AND

- **Part B** – this is the Outcome Report and Action Plan (Form 4) you will need to complete whether or not you proceed to a Full Impact Assessment;

Together, these forms will help to provide evidence of your Impact Assessment and how you have shown "due regard" to the duties.
You may also need to complete **Part C** (see separate Form) – if parts A and B indicate you need to undertake a Full Impact Assessment. This enables you to fully consider all the evidence that is available (including engagement with the people affected by your document or proposals) to tell you whether your document or proposal will affect people differently. It also gives you the opportunity to consider what changes you may need to make to eliminate or mitigate any adverse or negative impact you have identified.

Remember that these forms may be subject to external scrutiny e.g. under a Freedom of Information request

Once completed, the EqIA Forms should accompany your document or proposal when it is submitted to the appropriate body for approval.

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1.	What are you assessing i.e. what is the title of the document you are writing or the service review you are undertaking?	ICT Service Change Management Policy and Procedure
2.	Provide a brief description, including the aims and objectives of what you are assessing.	Policy to define the process for dealing with ICT Change Management within BCUHB
3.	Who is responsible for the document/work you are assessing – i.e. who has the authority to agree/approve any changes you identify are necessary?	System Owners Group
4.	Is the Policy related to, or influenced by, other Policies/areas of work?	BCMP01 – Business Contingency Management Policy IG26 Software Patch Management Procedure
5.	Who are the key Stakeholders i.e. who will be affected by your document or proposals?	Owners of ICT Systems with BCUHB
6.	What might help/hinder the success of whatever you are doing, for example communication, training etc?	N/A

Form 2: Considering the potential impact of your document, proposals etc in relation to equality and human rights

Characteristic or other factor to be considered	Potential Impact by Group. Is it:-		Please detail here, <u>for each characteristic listed on the left</u>:- (1) any Reports, Statistics, Websites, links etc. that are relevant to your document/proposal and have been used to inform your assessment; and/or (2) any information gained during engagement with service users or staff; and/or any other information that has informed your assessment of Potential Impact.
	Positive (+) Negative (**-**) Neutral (**N**) No Impact/Not applicable (**N/a**)	High Medium or Low	
Age	N/A		
Disability	N/A		
Gender Reassignment	N/A		
Marriage & Civil Partnership	N/A		
Pregnancy & Maternity	N/A		
Race / Ethnicity	N/A		
Religion or Belief	N/A		
Sex	N/A		
Sexual Orientation	N/A		
Welsh Language	N/A		
Human Rights	N/A		

Guidance on completing Form 2: For each of the characteristics listed, and considering the aims and objectives you detailed in Q2 on Form 1, you need to consider whether your document or proposal likely to affect people differently, and if so, will this be in a positive or negative way? For example, you need to decide:

- will it affect men and women differently?
- will it affect disabled and non-disabled people differently?
- will it affect people in different age groups differently? - and so on covering all the protected characteristics.

Use your judgement to indicate the scale of any impact identified. The factors used to determine an overall assessment for each characteristic should include consideration of scale and proportionality as well as potential impact.

Form 3: Assessing Impact Against the General Equality Duty

As a public sector organisation, we are bound by the three elements of the "General Duty". This means that we need to consider whether (if relevant) the policy or proposal will affect our ability to:- • Eliminate unlawful discrimination, harassment and victimisation; • Advance equality of opportunity; and • Foster good relations between different groups	
1. Describe here (if relevant) how you are ensuring your policy or proposal does not unlawfully discriminate, harass or victimise	N/A
2. Describe here how your policy or proposal could better advance equality of opportunity (if relevant)	N/A
3. Describe here how your policy or proposal might be used to foster good relations between different groups (if relevant)	N/A

Part B:

Form 4 (i): Outcome Report

Organisation:	BETSI CADWALADR UNIVERSITY HEALTH BOARD

1. What is being assessed? (Copy from Form 1)	ICT Service Change Management Policy and Procedure

2. Brief Aims and Objectives: (Copy from Form 1)	Policy to define the process for dealing with ICT Change Management within BCUHB

3a. Could the impact of your decision/policy be discriminatory under equality legislation?	Yes	No x
3b. Could any of the protected groups be negatively affected?	Yes	No x
3c. Is your decision or policy of high significance?	Yes	No x

4. Did the decision scoring on Form 3, coupled with your answers to the 3 questions above indicate that you need to proceed to a Full Impact Assessment?	Yes	No x
	Record here the reason(s) for your decision i.e. what did Forms 2 & 3 indicate in terms of positive and negative impact for each characteristic? There will not be a negative impact upon any of the protected groups by the introduction of this policy	

5. If you answered 'no' above, are there any issues to be addressed e.g. mitigating any identified minor negative impact?	Yes	X
	Record Details:	

6. Are monitoring arrangements in place so that you can measure what actually happens after you implement your document or proposal?	Yes x	No
	How is it being monitored?	Annual review of the percentage of change requests that do not adhere to the policy Number of unapproved changes taking place
	Who is responsible?	Informatics Performance & Improvement
	What information is being used?	E.g. will you be using existing reports/data or do you need to gather your own information? The document will be audited against the change requests logged within NWIS Service Point tool. These are recorded with the type of change and lead times and the reasons for approval or rejection.
	When will the EqIA be reviewed? (Usually the same date the policy is reviewed)	In line with review of Policy

7. Where will your decision or policy be forwarded for approval?	System Owners Group

8. Describe here what engagement you have undertaken with stakeholders including staff and service users to help inform the assessment	A Task and Finish group was established to develop the Policy with representative from the System Owners Group which is a sub group of the Digital Transformation Board. The policy was also sent to representatives of the Informatics User group for consultation.

9. Names of all parties involved in undertaking this Equality Impact Assessment:	Name	Title/Role
	Sharon Smith	Informatics P&I Facilitator
	Nick Husbands	ICT Systems Manager,
	Dave Slocombe	Data Communications Manager
	Jamie Johnson	Business Systems Development Manager, Finance
	James Rees	ICT Service Support & Delivery Manager,
	James Satelle	Operational Support Services Manager,
Please Note: The Action Plan below forms an integral part of this Outcome Report		

Form 4 (ii): Action Plan
This template details any actions that are planned following the completion of EqIA including those aimed at reducing or eliminating the effects of potential or actual negative impact identified.

	Proposed Actions	Who is responsible for this action?	When will this be done by?
1. If the assessment indicates significant potential negative impact such that you cannot proceed, please give reasons and any alternative action(s) agreed:	N/A		
2. What changes are you proposing to make to your document or proposal as a result of the EqIA?	N/A		
3a. Where negative impacts on certain groups have been identified, what actions are you taking or are proposed to mitigate these impacts? Are these already in place?	N/A		
3b. Where negative impacts on certain groups have been identified, and you are proceeding without mitigating them, describe here why you believe this is justified.	N/A		

	Proposed Actions	Who is responsible for this action?	When will this be done by?
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.	N/A		

Information Governance & Informatics Committee

9.5.19

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

To improve health and provide excellent care

Report Title:	Information Governance (IG) Strategy
Report Author:	Wendy Hardman, Head of Information Governance
Responsible Director:	Mrs Grace Lewis-Parry, Board Secretary
Public or In Committee	Public
Purpose of Report:	The strategic aims and purpose of this strategy is to describe the governance arrangements that will deliver Information Governance and assurance within BCUHB and will set out the overall principles that will promote a culture of best practice around the processing of information and the use of information and systems. That is, to ensure information is handled to ethical and quality standards and in a secure and confidential manner.
Approval / Scrutiny Route Prior to Presentation:	Reviewed and approved by the Board Secretary.
Governance issues / risks:	It is a statutory requirement to comply with Data Protection and the Freedom of Information Legislation. Non-compliance with the legislation can lead to penalties imposed by the Information Commissioner and loss of confidence by the public in the Health Board's ability to protect the privacy of their information.
Financial Implications:	Non-compliance with the legislation can lead to significant fines imposed by the Information Commissioners office.
Recommendation:	The Committee is asked to ratify the IG Strategy.

Health Board's Well-being Objectives *(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)*	√	**WFGA Sustainable Development Principle** *(Indicate how the paper/proposal has embedded and prioritised the sustainable development principle in its development. Describe how within the main body of the report or if not indicate the reasons for this.)*	√
1.To improve physical, emotional and mental health and well-being for all		1.Balancing short term need with long term planning for the future	
2.To target our resources to those with the greatest needs and reduce inequalities		2.Working together with other partners to deliver objectives	**x**

3.To support children to have the best start in life		3. Involving those with an interest and seeking their views	
4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being	**x**	4.Putting resources into preventing problems occurring or getting worse	**x**
5.To improve the safety and quality of all services	**x**	5.Considering impact on all well-being goals together and on other bodies	**x**
6.To respect people and their dignity	**x**		
7.To listen to people and learn from their experiences			
Special Measures Improvement Framework Theme/Expectation addressed by this paper **Not applicable** *http://www.wales.nhs.uk/sitesplus/861/page/81806*			
Equality Impact Assessment			

Disclosure:
Betsi Cadwaladr University Health Board is the operational name of Betsi Cadwaladr University Local Health Board

Version 4.4 draft

INFORMATION GOVERNANCE STRATEGY

Author & Title	Wendy Hardman, Head of Information Governance
Responsible dept / director:	Board Secretary, Office of the Board Secretary
Approved by:	Information Governance and Informatics Committee
Date approved:	
Date activated (live):	
Documents to be read alongside this document:	Risk Management Strategy, Policy and Procedures Information Governance Policies and Procedures Informatics Strategy Estates Strategy
Date of next review:	

First operational:	17/11/2014				
Previously reviewed:	April 2015	April 2016	Sept 2017	Jan 2018	
Changes made yes/no:	Yes	Yes	Yes	Yes	

N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out of date printed versions of the document. The Intranet should be referred to for the current version of the document.

Contents:

Appendices:

1. INTRODUCTION

1.1 Within the health and social care sector information is a vital asset, both in terms of the clinical management of individual patients and the efficient management of services and resources. It is therefore important to ensure that information is effectively managed and that appropriate policies, procedures and management accountability are in place to provide a robust governance framework for information management, both now and in the future.

1.2 Information Governance (IG) is about setting high standards for the handling of information and giving organisations the tools to achieve those standards. The ultimate aim is to demonstrate that an organisation can be trusted to maintain and demonstrate that personal information is being handled legally, securely, efficiently and effectively, in order to deliver the best possible care. It additionally enables organisations to put in place procedures and processes for their corporate information that support the efficient location and retrieval of corporate records where and when needed, in particular to meet requests for information and assist compliance with contractual requirements.

1.3 The Caldicott Principle in Practice (CPiP) Toolkit is an online self-assessment tool that enables NHS Wales organisations to measure their performance against 40 IG standards. Compliance against the toolkit is assessed on an annual basis and reported to the Information Governance & Informatics (IGI) Committee. This provides assurance to the Board that it has established best practice in respect of handling information and that we are actively promoting a culture of awareness and improvement to comply with legislation and other regulatory standards and best practice.

1.4 Reporting against the CPiP Toolkit will be replaced in 2020 by the All Wales Information Governance Toolkit which will provide a more robust level of assessment and assurance in line with the new National Data Guardian Standards and the National and Information Systems (NIS) Directive 2018.

1.5 This strategy includes the continuing development, implementation and embedding of a robust information governance framework. The information governance arrangements will underpin the requirements set out by the Wellbeing and Future Generations Act and the Health Board's strategic objectives by ensuring the integrity, availability and confidentiality of the information needed to support and deliver its services.

1.6 Betsi Cadwaladr University Health Board (BCUHB) is committed to securing the best quality health care for the population of North Wales. In doing so, it acknowledges that this can only be achieved through the skills and continuing commitment of its staff and those of its partner organisations.

1.7 BCUHB will support its employees by providing the skills and knowledge to deliver the organisations' strategic objectives and priorities, thus giving them the confidence to make the right choices at the right time.

2. STRATEGY STATEMENT

2.1 This strategy outlines the Health Boards plan to comply with Information Governance responsibilities and duties. The strategy has been developed from the standards outlined in the Caldicott Principles in Practice (C-PiP) and changes to data protection legislation following the implementation of the General Data Protection Regulation (GDPR) 2016.

3. STRATEGIC AIMS

3.1 The strategic aims and purpose of this strategy is to describe the governance arrangements that will deliver Information Governance and assurance within BCUHB and will set out the overall principles that will promote a culture of best practice around the processing of information and the use of information and systems. That is, to ensure information is handled to ethical and quality standards and in a secure and confidential manner.

3.2 **Caldicott Principles in Practice (C-PiP) Toolkit**
Completion of the C-PiP Toolkit is mandatory for all NHS Wales Health Boards and Trusts. The self-assessment generates a score that should demonstrate a good level of information governance practices. An annual Outturn Report is presented to the IGI Committee with an improvement plan against the standards. These improvements are transferred into the Information Governance operational plan which is regularly reviewed and monitored by the Information Governance Group. The C-PiP score is published and is shared with partner organisations to assess their suitability to share information and conduct business.

The All Wales IG Toolkit will replace the C-PiP self-assessment in 2020 and BCUHB has signed up to trial this tool during 2019 in readiness for its formal submission in 2020.

3.3 **Data Protection legislation**
Data protection legislation is the most fundamental piece of legislation that underpins Information Governance. BCUHB is registered with the Information Commissioners Office (ICO) and will seek to fully comply with all legal requirements of this legislation. A Data Protection Officer has been appointed to support the fulfilment of this requirement under the legislation.

BCHUB has in place an Information Asset Register and a process has been adopted to ensure that a review of all current and new information assets and systems will be carried out. Where there is a requirement to process personal data the impact of this will be assessed via a Data Protection Impact Assessment. All the elements of this assessment with actions will be completed and captured within the lifecycle of that asset on the Register.

3.4 **Risk Management**
Information plays a key part in corporate governance, strategic risk, clinical governance, service planning and performance management. This Strategy

links into all these aspects and sets out the approach to be taken across BCUHB to provide a robust information governance framework.

Information Governance risks have been identified in the BCUHB Corporate Risk Management Framework and in local department risk registers. The implementation of this strategy will facilitate and maintain a reduction in the level of current identified risks.

3.5 **Incident Management**

Information governance related incidents must be reported via the Incident Management Procedures. These incidents will have active involvement from the IG Team who will risk assess the incident as to whether it reaches the severity rating as reportable to the ICO and Welsh Government using the adopted HSCIC risk scoring matrix. Any such reporting must be done within 72 hours of knowledge of the incident in line with legislative requirements. Significant incidents will be subject to a full Root Cause Analysis investigation and reporting actions.

IG incidents may include, but is not limited to, breaches of policy, breaches of confidentiality and issues related to IT security.

3.6 **Accountability framework structure**

An Information Governance Group (IGG) has been established which provides assurance to the IGI Committee of the Health Board. This Group has delegated authority to oversee information governance issues, operational information risk management and the management of IG workplans and programmes. (See appendix B for terms of reference for this Group and appendix C for accountability framework structure).

4. OBJECTIVES

4.1 BCUHB's agreed Strategic Objectives for 2019/20 are as follows:

- Improve Health and Wellbeing for all and reduce health inequalities.
- Work in Partnership to design and deliver more care closer to home
- Improve the Safety and Outcomes of care to match the NHS's best
- Respect Individuals and maintain dignity and care
- Support, train and develop our staff to excel
- Use resources wisely, transforming services through innovation research

4.2 The supporting information governance related organisational objectives will be achieved by ensuring the effective management of Information Governance by:

- Ensuring that BCUHB meets its obligations under the Data Protection Act 2018 and GDPR;
- Lead on the implementation and actions required to support the Office of the Board Secretary in the event of an EUexit with regards

identifying information flows into and out of the EEA and ensuring appropriate contracts and security arrangements are in place;
- Lead on the response to the Infected Blood Inquiry, ensuring access to corporate information is made available upon request;
- Ensuring that privacy by design and default is considered at all stages of service design, system procurement and partnership working;
- Streamline service referral process in line with the local authorities to implement solutions to enable the removal of faxes;
- Continue to support cluster working modules within Primary Care as shared resources;
- Ensure IG Strategies, policies, procedures and training plans are all updated to reflect best practice and changes in legislation;
- Maintain compliance with the data protection legislation by regular monitoring of IG KPI reports and submission of evidence to support the Information Commissioners follow up audit during 2019;
- Improve IG Training Compliance from 81% to national target of 85% to raise staff understanding and awareness;
- Improve compliance with Freedom of Information response times in line with legislative requirements from 70% to 85% by supporting governance leads and raising awareness;
- Support the Health Boards move towards its 'Digital Future' by working with the Patient Record Transition Programme.

5. SCOPE

5.1 This strategy applies to all employees, contractors, volunteers and students working for, or supplying services for the Health Board.

5.2 Primary Care Contractors are independent to the Health Board; however the principles within this strategy should be embedded into working practice.

6. ROLES AND RESPONSIBILITIES

6.1 **Chief Executive** - The Chief Executive takes overall responsibility for the Health Boards information governance performance and in particular is required to ensure that:
- the Health Board can demonstrate accountability against the requirements within the Data Protection Act.
- decision-making is in line with the Boards policy and procedure for information governance and any statutory provisions set out in legislation;
- the information risks are assessed and mitigated to an acceptable level and information governance performance is continually reviewed;
- suitable action plans for improving information governance are developed and implemented;
- ensure IG training is mandated for all staff and is provided at a level relevant to their role.

To satisfy the above, the Chief Executive has delegated this responsibility to the Board Secretary who will be accountable for the Boards overall information governance arrangements.

6.2 **Senior Information Risk Owner (SIRO)** – The Board Secretary has delegated responsibility for ensuring that the Board corporately meets its legal responsibilities, and for the adoption of internal and external information governance requirements. They will act as the conscience for information governance on the Board and advises on the effectiveness of information governance management across the organisation. They are also the identified Senior Information Risk Owner (SIRO) and will take ownership of information risk and is a key factor in successfully raising the profile of information risks and embedding information risk management into the Health Board's culture.

6.3 **Caldicott Guardian** - The Associate Medical Director has been nominated as the Boards Caldicott Guardian and is responsible for protecting the confidentiality and reflecting patients' interests regarding the use of patient identifiable information. They are responsible for ensuring patient identifiable information is shared in an appropriate, ethical and secure manner. The Caldicott Guardian is the Chair of the Information Governance Group.

6.4 **Data Protection Officer** – The Assistant Director of Information Governance and Assurance has been appointed as the Data Protection Officer as required by GDPR. This role plays a key part in fostering a data protection culture to help implement essential elements of the GDPR such as, principles of data processing, data subjects' rights, data protection by design and by default – privacy impact assessments. The Information Governance structure sits within this department.

6.5 **Information Governance Team** - The Head of Information Governance will be responsible for the development, communication and monitoring of policies, procedures and action plans ensuring the Board adopts information governance best practice and standards. This role will report to the Assistant Director of Information Governance and Assurance and will be supported by the Information Governance Team who will also work in collaboration with the Information Governance Leads and Information Asset Owners.

6.6 **Chief Information Officer** - The Chief Information Officer has overall responsibility for the technical infrastructure to ensure the security and data quality of the information assets and systems held within the Board. This role is also the Deputy SIRO.

6.7 **Head of ICT** – is the Health Board's identified IT Security Lead and provides expert technical advice on matters relating to IT Security and ensures compliance and conformance against the NHS Wales Code of Connection and NIS Directive.

6.8 **Head of Digital Records** – This role is responsible for the overall management and performance of the Health Records Service within BCUHB including the provision of organisation-wide access to health records.

6.9 **Executive Director/Secondary Care Director/Area Director** - Each Director is responsible for the information within their Division and therefore must take responsibility for information governance matters. In particular they must appoint an Information Governance Lead.

6.10 **Information Governance Leads** – The IG Leads work with the IG Team to ensure compliance with corporate IG policies, procedures, standards, legislation and to promote best practice.

6.11 **Information Asset Owners (IAO) -** their role is to understand what information is processed by their department i.e. what information is held, added, removed, how it is moved, who has access to it and why. As a result, they are able to understand and address risks to the information, to ensure that information is processed within legislative requirements.

6.12 **Information Asset Administrator (IAA) -** will recognise actual or potential security incidents, consult with their IAO on appropriate incident management and ensure that information asset registers are accurate and up to date.

6.13 **System Owners –** will be responsible for identifying and managing system risks; understand procurement requirements around contracts and licencing; put in place and test business continuity and disaster recovery plans, control access permissions and ensure the system asset record is regularly reviewed and updated on the asset register.

6.14 **All Staff** - All employees, contractors, volunteers and students working for or supplying services for the Health Board are responsible for any records or data they create and what they do with information they use.

Staff must attend mandatory information governance training and/or refresher/ awareness sessions to maintain their knowledge and skills every two years.

All staff have a responsibility to adhere to information governance policies and procedures and standards which are written into the terms and conditions of their contracts of employment and the organisations Staff Code of Conduct.

6.13 **Third Party Contractors** – appropriate contracts and confidentiality agreements shall be in place with third parties where potential or actual access to the Health Boards confidential information assets is identified.

7. IMPLEMENTATION AND MONITORING

7.1 BCUHB have implemented a number of Information Governance policies and procedures which are regularly reviewed and updated. These are published in line with the Corporate Policy on Policies and awareness is raised via communication channels such as the Corporate Bulletin, IG Bulletin, staff alerts and IG training. The key policies relate to:

- Information Governance (Data Protection & Confidentiality)

- Information Management and Technology (IM&T) Security (incl. incident management)
- Access to Information (incl. Freedom of Information and Subject Access Requests)
- Records Management (corporate and personal records)

7.2 All staff will have access to a programme of training and awareness to enable them to comply with these policies.

7.3 Robust controls and auditing processes have been put in place to monitor compliance and manage any incidents with regard to data security breaches.

7.4 Quarterly KPI reports are presented to the Information Governance Group with issues of significance reported to the IGI Committee.

7.5 The IG operational plan will be managed by the IG Team, monitored via the IG Group and issues of significant escalated to the IGI Committee.

7.6 Annual self-assessment against the C-PiP Toolkit will be carried out and presented to the IGI Committee as an Outturn Report and improvement plan.

7.7 An IG Annual report will be presented to the IGI Committee to demonstrate assurance against the IG Framework and its associated policies.

8. RESOURCES

8.1 The Information Governance Team should have sufficient resource in order to ensure the Health Board remains complaint against its legislative requirements and timescales.

8.2 Divisions should ensure that their appointed Information Governance Leads, Information Asset Owners and System Owners have sufficient time and resource in order to execute the requirements within these job roles.

9. TRAINING

9.1 All staff within BCUHB are mandated to undertake Information Governance training. This training must be renewed every two years.

9.2 In addition to induction and mandatory training requirements, there are certain posts/job roles which require specialised IG training in order to fulfill their duties, for example: Caldicott Guardian, DPO, SIRO, IG Team, IAO, IAA, System Owners and staff who handle subject access requests.

9.3 The Information Governance Team are responsible for developing and delivering the IG training programme which is supported by a 3 year IG Training Strategy and action plan.

9.4 In 2018 NHS Wales has put in place a national compliance target of 85% for Information Governance training. The 3 year IG Training Strategy will be reviewed and updated in order to achieve and maintain compliance of this target.

10. IMPACT ANALYSES

10.1 Equality

In accordance with equality duties, an Equality Impact Assessment has been carried out on this Strategy (Appendix 1). There is no evidence to suggest that the Strategy would have an adverse impact in relation to race, disability, gender, age, sexual orientation, religion and belief or infringe individuals' human rights.

10.2 Welsh Language

The Information Governance Team have responded to the requirements within the Welsh Language Standards document by ensuring that:

- All correspondence received from the public will be responded to in the language in which it was received.
- All telephone calls will be answered bilingually. If an individual wishes to continue in Welsh the call can either be put through to the IG Manager in West or the Welsh Translation Team.
- Out of hours, all phones will be transferred to an answering machine with a bilingual message.
- All information developed specifically for the public is available bilingually.
- All offices will have bilingual door signs on entry.
- All staff members have bilingual ID badges.
- All staff members have fully bilingual email signatures for internal and external emails.
- Any new policies and procedures developed will use the new BCUHB template which ensures that welsh language is considered.
- All staff will request access to Cysgair and Cysillt software which can assist with informal translation.
- The IG training handout for staff will be translated into Welsh.

10.3 Well-being of future generations

The five ways of working have been interwoven within this Strategy, those being:

- **Long term** – balancing short-term needs with long-term needs.
- **Prevention** – stopping problems happening or getting worse.
- **Integration** – thinking about how this strategy works with other plans.
- **Collaboration** – working together with other services to meet our goals.
- **Involvement** – involving people so they have a say in decisions.

10.4 Environmental

The Environmental Department carried out a risk assessment of the Lorries that came on site to carry out confidential waste shredding. The outcome of

the assessment was that the Lorries caused excessive noise and emissions when carrying out the shredding process. The confidential waste contract was re-negotiated this financial year to enable confidential waste to be shredded off site. These risks have now been eliminated and no further environmental risks have been identified.

11. AUDIT

11.1 Internal Audit will provide an independent and objective opinion on Information Governance risk management, control and governance arrangements by measuring and evaluating their effectiveness.

11.2 The Health Board will respond to the ICO audit on how we manage the processing of personal data, in particular looking at: Governance & Accountability; Records Management and Requests for Information

11.3 The IG Team will carry out audits to:

a) review IG compliance across departments and teams within BCUHB;
b) review and risk assess Information/System asset register submissions;
c) assess the data protection impact of all new or revised system or service development;
d) undertaken assurance audits in line with the Estates Strategy.

11.4 The System Owners Group, led by Informatics, will take over the responsibility of auditing and monitoring the system asset element of the Asset Register and will put in place a programme of training for System Owners. IG are represented as part of the membership of this Group.

12. REVIEW

This Strategy will be reviewed in one year. Earlier review may be required in response to exceptional circumstances, organisational change or changes to legislation / guidance.

13. LEGISLATION AND COMPLIANCE WITH STANDARDS

13.1 The legislation and guidance supporting this strategy includes:

- Freedom of Information Act 2000
- Environmental Information Regulation 2004
- Data Protection Act 2018
- General Data Protection Regulation 2016
- Human Rights Act 1998
- Access to Health Records Act 1990
- Common Law – duty of confidence
- Computer Misuse Act 2000
- Copyright, designs and Patents Act 1988 (as amended by the Copyright Computer programs regulations 1992)
- Network and Information Systems (NIS) Directive
- Crime and Disorder Act 1998

- Electronic Communications Act 2000
- Regulation and Investigatory Powers Act 2000

13.2 **References**

- Lord Chancellor's Code of Practice on the Management of Records Under Section 46 of the FOI Act 2000
- Records Management: NHS Code of Practice
- Caldicott Report
- Caldicott: Principles into Practice (C-PIP) Foundation Manual for Caldicott Guardians
- National Data Guardian Standards
- Information Security ISO/IEC 27001:2005; ISO/IEC 27001:2013
- Confidentiality: Code of Practice for Health & Social Care in Wales
- Wales Accord for Sharing Personal Information (WASPI)

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Betsi Cadwaladr
University Health Board

EQUALITY IMPACT ASSESSMENT FORMS
PARTS A and B: SCREENING AND OUTCOME REPORT

Introduction:
These forms have been designed to enable you to record, and provide evidence of how you have considered the needs of all people (including service users, their carers and our staff) who may be affected by what you are writing or proposing, whether this is:

- a policy, protocol, guideline or other written control document;
- a strategy or other planning document e.g. your annual operating plan;
- any change to the way we deliver services e.g. a service review;
- a decision that is related to any of the above e.g. commissioning a new service or decommissioning an existing service.

This is not optional: Equality Impact Assessment is a specific legal requirement on public sector organisations under equalities legislation and failure to comply could result in a legal challenge to a decision or strategy. More importantly, equality impact assessment helps to inform better decision-making and policy development leading to improved services for patients. **This form should not be completed by an individual alone, but should form part of a working group approach.**

The Forms:
You must complete:

- **Part A** – this is the Initial Screening that is always undertaken and consists of Forms 1 to 3; these forms are designed to enable you to make an initial assessment of the potential impact of what you are doing, and decide whether or not you will need to proceed to a Full Impact Assessment (Part C);

AND

- **Part B** – this is the Outcome Report and Action Plan (Form 4) you will need to complete whether or not you proceed to a Full Impact Assessment;

Together, these forms will help to provide evidence of your Impact Assessment and how you have shown "due regard" to the duties.

You may also need to complete **Part C** (see separate Form) – if parts A and B indicate you need to undertake a Full Impact Assessment. This enables you to fully consider all the evidence that is available (including engagement with the people affected by your document or proposals) to tell you whether your document or proposal will affect people differently. It also gives you the opportunity to consider what changes you may need to make to eliminate or mitigate any adverse or negative impact you have identified.

Remember that these forms may be subject to external scrutiny e.g. under a Freedom of Information request.

To enter text, click on the grey box in the part of the form you are completing. Help text will appear in the status bar at the foot of the page. Some boxes have drop-down lists from which you can select options. Others may simply be a box to answer a question. Once completed, the EqIA Forms should accompany your document or proposal when it is submitted to the appropriate body for approval.

GIG CYMRU NHS WALES
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Part A

Form 1: Preparation

1.	What are you equality impact assessing? What is the title of the document you are writing or the service review you are undertaking?	Information Governance Strategy	
2.	Provide a brief description, including the aims and objectives of what you are assessing.	The Health Board aims to achieve a high level of excellence in information governance by ensuring information is dealt with legally, securely, efficiently and effectively in the course of its business, in order to support high quality patient care. The strategy supports the Board to deliver a positive culture of information governance management and ensures that all staff recognise "information governance as everyone's business". It supports decision making in a way in which contributes to the achievement of the organisation's purpose, values and corporate objectives.	
3.	Who is responsible for the document/work you are assessing – i.e. who has the authority to agree/approve any changes you identify are necessary?	Grace Lewis-Parry	
4.	Who is Involved in undertaking this EqIA? Include the names of all the people in your sub-group.	Name	Title/Role
		Justine Parry	Assistant Director of IG & Assurance
		Wendy Hardman	Head of Information Governance
5.	Is the Policy related to, or influenced by, other Policies/areas of work?	Informatics Strategy Risk Management Policy & Strategy Associated Information Governance policies and procedures	
6.	Who are the key Stakeholders i.e who will be affected by your document or proposals?	The Board and all employees.	

7.	What might help/hinder the success of whatever you are doing, for example communication, training etc?	Information Governance training is a mandatory requirement for all staff however it is difficult for managers to find time to release staff from clinical duties to attend the training

Form 2: Considering the potential impact of your document, proposals etc in relation to equality and human rights

Characteristic or other factor to be considered	Potential Impact by Group. Is it:-		Please detail here, <u>for each characteristic listed on the left</u>:- (1) any Reports, Statistics, Websites, links etc. that are relevant to your document/proposal and have been used to inform your assessment; and/or (2) any information gained during engagement with service users or staff; and/or (3) any other information that has informed your assessment of Potential Impact.
	Positive (+) Negative (**-**) Neutral (**N**) No Impact/Not applicable (**N/a**)	Scale (see Table A on next page)	
Age	(N/a)	No impact/Not applicable (N/a)	
Disability	(N/a)	No impact/Not applicable (N/a)	
Gender Reassignment	(N/a)	No impact/Not applicable (N/a)	
Pregnancy & Maternity	(N/a)	No impact/Not applicable (N/a)	
Race / Ethnicity	(N/a)	No impact/Not applicable (N/a)	
Religion or Belief	(N/a)	No impact/Not applicable (N/a)	
Sex	(N/a)	No impact/Not applicable (N/a)	
Sexual Orientation	(N/a)	No impact/Not applicable (N/a)	
Welsh Language	(N/a)	No impact/Not applicable (N/a)	
Human Rights	(N/a)	No impact/Not applicable (N/a)	

Guidance on completing Form 2: For each of the characteristics listed, and considering the aims and objectives you detailed in Q2 on Form 1, you need to consider whether your document or proposal likely to affect people differently, and if so, will this be in a positive or negative way? For example, you need to decide:

- will it affect men and women differently?
- will it affect disabled and non-disabled people differently?
- will it affect people in different age groups differently? - and so on covering all the protected characteristics.

Use the table below to indicate the scale of any impact identified. The factors used to determine an overall assessment for each characteristic should include consideration of scale and proportionality as well as potential impact.

Table A

High negative	Note: It is important to understand that we will be required to demonstrate what we have considered and/or done in order to mitigate or eliminate any negative impact on protected groups identified within the assessment. Details should be recorded in sections 3a/3b in the Action Plan in Form 4.
Medium negative	
Low negative	
Neutral	
Low positive	
Medium positive	
High positive	
No impact/Not applicable	

Form 3: Assessing Impact Against the General Equality Duty

As a public sector organisation, we are bound by the three elements of the "General Duty". This means that we need to consider whether (if relevant) the policy or proposal will affect our ability to:- • Eliminate unlawful discrimination, harassment and victimisation; • Advance equality of opportunity; and • Foster good relations between different groups	
1. Describe here (if relevant) how you are ensuring your policy or proposal does not unlawfully discriminate, harass or victimise	The Information Governance Strategy is aligned to the Standing Orders which include the development of a robust governance framework to achieve the highest standards of patient safety and public service delivery, improve health and reduce inequalities and achieve the best possible outcomes for it's citizens, in a manner that promotes human rights.
2. Describe here how your policy or proposal could better advance equality of opportunity (if relevant)	N/A

3. Describe here how your policy or proposal might be used to foster good relations between different groups (if relevant)	N/A

Part B:

Form 4 (i): Outcome Report

Organisation:	BETSI CADWALADR UNIVERSITY HEALTH BOARD

1. What is being assessed?	Information Governance Strategy

2. Brief Aims and Objectives:	The aim of this document is to set out the commitment of the Health Board to ensure the effective management of information and identify how this will be achieved. It will specify who is responsible at each stage of the process. The Health Board considers that its approach to information governance is integral to achieving its strategic objectives and corporate priorities. The Health Board aims to achieve a high level of excellence in information governance by ensuring information is dealt with legally, securely, efficiently and effectively in the course of its business, in order to support high quality patient care. All information processing will be undertaken in accordance with relevant legislation, standards and best practice. The Health Board will set policies and procedures to ensure that appropriate standards are defined, implemented and maintained. The Health Board aims to reduce the risks arising from information handling processes, these being: • Legal action due to non-compliance with statutory and regulatory requirements • Loss of public confidence in the Health Board • Contribution to clinical or corporate negligence

	• Damage or stress to individuals. The Health Board aims to provide support to its staff to be consistent in the way they handle information and to avoid duplication of effort. This will lead to: • Improvements in information handling activities; • Improving patient confidence in the Health Board; • Increasing staff knowledge and awareness in information governance to empower them to make appropriate decisions; • Embed a culture of good information governance practice across the Health Board.

3a. Could the impact of your decision/policy be discriminatory under equality legislation?	Yes ☐	No ☒
3b. Could any of the protected groups be negatively affected?	Yes ☐	No ☒
3c. Is your decision or policy of high significance – consider the scale and potential impact across BCUHB including costs/savings, the numbers of people affected and any other factors?	Yes ☒	No ☐

4. Did the assessment of potential impact on Form 2, coupled with your answers to the 3 questions above indicate that you need to proceed to a Full Impact Assessment?	Yes ☐	No ☒	
	Record Reasons for Decision i.e. what did the assessment of scale on Form 2 indicate in terms of positive and negative impact for each characteristic? N/A		
5. If you answered 'no' above, are there any issues to be addressed e.g. mitigating any identified minor negative impact?	Yes ☐	No ☒	Not applicable ☐
	Record Details:		

6. Are monitoring arrangements in place so that you can measure what actually happens after you implement your document or proposal?	Yes ☒	No ☐
	How is it being monitored?	Information Governance Team and Information Governance Group
	Who is responsible?	
	What information is being used?	E.g. will you be using existing reports/data or do you need to gather your own information? i) An annual self-assessment is carried out against the Caldicott C-PiP with an Outturn Report presented to the IGI Committee ii) IG operational plan is actioned and updated by the IG Team and monitored by the IGG with issues of significance escalated to the IGI Committee. ii) Information Governance Team produce quarterly IG KPI reports which are submitted to the Information Governance Group with issues of significance reported to the IGI Committee.
	When will the EqIA be reviewed? (Usually the same date the policy is reviewed)	Every year.

7. Where will your decision or policy be forwarded for approval?	Information Governance & Informatics Committee

8. Describe here what engagement you have undertaken with stakeholders including staff and service users to help inform the assessment	Engagement has taken place with the Assistant Director of IG and Assurance and the IG Team to help inform the assessment.

	Name	Title/Role

9. Name/role of person responsible for this Impact Assessment	Wendy Hardman	Head of Information Governance
10. Name/role of person approving this Impact Assessment	Grace Lewis-Parry	Board Secretary
Please Note: The Action Plan below forms an integral part of this Outcome Report		

Form 4 (ii): Action Plan

This template details any actions that are planned following the completion of EqIA including those aimed at reducing or eliminating the effects of potential or actual negative impact identified.

	Proposed Actions	Who is responsible for this action?	When will this be done by?
1. If the assessment indicates significant potential negative impact such that you cannot proceed, please give reasons and any alternative action(s) agreed:	N/A		
2. What changes are you proposing to make (or have already made) to your document or proposal as a result of the EqIA?	N/A		
3a. Where negative impact(s) on certain groups have been identified, what actions are you taking or are proposed to mitigate these impacts? Are these already in place?	N/A		
3b. Where negative impact(s) on certain groups have been identified, and you are proceeding without mitigating them, describe here why you believe this is justified.	N/A		

	Proposed Actions	Who is responsible for this action?	When will this be done by?
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.	N/A		

NOTE: If your decision recorded above is that you will need to proceed to a Full Equality Impact Assessment, then you should refer to the Full Impact Assessment Forms (Part C)

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Note: For detailed guidance on the completion of these forms, please refer to Chapter 3 of the Toolkit that is available on the Equality pages of the BCUHB Intranet site.

BETSI CADWALADR UNIVERSITY HEALTH BOARD

INFORMATION GOVERNANCE GROUP (IGG)

TERMS OF REFERENCE

1. INTRODUCTION

1.1 The Health Board has a responsibility to ensure robust information Governance systems and processes are in place to protect patient, person and corporate information. This Group will provide assurance across the key areas of information governance.

2. PURPOSE

2.1 The Information Governance Group "the IGG" will co-ordinate all work in relation to information governance, which will cover the following key areas:

- Data Protection and Confidentiality
- Caldicott
- Freedom of Information
- Information Management and Security
- Records Management
- Data Quality

3. FUNCTIONS OF THE GROUP

3.1 The IGG will:

- Prepare for implementation of the General Data Protection Regulation (GDPR) and receive quarterly highlight reports.

- Ensure that the Health Board has effective policies and management arrangements covering all aspects of Information Governance in line with the Health Boards overarching Information Governance Strategy

- Ensure that the Health Board undertakes annual assessments and audits of its Information Governance policies and arrangements via its assurance framework.

- Establish an annual Information Governance Workplan, secure the necessary implementation resources, and monitor the implementation of that plan.

- Will review operational information governance risk and health records risks that are assigned to the Group and advise the appropriate Director on any risks requiring escalation.

- Monitor quarterly IG KPI reports which will include performance data relating to access to health records.

- Receive and consider reports into breaches of confidentiality and security and where appropriate undertake or recommend remedial action.

- Receive Chairs assurance report from the Patient Records Group and the ICT Security & Governance Group.

- Report and provide assurance to the Information Governance and Informatics (IGI) Committee on a quarterly basis.

- Liaise with other Health Board committees, Management Teams, and Project Boards in order to promote Information Governance issues.

Task and Finish Groups

3.2 The IGG may establish task and finish groups to carry out on its behalf specific aspects of IGG business.

4. MEMBERSHIP

4.1 The IGG will be chaired by the BCUHB Senior Associate Medical Director, who is the nominated Caldicott Guardian, or the Vice Chair, Assistant Director of Information Governance & Assurance (DPO) in their absence, who is the nominated Data Protection Officer. The Group will be serviced by the Head of Information Governance. Secretariat will be provided by the Information Governance Service.

Members

- Head of Information Governance
- Head of ICT
- Head of Digital Records / Health Records Service
- Office of the Nursing Director representative
- Finance representative
- Head of Chief Operating Officer's Office
- Head of Secondary Care Office
- Business Manager, Primary Care
- Mental Health and Learning Disabilities representative

In attendance:

- Information Governance Managers
- Head of Information

- Informatics Operational Support Services
- Workforce Governance Manager
- Strategy representative
- Prison Health representative

4.2 If a member is unable to attend a meeting they will be required to arrange a representative to attend on their behalf, who is able to actively contribute to the group discussions.

4.3 Responsibilities of IGG Members will include liaison/feedback (between division and area groups), updating the group on issues relating to Information Governance from their areas, promoting the work/actions of the group and performing allocated actions as requested by the IGG.

5. GROUP MEETING

Quorum

5.1 At least four members must be present to ensure the quorum of the Group, one of whom should be either the Chair or Vice Chair; one from the Information Governance Service, and two representatives from Divisions or Area Teams.

Frequency of Meetings

5.2 Meetings shall be held quarterly or otherwise as the Chair of the IGG deems necessary.

6. REPORTING AND ASSURANCE ARRANGEMENTS

6.1 The IGG shall report to IGI by:

- Submitting an annual report and quarterly update reports on IG and Health Records assurance. Detailing progress, risks and issues concerning compliance with data protection legislation.
- Highlighting issues of significance.
- The IGG will also ensure appropriate escalation arrangements are in place to alert other relevant committees/groups of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.
- Submitting the Annual Caldicott Outturn Report and improvement plan.

7. REVIEW

7.1 The terms of reference and operating arrangements shall be reviewed annually.

8. CHAIR'S ACTION ON URGENT MATTERS

8.1 There may, occasionally, be circumstances where decisions which would normally be made by the Group need to be taken between scheduled meetings. In these circumstances, the Group's Chair, supported by the Group's Secretariat as appropriate, may deal with the matter on behalf of the Group. The Secretariat must ensure that any such action is formally recorded and reported to the next meeting of the Group for consideration and ratification.

8.2 Chair's action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

BETSI CADWALADR UNIVERSITY HEALTH BOARD

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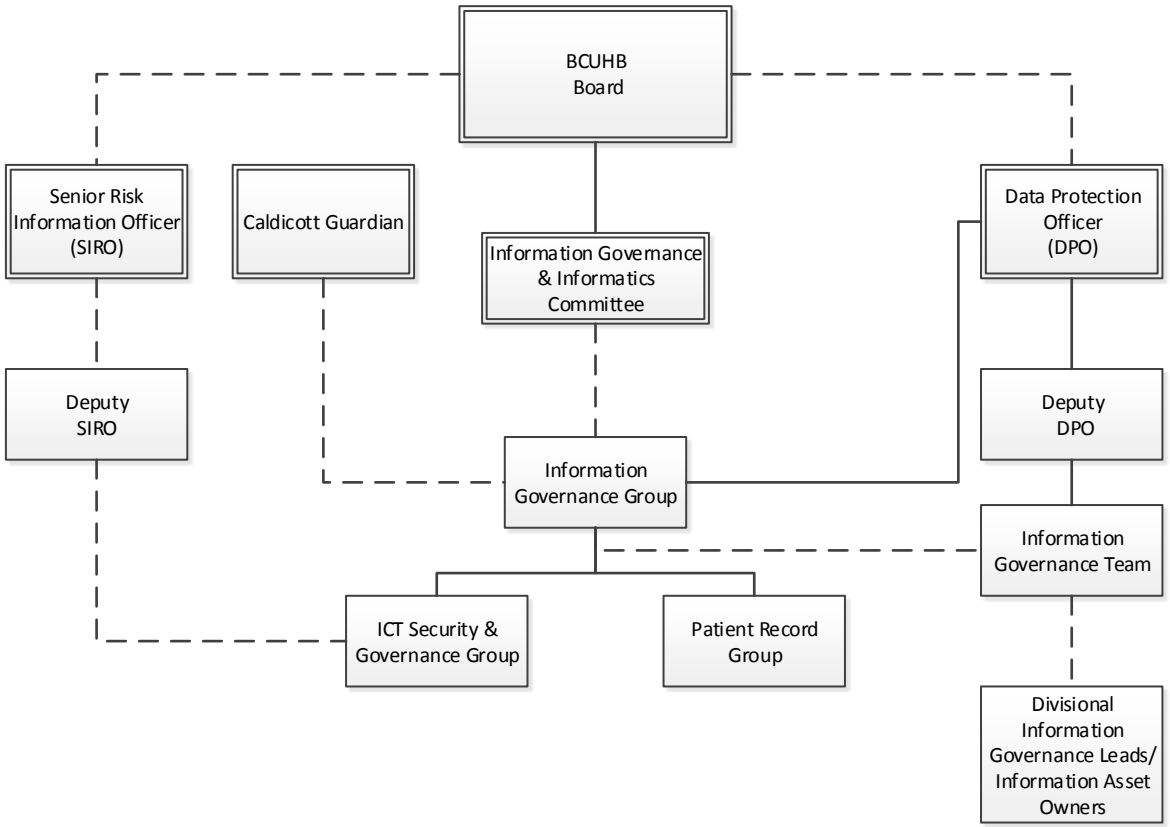
8.2 Chair's action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

Appendix D

Information Governance Accountability and Performance Framework



Information Governance and Informatics Committee 9.5.19	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board *To improve health and provide excellent care*

Chair's Report

Name of Group:	Information Governance Group
Meeting date:	10th April 2019
Name of Chair:	Melanie Maxwell, Senior Associate Medical Director (Chair)
Responsible Director:	Grace Lewis-Parry, Board Secretary

Summary of business discussed:	• The Group received the Quarter 4 Information Governance (IG) key performance indicator report which highlighted during the months for December, January and February (due to response timeframes):
	  • This quarter showed a reduction in the volume of Freedom of Information (FOI) requests received from 176 in Quarter 3 to 127 this quarter. Improvements in responding to FOI requests rose from 79% to 84% (a reduction in the volume of delays from 36 to 20);
	  • A slight reduction in the volume of non-clinical subject access requests received from 17 in Quarter 3 to 16 this quarter. Improvements in responding to non-clinical subject access requests rose from 76% to 94% (a reduction in the volume of delays from 4 to 1);
	  • A reduction in the volume of Access to Health Record requests received from 877 in Quarter 3 to 868 this quarter. However, this quarter showed a reduction in responding to requests from 94% to 92% (an increase in the volume of delays from 52 to 70). This has been impacted by the reduction in time frame for responses as part of legislative changes from 40 to 28 days;
	  • A reduction in the volume of Mental Health – West service with Access to Health Record requests received from 56 in Quarter 3 to 26 this quarter. However, this quarter showed a slight reduction in responding to request from 100% to 96% (an increase in the volume of delays from 0 to 1);
	  • A slight increase in the volume of HMP Berwyn Access to Health Record requests received from 38

	in Quarter 3 to 40 this quarter. However, this quarter showed a reduction in responding to request from 100% to 73% (an increase in the volume of delays from 0 to 11), this was attributed to staff shortages; • Continued reporting and follow up to ensure lessons learnt from IG incidents, 76 reported this quarter (a reduction from 92 reported in Quarter 3), with 2 assessed as requiring notification to the Information Commissioners Office (ICO) and Welsh Government. The first incident relates to the personal data of a patient being sent to an incorrect address. The second incident relates to inappropriate access to staff information. The ICO have closed both incidents with no further action required following the detailed confirmation of the remedial action the Health Board had already put in place. Lessons learnt have included reminders issued for checking patient information on systems and when to update address details, a reminder issued regarding the importance of good record keeping, reminder regarding inappropriate access to systems and ensuring acceptable use statements signed by all staff who have full access rights to information systems; • 1 complaint was received directly from the ICO regarding an access to health records response which contained the health information of two further patients. The incident was investigated fully in accordance with Health Board's incident reporting process. The ICO has closed this complaint with no further action required following the detailed confirmation of the remedial action the Health Board; • Due to changes in legislation individuals now have a right to claim for damages as a result of a data breach, and the process for managing such claims will be done through the Health Board's legal team, with support from Information Governance. During this quarter, the Health Board received 1 claim for damages for distress and other losses arising out of the disclosure of the Claimant's personal data to another patient in error. This case is currently ongoing; • Maintained level of mandatory information governance training at 81% (2227 staff completing the training this quarter); • Continued reduction in the reported notifications issued from the National Intelligent Integrated Auditing Solution (NIIAS) from 79 to 72;

	• The Group received a report on the good progress made on the operational IG Workplan and the remaining outstanding actions to be transferred into the 2019/20 plan. • The Group were presented with the latest tier 3 Information Governance Risk Register. Risks will be revised to reduce the duplication between corporate and health records management. • The Group received the Freedom of Information Internal audit Report which noted a reasonable level of assurance. The audit noted 2 recommendations regarding the location and accuracy of the FOI Publication Scheme, and it was noted that both recommendations have been actioned and closed; • The Group received a report on the Health Board's preparedness for the EUexit and noted the progress made with reviewing information flows and sharing arrangements; • The Group received a report and update from the Health Records Transition Programme and noted the progress with implementing a centralised and digitised access to health records service; • The Group received a verbal update regarding the impact on the Health Board with the embargo on the destruction of records and that a further report will be presented to EMG on the future proposals and costs; • The Group reviewed its Terms of Reference and requested further updates be made to the membership.
Key assurances provided at this meeting:	• Progress against performance indicators, internal and external Information Commissioners improvement plans. • Communications provided widely across the Health Board to support learning lessons from reported incidents and audit findings.
Key risks including mitigating actions and milestones	• Compliance with legislation. This is being monitored via the work programmes and reported as part of the key performance indicator reports.
Special Measures Improvement Framework Theme/Expectation addressed	• N/A
Issues to be referred to another Committee	None
Matters requiring escalation to the committee	• Information Governance Strategy
Well-being of Future Generations Act Sustainable Development Principle	*The work of the IG group will help to underpin the delivery of the sustainable development principles by* *Supporting a productive and low carbon society through the development of systems and procedures to increase the responsible use of informatics.* *Working collaboratively across Wales to deliver solutions with partners to improve planning and delivery of services.*

Planned business for the next meeting:	Range of regular reports plus • Quarter 1 Key Performance Indicator compliance • Quarter 1 Work programme
Date of next meeting:	24th July 2019

Information Governance and Informatics Committee **9.5.19**	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board To improve health and provide excellent care

Report Title:	Committee Annual Report 2018/19
Report Author:	Diane Davies, Corporate Governance Manager
Responsible Director:	Dr Evan Moore, Executive Medical Director
Public or In Committee	Public
Purpose of Report:	To seek Committee input to the annual report for 2018-19 which has been prepared on a BCU-wide template which was amended following Audit Committee consideration of the previous year's annual reports. The report will require further amendment to incorporate input from the May Committee meeting and will be submitted to a workshop of the Audit Committee on the 14th May 2019.
Approval / Scrutiny Route Prior to Presentation:	None
Governance issues / risks:	None identified
Financial Implications:	None identified
Recommendation:	The Committee is asked to: 1. Review the draft Annual Report for 2018-19 2. Provide comments and feedback as necessary 3. Review Terms of Reference (Appendix 1) 4. Review and approve Cycle of Business 2019/20 (Appendix 2) 5. Approve that Chair's Action can be taken to agree the final version for submitting to Audit Committee

Health Board's Well-being Objectives *(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)*	√	**WFGA Sustainable Development Principle** *(Indicate how the paper/proposal has embedded and prioritised the sustainable development principle in its development. Describe how within the main body of the report or if not indicate the reasons for this.)*	√
1.To improve physical, emotional and mental health and well-being for all		1.Balancing short term need with long term planning for the future	✓

2.To target our resources to those with the greatest needs and reduce inequalities		2.Working together with other partners to deliver objectives	✓
3.To support children to have the best start in life		3. Involving those with an interest and seeking their views	
4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being	✓	4.Putting resources into preventing problems occurring or getting worse	✓
5.To improve the safety and quality of all services		5.Considering impact on all well-being goals together and on other bodies	✓
6.To respect people and their dignity			
7.To listen to people and learn from their experiences	✓		
Special Measures Improvement Framework Theme/Expectation addressed by this paper Governance			
Equality Impact Assessment Equality impact assessment is not considered necessary for this paper.			

Disclosure:
Betsi Cadwaladr University Health Board is the operational name of Betsi Cadwaladr University Local Health Board

Committee Annual Report 2018/19

1. Title

Information Governance and Informatics Committee

2. Name and role of person submitting this report:

Dr Evan Moore, Executive Medical Director

3. Dates covered by this report:

01/04/2018-31/03/2019

4. Number of times the Committee met during this period:

The Committee was routinely scheduled to meet twice. Attendance at meetings is detailed within the table below:

INDEPENDENT MEMBERS	13.11.18 Inaugural meeting	14.2.19
John Cunliffe (Chair)	✓	✓
Jo Ryecroft Malone (Vice Chair)	✓	A
Cheryl Carlisle	✓*	✓
Lucy Reid	✓	✓
Directors and Officers in Attendance	13.11.18 Inaugural meeting	14.2.19
Dr Evan Moore Executive Medical Director (Lead Director)	✓	✓

Dr Mark Walker Deputy Medical Director / Caldicott Guardian	A	◆
Dr Melanie Maxwell Senior Associate Medical Director / Caldicott Guardian	◆	✓
Grace Lewis-Parry Board Secretary / Senior Information Risk Owner (SIRO)	✓	✓
Dylan Williams Chief Information Officer	✓	✓
Justine Parry Assistant Director Information Governance and Assurance / Data Protection Officer (DPO)	✓	✓

Key:

✓ Present

✓* Part meeting

A Apologies/Absent

◆ Not a member of the Committee at this time.

In addition to the above core membership, other Directors and Officers from the Health Board regularly attend meetings of the Committee. For a full list of attendance, please see the detailed Minutes which can be accessed on the Health Board's website via the following link:-
http://www.wales.nhs.uk/sitesplus/861/page/97583

5. Assurances the Committee is designed to provide:

The Committee is designed to provide assurance to the Board on the following key areas as set out in its Terms of Reference as follows:-

- oversee the development of the Health Board's strategies and plans for maintaining the trust of patients and public through its arrangements for handling and using information, including personal information, safely and securely, consistent with the Board's overall strategic direction and any requirements and standards set for NHS bodies in Wales;

- oversee the direction and delivery of the Health Board's informatics and information governance strategies to drive change and transformation in line with the Health Board's integrated medium term plan that will support modernisation through the use of information and technology;

- consider the information governance and informatics implications arising from the development of the Health Board's corporate strategies and plans or those of its stakeholders and partners;

- consider the information governance and informatics implications for the Health Board of internal and external reviews and reports;

- oversee the development and implementation of a culture and process for data protection by design and default (including Privacy Impact Assessments) in line with legislation (e.g. General Data Protection Regulation).

The Committee will, in respect of its assurance role, seek assurances that information governance and the informatics (including patient records) arrangements are appropriately designed and operating effectively to ensure the safety, security, integrity and effective use of information to support the delivery of high quality, safe healthcare across the whole of the Health Board's activities.

To achieve this, the Committee's programme of work will be designed to ensure that, in relation to information governance, informatics and patient records:

- there is clear, consistent strategic direction, strong leadership and transparent lines of accountability;

- there is a citizen centred approach, striking an appropriate balance between openness and confidentiality in the management and use of information and technology;

- the handling and use of information and information systems across the organisation is consistent, and based upon agreed standards;

- there is effective communication, engagement and the workforce is appropriately trained, supported and responsive to requirements in relation to the effective handling and use of information (including IT Systems) – consistent with the interests of patients and the public;

- there is effective collaboration with partner organisations and other stakeholders in relation to the sharing of information in a controlled manner, to provide the best possible outcomes for its citizens (in accordance with the Wales Accord for the Sharing of Personal Information and Caldicott requirements);

- the integrity of information is protected, ensuring valid, accurate, complete and timely information is available to support decision making across the organisation;

- the Health Board is meeting its responsibilities with regard to the General Data Protection Regulation, the Freedom of Information Act, Caldicott, Information Security, Records Management, Information Sharing, national Information Governance policies and Information Commissioner's Office Guidance;

- The Health Board is safeguarding its information, technology and networks through monitoring compliance with the Security of Network and Information Systems regulations and relevant standards;

- all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the safety, security and use of information, and in particular that:

    - Sources of internal assurance are reliable, and have the capacity and capability to deliver;
    - Recommendations made by internal and external reviewers are considered and acted upon on a timely basis;
    - Lessons are learned from breaches in the safe, secure and effective use of information, as identified for example through reported incidents, complaints and claims; and
    - Training needs are assessed and met.

- receive assurance on the delivery of the informatics and information governance operational plans including performance against the annual Informatics Capital Programme;

- seek assurance on the effectiveness and impact of the Health Board's Digital Transformation Plans;

- seek assurance on the performance and delivery of the rollout of the core national IT systems which could have significant impact on the Health Board's operational services and escalate to the Board as appropriate.

The Committee will receive assurance on compliance with key performance indicators in relation to the quality and effectiveness of information and information systems against which the Health Board's performance will be regularly assessed.

Maintain oversight of the effectiveness of the relationships and governance arrangements with partner organisations in relation to informatics and information governance. This will include NHS Wales Informatics Service (NWIS).

During the period that this Annual Report covers, the Committee operated in accordance with its terms of reference V1.0 which were operative from October 2018 following its inaugural meeting. The Terms of Reference are appended at Appendix1.

An integral part of the process is the requirement for the Committee to undertake a self-assessment. This year the Health Board has adopted a different approach as recommended by Wales Audit Office with quarterly reviews of Committee performance being undertaken collectively by the Committee Business Management Group (CBMG) who perform a more integrated governance role in this respect. Modifications to the overall Committee structure have been undertaken in year.

18.10.18 CBMG meeting – it was reported that the Executive Lead and Committee Chair had reviewed the inaugural ToRs and Cycle of Business. Members noted that this was a new committee and that updated the COB would be an iterative process as the Committee became more established.

At a workshop of the Audit Committee held on the 15th May 2018 members reviewed each of the Committee and Advisory Group's annual reports for 2017-18 with the aim of providing evidence on the scope and effectiveness of Committees and of their evaluation of the sources of assurance available to them. As the Committee had not been established until October 2018, no comments were provided.

In addition, Audit Committee members made the following generic comments pertaining to the Committee and Advisory Group Annual Reporting process:-

Recurring themes around the need for training for members in respect of specific Committee responsibilities, and concerns around the volume of work some Committees were dealing with.	A full review and refresh of the cycle of business has been undertaken with the Committee Chair and Lead Executive. Meeting duration has been extended to allow for full discussion of items. Committee members have also increased their skillset through the wider Board Development and Workshop programme. Other specific training has also been provided eg risk management, equality, safeguarding and continuing health care.
Externally commissioned/produced reports e.g. Deanery/Royal Colleges should be centrally logged.	Central logging now in place within Office of the Board Secretary.
Chairs assurance reports to in future confirm actions being taken to address key risks identified.	Template amended in July 2018
Template for future Committee Annual reports to be amended to detail "focus for the year ahead" at the end of the	Completed (see section 9)

report.	
Any difficulties in identifying sources of assurance to be included as a key focus for the year ahead.	Completed (see section 9)
In respect of internal or external audit reports individual committees are asked to review and provide commentary within their annual report on whether the implementations of the recommendations arising from audits relevant to their remit have led to overall qualitative improvements.	Committee to consider 9.5.19
Ensure new assurance map addresses quality of primary care and quality of commissioned services.	Completed as part of ongoing development of Board Assurance Framework
Sources of assurance document to be updated as follows:- • Outcome findings of local clinical audit work to be included (ACS 21A) • Systems of internal control to be included (ACS 11A) • Team Central Tracker aligned to Audit Committee to be included (ACS66). • Delete RAG colour coding from document.	Completed as part of ongoing development of Board Assurance Framework

6. Overall **RAG status against Committee's annual objectives / plan: To be decided

The summary below reflects the Committee's assessment of the degree to which it has met these objectives. The supporting narrative included alongside the assessment below describes this in more detail.

Objective as set out in Terms of Reference	Was sufficient assurance provided? RAG	Was the assurance positive? RAG	Supporting narrative (Please provide detail for all actions showing amber or red assurance levels in terms of actions being taken to address these issues).
Oversee the development of the Health Board's strategies and plans for maintaining the trust of patients and public through its arrangements for handling and using information, including personal information, safely and securely, consistent with the Board's overall strategic direction and any requirements and standards set for NHS bodies in Wales;			Draft 2019 2020 Informatics operational plan presented to committee detailing approval and scrutiny routes.
Oversee the direction and delivery of the Health Board's informatics and information governance strategies to drive change and transformation in line with the Health Board's integrated medium term plan that will support modernisation through the use of information and technology;			Routes consistent with requirements. Final plans required following budgetary agreements.
Consider the information governance and informatics implications arising from the development of the Health Board's corporate strategies and plans or those of its stakeholders and partners;			Corporate risks covering National IT systems, local IT services and Health records identified
Consider the information governance and informatics implications for the Health Board of internal and external reviews and reports;			Reported in Quarterly Assurance reports.
Oversee the development and implementation of a culture and process for data protection by design			

and default (including Privacy Impact Assessments) in line with legislation (e.g. General Data Protection Regulation).			
The Committee will, in respect of its assurance role, seek assurances that information governance and the informatics (including patient records) arrangements are appropriately designed and operating effectively to ensure the safety, security, integrity and effective use of information to support the delivery of high quality, safe healthcare across the whole of the Health Board's activities.			A number of issues such as backlog of coding, inadequate facilities to store records and increased demands from national blood enquiry. Quarterly assurance report designed. Iterative development anticipated over the following two quarters to meet committee requirements.
To achieve this, the Committee's programme of work will be designed to ensure that, in relation to information governance, informatics and patient records:			
■ there is clear, consistent strategic direction, strong leadership and transparent lines of accountability;			
■ there is a citizen centred approach, striking an appropriate balance between openness and confidentiality in the management and use of information and technology;			
■ the handling and use of information and information systems across the organisation is consistent, and based upon agreed standards;			Change control policy defined.
■ there is effective communication, engagement and the workforce is appropriately trained, supported and responsive to requirements			Some concerns regarding system owners

in relation to the effective handling and use of information (including IT Systems) – consistent with the interests of patients and the public;			
■ there is effective collaboration with partner organisations and other stakeholders in relation to the sharing of information in a controlled manner, to provide the best possible outcomes for its citizens (in accordance with the Wales Accord for the Sharing of Personal Information and Caldicott requirements);			
■ the integrity of information is protected, ensuring valid, accurate, complete and timely information is available to support decision making across the organisation;			Limited assurance to date as evidence based upon limited number of meetings/reports. KPI's require development.
■ the Health Board is meeting its responsibilities with regard to the General Data Protection Regulation, the Freedom of Information Act, Caldicott, Information Security, Records Management, Information Sharing, national Information Governance policies and Information Commissioner's Office Guidance;			
■ The Health Board is safeguarding its information, technology and networks through monitoring compliance with the Security of Network and Information Systems regulations and relevant standards;			Via Quarterly Assurance report.
■ all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the safety, security and use of information, and in particular			Via Quarterly Assurance report.

that: • Sources of internal assurance are reliable, and have the capacity and capability to deliver; • Recommendations made by internal and external reviewers are considered and acted upon on a timely basis; • Lessons are learned from breaches in the safe, secure and effective use of information, as identified for example through reported incidents, complaints and claims; and • Training needs are assessed and met.			
• receive assurance on the delivery of the informatics and information governance operational plans including performance against the annual Informatics Capital Programme;			Via year end report, progress against operational plan reports.
• seek assurance on the effectiveness and impact of the Health Board's Digital Transformation Plans;			Consistent under investment in IT restricts ability to implement transformation plans. Assurance via year end report, operational plan updates and corporate risks.
• seek assurance on the performance and delivery of the rollout of the core national IT systems which could have significant impact on the Health Board's operational services and escalate to the Board as appropriate.			Delays and barriers related to NWIS and national system programmes having a significant detrimental impact on health board performance.

The Committee will receive assurance on compliance with key performance indicators in relation to the quality and effectiveness of information and information systems against which the Health Board's performance will be regularly assessed.			
Maintain oversight of the effectiveness of the relationships and governance arrangements with partner organisations in relation to informatics and information governance. This will include NHS Wales Informatics Service (NWIS).			Perception that NWIS not working to support our priorities

7. Main tasks completed / evidence considered by the Committee during this reporting period:

Standing Items
- Informatics Operational Plan quarterly performance and update
- Review and approval of Informatics Operational Plan 2019/20

Regular Items
- Digital Transformation Group Chair's Assurance report
- Digital Strategy Development update
- Information Governance Group Chair's Assurance report incorporating quarterly KPI and compliance report
- Information Governance Summary KPI Summary quarterly report

Ad-Hoc
- Update in national response to Wales Audit Office Informatics report
- All Wales Information Governance Policy approvals for use by BCUHB :
    - Information Governance Policy
    - Email Use Policy
    - Internet Use Policy
    - Information Security Policy

Governance Items
- Review of minutes and actions
- Approval of Committee terms of reference
- Approval of Cycle of Business
- Agreement and review of corporate risks assigned to the Committee
- Endorsed Information Governance annual report 2017/18

InCommittee items
- Outline Business Case for delivering an Acute Digital Health Record

Full details of the issues considered and discussed by the Committee are documented within the agenda and minutes which are available on the Health Board's website and can be accessed from the following link:-
http://www.wales.nhs.uk/sitesplus/861/page/97583

8. Key risks and concerns identified by this Committee in-year which have been highlighted and addressed as part of the Chair's reports to the Board:

Meeting Date	Key risks including mitigating actions and milestones
13.11.18	In respect of risk and the potential actions and mitigation costs outlined in supporting the Telepath system and the Committee's concern regarding escalation, the Board Secretary clarified the governance system in place. BCU's position on the Electronic Patient Record was discussed and concern raised regarding progress and whether the risks were adequately monitored Concerns with the performance of national systems were highlighted in the WAO Informatics report and the PAC report
14.2.19	The Committee requested further work to clarify the assigned corporate risks and to strengthen the sources of assurance. Of particular concern are the delays, functionality and prioritisation of National systems and programmes. The Committee raised a general point regarding the accurate completion of coversheets and that where risks or concerns were included within the accompanying narrative paper, these should also be highlighted on the coversheet. This had been brought to the attention of the Board Secretary. The Committee were concerned that models for integrating services would be at risk if national developments were not delivered. The progress with the CHAI (a mobile nursing application within paediatrics) remained of concern.

9. Focus for the year ahead:

The primary focus of the Committee over the next twelve months will be:

Key areas of review in the coming year will include:

- Monitoring of revised corporate risk actions and controls.
- Scrutiny of the outcomes from the Welsh Government Informatics and Governance and National Architecture Reviews to ensure they support and are reflected in local plans, strategies and business cases.

The Committee has established a Cycle of Business for the year ahead covering the breadth of its work, and primarily focussing on its key areas of risk, as defined in the Board's Corporate Risk and Assurance Framework. This is attached as Appendix 2 *(following consideration at 9.5.19 meeting)*

***Key:*

Red	*= not on target to achieve all actions, and may not achieve these actions by the next quarter*
Amber	*= not on target to achieve all actions, but has plans in place to see these actions achieved by the next quarter*
Green	*= on target to achieve all actions*

V0.02

Betsi Cadwaladr University Health Board
Terms of Reference and Operating Arrangements

INFORMATION GOVERNANCE AND INFORMATICS COMMITTEE

1. INTRODUCTION

The Board shall establish a committee to be known as the Information Governance and Informatics Committee (IGI). The detailed terms of reference and operating arrangements in respect of this Committee are set out below.

2. PURPOSE

The purpose of the Committee is to advise and assure the Board in discharging its responsibilities with regard to the quality and integrity; safety and security and appropriate access and use of information to support health improvement and the provision of high quality healthcare.

The Committee will seek assurance on behalf of the Board in relation to the Health Board's arrangements for appropriate and effective management and protection of information (including patient and personal information) in line with legislative and regulatory responsibilities.

The Committee will also provide advice and assurance to the Board in relation to the direction and delivery of the Informatics and Information Governance Strategies to drive continuous improvement and support IT enabled health care to achieve the objectives of the Health Board's integrated medium term plan.

3. DELEGATED POWERS

3.1 The Committee, in respect of its provision of advice and assurance will, and is authorised by the Board to: -

- oversee the development of the Health Board's strategies and plans for maintaining the trust of patients and public through its arrangements for handling and using information, including personal information, safely and securely, consistent with the Board's overall strategic direction and any requirements and standards set for NHS bodies in Wales;

- oversee the direction and delivery of the Health Board's informatics and information governance strategies to drive change and transformation in line with the Health Board's integrated medium term plan that will support modernisation through the use of information and technology;

- consider the information governance and informatics implications arising from the development of the Health Board's corporate strategies and plans or those of its stakeholders and partners;

- consider the information governance and informatics implications for the Health Board of internal and external reviews and reports;

- oversee the development and implementation of a culture and process for data protection by design and default (including Privacy Impact Assessments) in line with legislation (e.g. General Data Protection Regulation).

3.2 The Committee will, in respect of its assurance role, seek assurances that information governance and the informatics (including patient records) arrangements are appropriately designed and operating effectively to ensure the safety, security, integrity and effective use of information to support the delivery of high quality, safe healthcare across the whole of the Health Board's activities.

3.3 To achieve this, the Committee's programme of work will be designed to ensure that, in relation to information governance, informatics and patient records:

- there is clear, consistent strategic direction, strong leadership and transparent lines of accountability;

- there is a citizen centred approach, striking an appropriate balance between openness and confidentiality in the management and use of information and technology;

- the handling and use of information and information systems across the organisation is consistent, and based upon agreed standards;

- there is effective communication, engagement and the workforce is appropriately trained, supported and responsive to requirements in relation to the effective handling and use of information (including IT Systems) – consistent with the interests of patients and the public;

- there is effective collaboration with partner organisations and other stakeholders in relation to the sharing of information in a controlled manner, to provide the best possible outcomes for its citizens (in accordance with the Wales Accord for the Sharing of Personal Information and Caldicott requirements);

- the integrity of information is protected, ensuring valid, accurate, complete and timely information is available to support decision making across the organisation;

- the Health Board is meeting its responsibilities with regard to the General Data Protection Regulation, the Freedom of Information Act, Caldicott, Information Security, Records Management, Information Sharing, national Information Governance policies and Information Commissioner's Office Guidance;

- The Health Board is safeguarding its information, technology and networks

through monitoring compliance with the Security of Network and Information Systems regulations and relevant standards;

- all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the safety, security and use of information, and in particular that:

    - Sources of internal assurance are reliable, and have the capacity and capability to deliver;
    - Recommendations made by internal and external reviewers are considered and acted upon on a timely basis;
    - Lessons are learned from breaches in the safe, secure and effective use of information, as identified for example through reported incidents, complaints and claims; and
    - Training needs are assessed and met.

- receive assurance on the delivery of the informatics and information governance operational plans including performance against the annual Informatics Capital Programme;

- seek assurance on the effectiveness and impact of the Health Board's Digital Transformation Plans;

- seek assurance on the performance and delivery of the rollout of the core national IT systems which could have significant impact on the Health Board's operational services and escalate to the Board as appropriate.

3.4 The Committee will receive assurance on compliance with key performance indicators in relation to the quality and effectiveness of information and information systems against which the Health Board's performance will be regularly assessed.

3.5 Maintain oversight of the effectiveness of the relationships and governance arrangements with partner organisations in relation to informatics and information governance. This will include NHS Wales Informatics Service (NWIS).

4. AUTHORITY

4.1 The Committee may investigate or have investigated any activity within its terms of reference. It may seek relevant information from any:

- employee (and all employees are directed to cooperate with any legitimate request made by the Committee); and

- other committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.

4.2 May obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it

considers it necessary, in accordance with the Board's procurement, budgetary and other requirements;

4.3 May consider and where appropriate, approve on behalf of the Board any policy within the remit of the Committee's business;

4.4 Will review risks from the Corporate Risk Register that are assigned to the Committee by the Board and advise the Board on the appropriateness of the scoring and mitigating actions in place.

5. SUB-COMMITTEES

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

6. MEMBERSHIP

6.1 Members

Four Independent Members of the Board

6.2 In Attendance

Executive Medical Director (lead director)
Chief Information Officer, Informatics
Board Secretary/ Senior Information Risk Owner (SIRO)
Caldicott Guardian
Assistant Director Information Governance & Assurance/ Data Protection Officer (DPO)

6.2.1 Other Directors/Officers will attend as required by the Committee Chair, as well any others from within or outside the organisation who the Committee considers should attend, taking into account the matters under consideration at each meeting.

6.3 Member Appointments

6.3.1 The membership of the Committee shall be determined by the Chairman of the Board taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government. This includes the appointment of the Chair and Vice-Chair of the Committee who shall be Independent Members.

6.3.2 Appointed Independent Members shall hold office on the Committee for a period of up to 4 years. Tenure of appointments will be staggered to ensure business continuity. A member may resign or be removed by the Chairman of the Board. Independent Members may be reappointed to the Committee up to a maximum period of 8 years.

6.4 Secretariat

6.4.1 Secretary: as determined by the Board Secretary.

6.5 Support to Committee Members

6.5.1 The Board Secretary, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and
- Ensure the provision of a programme of development for Committee members as part of the overall Board Development programme.

7. COMMITTEE MEETINGS

7.1 Quorum

7.1.1 At least two Independent Members must be present to ensure the quorum of the Committee, this should include either the Chair or the Vice-Chair of the Committee. In the interests of effective governance it is expected that at least one of those named officers listed above will also be in attendance.

7.2 Frequency of Meetings

7.2.1 Meetings shall be routinely be held on a quarterly basis.

7.3 Withdrawal of individuals in attendance

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

8. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

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

8.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference,

8.3 The Committee, through its Chair and members, shall work closely with the Board's other Committees including joint committees/Advisory Groups to provide advice and assurance to the Board through the:

8.3.1 joint planning and co-ordination of Board and Committee business; and

8.3.2 sharing of information

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

8.4 The Committee shall embed the corporate goals and priorities through the conduct of its business, and in doing and transacting its business shall seek assurance that adequate consideration has been given to the sustainable development principle and in meeting the requirements of the Well-Being of Future Generations Act.

9. REPORTING AND ASSURANCE ARRANGEMENTS

9.1 The Committee Chair shall:

9.1.1 report formally, regularly and on a timely basis to the Board on the Committee's activities via the Chair's assurance report, the presentation of an annual report; and membership of the Health Board's committee business management group.

9.1.2 ensure appropriate escalation arrangements are in place to alert the Health Board Chair, Chief Executive or Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

9.2 The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation.

10. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

- Quorum

11. REVIEW

11.1 These terms of reference and operating arrangements shall be reviewed annually by the Committee and any changes recommended to the Board for approval.

Date of approval by the Board 6.9.18
Reported to Committee
V1.0

INFORMATION GOVERNANCE & INFORMATICS COMMITTEE CYCLE OF ANNUAL BUSINESS AND FORWARD PLANNER 2019/20 v.02 draft last updated 02/05/2019 11:23

Part 1 – Annual Recurring Business

Agenda Items	Notes	May	Aug	Nov	Feb
Apologies	Standard Committee item	x	x	x	x
Declarations of Interest	Standard Committee item	x	x	x	x
Draft minutes of previous meeting, matters arising and review of Summary Action Plan	Standard Committee item	x	x	x	x
Governance matters					
Committee Annual Report (including annual review of ToR and cycle of business)	Submission to May Audit Committee prior to Board	x			
Terms of Reference review	Annual review			x	
Review of Corporate Risks allocated to the Committee	ToR 4.4	x		x	
Policies (compliance with national policy and development of organisational policy) – *as arise*	ToR	x	x	x	x
Periodic updates on Limited Assurance Audit reports	Per Audit Committee				
Informatics					
Digital Strategy – annual review	ToR 3.1.1			x	
Approval of Informatics – Operational Plan	ToR 3.1.2/10				x
Quarterly Update on Informatics Operational Plan					
Informatics Operational plan – quarterly update To include • updates against agreed plans • Capital expenditure and Revenue expenditure		x	x	x	x

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Agenda Items	Notes	May	Aug	Nov	Feb
Quarterly Assurance report • National Audit responses / progress updates on recommendations • Compliance against relevant regulations • Digital Transformation Group update (not minutes) • monitoring of existing national and local IT systems • updates on downtime and stability of systems and impact • Information security		x	x	x	x
System Demonstrations (ad hoc as relevant)					
(as appropriate for escalation)					
Partner organisation arrangements – other partners to be identified	ToR 3.5				
NWIS Annual attendance to present annual programme and priorities		x			
Information Governance					
Information Governance Strategy – annual review	ToR 3.1.1			x	
Information Governance Assurance quarterly report (KPI and compliance report) To include: • Emerging Risks • FOI requests and compliance • DPA SAR requests and compliance	ToR	x	x	x	x

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Agenda Items	Notes	May	Aug	Nov	Feb
• Access to Health Records requests and compliance • IG Incidents reported and lessons learnt • IG Training compliance • IG Helpdesk support calls and actions • NIIAS reporting and compliance • Communication / compliance audits and findings • Sharing of information/WASPI • Data Protection Impact Assessments - Patient records - Issues of Significance from IGG					
Information Governance Annual Report	ToR 3.1.2 /10		x		
Toolkit Progress Report	Transfer from F&P				
Caldicott	ToR 3.3.5				
Health Records					
Corporate Records Management Project Update Report	Transfer from F&P				

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Agenda Items	Notes	May	Aug	Nov	Feb
Health Care Records (including Annual Report)					
To be determined:					
Data Protection (including General Data Protection Regulations)	ToR				
Integrated Quality Performance Review – relevant dimensions	ToR 3.4				
Implications of internal and external reviews and reports	ToR				
Strategy / plan development (eg; handling of PPI)	ToR				
Lessons learned from information breaches	ToR 3.4				
National Infected Blood Inquiry update	per Nov 2018 Board paper recommendation				
Closing Business (standing items)					
Summary of InCommittee business to be reported in public (if applicable)	Standard Committee item	x	x	x	x
Issues of significance to inform Chair assurance report	Standard Committee item	x	x	x	x
Date of next meeting	Standard Committee item	x	x	x	x
Exclusion of press and public (if applicable)	Standard Committee item	x	x	x	x
InCommittee Business (if applicable)					
Draft minutes of previous InCommittee meeting, matters arising and summary action plan	Standard Committee item	x	x	x	x

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Part 2 Rolling Plan of Ad-Hoc Business

	ITEM	FROM	NOTES
May 2019			
	Change management Policy	Sharon Smith *Informatics*	Email notification 25.2.19
August 2019			
November 2019			
February 2020			

Meeting date	Submission deadline for paper review/quality assurance	Publication date
9.5.19	26.4.19	2.5.19
15.8.19	5.8.19	8.8.19
21.11.19	11.11.19	14.11.19
13.2.20	3.2.20	6.2.20

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Information Governance and Informatics Committee 9.5.19	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board ***To improve health and provide excellent care***

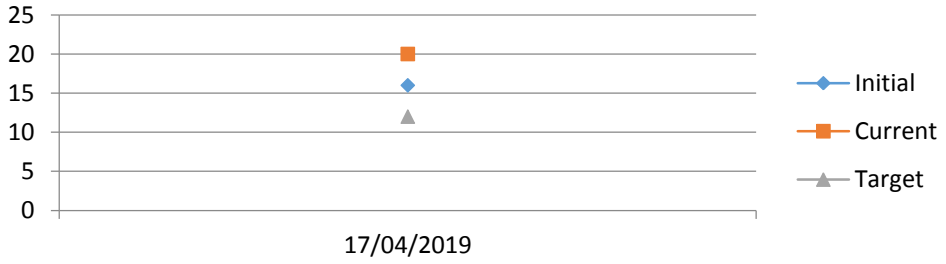
Report Title:	Review of Corporate Risks Assigned to the Information Governance and Informatics Committee
Report Author:	Mr Peter Barry, Head of Risk Management
Responsible Director:	Dr Evan Moore, Executive Medical Director
Public or In Committee	Public
Purpose of Report:	The attached report has been produced from the web-based Datix system and details the risk entries allocated to the Information Governance and Informatics Committee: CRR10 Informatics - In the November 2018 IGI Committee meeting it was identified that this risk entry in its present format is too nebulous, covers many strands of service delivery and limits the ability of the Health Board to focus on and address key issues. Following discussions, it was recommended that this risk is disaggregated to two key components – Informatics infrastructure and Health Records. Following the Chairs assurance report to the Board, 28/03/2019 at which he informed of the need to introduce a 3rd risk to the Corporate Risk Register, a Tier 1 risk National Infrastructure and Products, has been prepared. The following risks have been developed and included for consideration; CRR10a National Infrastructure and Products CRR10b Informatics – Health Records CRR10c Informatics – Infrastructure capacity, resource and demand It has been agreed that the CRAF risks will be formally reviewed twice per year by the Board's Committees. These risks will next be presented to the Committee in November 2019.
Approval / Scrutiny Route Prior to Presentation:	The full Corporate Risk and Assurance Framework (CRAF) is scrutinised by the Health Board twice per year and is published on the Board's external facing website. Individual risks are allocated to one of the Board's Committees for regular consideration and review.
Governance issues / risks:	The report provides for the identification of the risk, the arrangements in place presently to control the risk and further mitigation action/s required.
Financial	These are identified through development of business cases and

Implications:	strategic outline plan required as part of further actions to achieve the target risk score.
Recommendation:	The Committee is asked to approve 10a, 10b & 10c for inclusion on the Corporate Risk Register, consider the relevance of the current controls, review the actions in place and consider whether the risk scores remain appropriate.

Health Board's Well-being Objectives *(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)*	√	**WFGA Sustainable Development Principle** *(Indicate how the paper/proposal has embedded and prioritised the sustainable development principle in its development. Describe how within the main body of the report or if not indicate the reasons for this.)*	√
1.To improve physical, emotional and mental health and well-being for all		1.Balancing short term need with long term planning for the future	
2.To target our resources to those with the greatest needs and reduce inequalities		2.Working together with other partners to deliver objectives	
3.To support children to have the best start in life		3. Involving those with an interest and seeking their views	
4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being		4.Putting resources into preventing problems occurring or getting worse	√
5.To improve the safety and quality of all services	√	5.Considering impact on all well-being goals together and on other bodies	
6.To respect people and their dignity			
7.To listen to people and learn from their experiences			
Special Measures Improvement Framework Theme/Expectation addressed by this paper Governance – management of risk. Strategic and Service Planning.			
Equality Impact Assessment Not applicable for governance paper of this nature.			

CRR10A	**Director Lead:** Executive Medical Director	**Date Opened:** 23/10/2017
	Assuring Committee: Information Governance & Informatics Committee	**Date Last Reviewed:** 17/04/2019
	Risk: National Infrustructure and Products	**Target Risk Date:** 28/12/2020

There is a risk that the national infrastructure, technical architecture and products are not fit for purpose and do not allow the organistion to deliver benefits as planned. This may be caused by
a) a one size fits all approach.
b) products which are not delivered as specified (e.g. time, functionality and quality).
c) the approach of the National Programme to mandate/design systems rather than standards.
d) poor resilience and a "lack of focus on routine maintenance".
e) Supplier capacity leading to commitment or delivery delays.
f) Historic pricing models that are difficult to influence / may not be equitable.
This could result in negative impacts in several key areas including:- Patient outcomes. An inability to support the strategic direction of the Health Board. Delays to delivery of transformational change. Inefficient work flows, poor system usage. Increased costs as we maintain multiple systems / pay inequitable prices. Delays with the delivery of cost saving schemes.

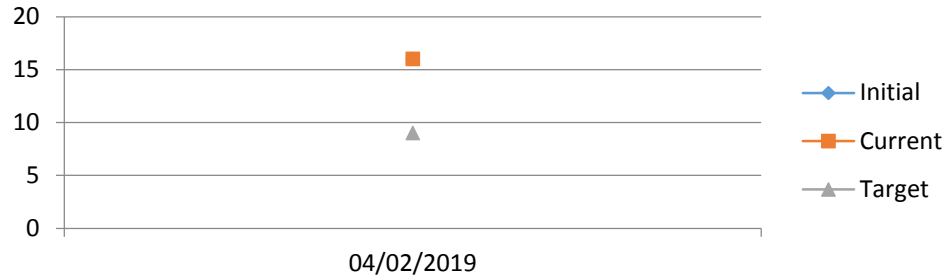


	Impact	Likelihood	Score
Initial Risk Rating	4	4	16
Current Risk Rating	4	5	20
Target Risk Score	4	3	12
Movement in Current Risk Rating since last presented to Board in NA	New Corporate Risk		

Controls in place	**Further action to achieve target risk score**
1.Scruitiny of NWIS by IGIC. 2. Project Governance.	1. Viable SLA. 2. Development and approval of local Digital Record. 3. Implementation of recommenations from Architecture and Governance Reviews (due in May 19).

Assurances	Links to		
1.Parlimentery Review of NWIS. 2. Reports from the Digital Transformation Group to IGIC / EMG. 3. WAO – review. 4. National Architecture and Informatics Governance Reviews.	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	7	PR6	Not Applicable

CRR10B	**Director Lead:** Executive Medical Director	**Date Opened:** 04/02/2019
	Assuring Committee: Information Governance & Informatics Committee	**Date Last Reviewed:** 17/04/2019
	Risk: Informatics - Health Records	**Target Risk Date:** 31/12/2019
There is a risk that patient information is not available when are where required. This may be caused by a lack of suitable storage space, uncertain retention periods, and the logistical challenges with sharing and maintaining standards associated with the paper record. This coul result in substandard care, patient harm and an inability to meet our legislative duties.		



	Impact	Likelihood	Score
Initial Risk Rating	4	4	16
Current Risk Rating	4	4	16
Target Risk Score	3	3	9
Movement in Current Risk Rating since last presented to Board in NA	Risk has not been reviewed by Board. Risk developed to part replace CRR10 - Informatics		

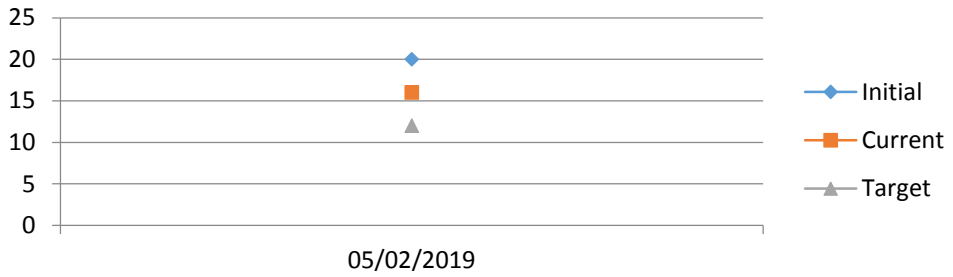
Controls in place	**Further action to achieve target risk score**
1. Corporate and Health Records Management policies and procedures are in place pan-BCUHB. 2. iFIT RFID casenote tracking software and asset register in place to govern the management and movement of patient records. 3. Escalation via appropriate committee reporting. 4. Key performance indicators monitored at BCUHB Patient Records Group (reported into the Information Governance Group).	1. Enable actions to meet the regulatory recommendations from the ICO, HASCAS/Ockenden and Internal Audit reports. 2. (Project) Development of a local Digital Health Records system to digitise the 'acute general' patient record. 3. (Project) Improve the assurance of Results Management (stop printing results). 4. (Project) Digitise the clinic letters for outpatients through implementation of Digital Dictation, and as appropriate Speech Recognition software. 5. (Project) Digitise nursing documentation through the implementation of CHAI Paediatrics, and Adults National Nursing systems. 6. (Project) Baseline the; storage, processes, management arrangements and standards compliance, and present the recommendations and funding requirements to work towards PAN-BCUHB Patient Records Compliance with legislation and standards in

	patient records management across all casenote types. 7. Engage with the Estates Rationalisation Programme to secure the future of 'fit for purpose' file libraries for legacy paper records.

Assurances	**Links to**		
1.Chairs reports from Patient Record Group. 2.ICO Audit. 3.HASCAS Audit.	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	8	PR1	Not Applicable

CRR10C	**Director Lead:** Executive Medical Director	**Date Opened:** 01/08/2015
	Assuring Committee: Information Governance & Informatics Committee	**Date Last Reviewed:** 17/04/2019
	Risk: Informatics infrastructure capacity, resource and demand.	**Target Risk Date:** 31/12/2019

There is a risk that digital services within the Health Board are not fit for purpose. This may be due to:
(a) A lack of capacity and resource to deliver services / guide the organisation.
(b) Increasing demand (internally from users e.g. for devices/ training and externally from the public, government and regulators e.g. growing need for digital services.).
(c) the moving pace of technology.
This could lead to failures in clinical and management systems, and a failure to support the delivery of the Health boards strategy / plans impacting negatively on patient safety/outcomes. It may also pose a greater risk to the Health board of infrastructure failures and cyber attack.



	Impact	Likelihood	Score
Initial Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	3	12
Movement in Current Risk Rating since last presented to Board in NA	Risk has not been reviewed by Board. Risk developed to part replace CRR10 - Informatics		

Controls in place	**Further action to achieve target risk score**
1. Governance structures in place to approve and monitor plans. Monitoring of approved plans for 2018 (Capital, IMTP and Operational). Approved and established process for reviewing requests for services. 2. Integrated planning process and agreed timescales with BCU and third party suppliers. 3. Key performance metrics to monitor service delivery and increasing demand. 4. Risk based approach to decion making e.g. local hosting v's National hosting. 5. DTG - whose remit includes review of resource conflicts.	1. Develop associated business cases for resource required based upon risks and opportunities e.g. Digital Health Record. 2. Review workforce plans and establish future proof informatics/digital capability and capacity.

Assurances	Links to		
1. Annual Internal Audit Plan. 2. WAO reviews and reports e.g. structured assessments and data quality. 3. Scrutiny of Clinical Data Quality by CHKS. 4. Auditor General Report - Informatics Systems in NHS Wales. 5. Regular reporting to IGIC (for Governance).	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	2 3 4 5 6 7	PR6 PR5 PR2	Strategic and Service Planning

Information Governance and Informatics Committee

9.5.19

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

To improve health and provide excellent care

Report Title:	Summary of In-Committee business to be reported in public
Report Author:	Diane Davies, Corporate Governance Manager
Responsible Director:	Dr Evan Moore, Executive Medical Director
Public or In Committee	Public
Purpose of Report:	To report in public session that the following items were considered at the Information Governance and Informatics Committee held in private session on 14.2.19 • Outline Business Case (OBC) for Delivering an Acute Digital Health Record
Approval / Scrutiny Route Prior to Presentation:	The issues were considered by the Committee at its private in-committee meeting
Governance issues / risks:	Standing Order 6.5.3 requires the Board to formally report any decisions taken in private session to the next meeting of the Board in public session. This principle is also applied to Committee meetings.
Financial Implications:	The financial implications were discussed at the meetings
Recommendation:	The Committee is asked to note the report

Health Board's Well-being Objectives *(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)*	√	**WFGA Sustainable Development Principle** *(Indicate how the paper/proposal has embedded and prioritised the sustainable development principle in its development. Describe how within the main body of the report or if not indicate the reasons for this.)*	√
1.To improve physical, emotional and mental health and well-being for all	✓	1.Balancing short term need with long term planning for the future	✓
2.To target our resources to those with the greatest needs and reduce inequalities	✓	2.Working together with other partners to deliver objectives	✓
3.To support children to have the best start in life		3. Involving those with an interest and seeking their views	

4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being		4.Putting resources into preventing problems occurring or getting worse	✓
5.To improve the safety and quality of all services	✓	5.Considering impact on all well-being goals together and on other bodies	
6.To respect people and their dignity			
7.To listen to people and learn from their experiences			

Special Measures Improvement Framework Theme/Expectation addressed by this paper

- Leadership and governance
- Strategic and service planning

Equality Impact Assessment

Not applicable for a paper of this nature

Disclosure:
Betsi Cadwaladr University Health Board is the operational name of Betsi Cadwaladr University Local Health Board