Bundle Digital Information and Governance Committee 18 June 2021

Agenda attachments

Agenda_Digital_Information_and_Governance_Committee_18_June_2021 V1.0.docx

1 OPENING BUSINESS

1.1 09:30 - DIG21/28 Chair's opening remarks

1.2 09:32 - DIG21/29 Apologies

1.3 09:34 - DIG21/30 Declarations of Interest

1.4 09:36 - DIG21/31 Draft minutes of the previous meeting held on 26.3.21

DIG21.31 Draft Public - Draft Minutes DIGC 26 3 2021_ V0.04 JC track changes.docx

1.5 09:41 - DIG21/32 Matters arising and Review of Summary Action Log

DIG21.32 Summary Action Log Public (Live version) 9.06.21.doc

2 DIGITAL

2.1 09:46 - DIG21/33 Digital Operational Plan – quarterly update

Dylan Williams, Chief Information Officer, Informatics
Andrea Williams, Head of Informatics Programmes Assurance and Improvement, Informatics
Recommendation:
The Committee is asked to:-
1\. To decide if the report provides them with the appropriate level of assurance\.
2\. To note the report\.

DIG21.33a 2020 2021 QTR4 Informatics Plan Progress Monitoring Report.docx

DIG21.33b QTR4 Informatics Plan Progress Monitoring Report.pdf

2.2 10:01 - DIG21/34 Digital Operational Plan - 2021/22

Dylan Williams, Chief Information Officer, Informatics
Andrea Williams, Head of Informatics Programmes Assurance and Improvement, Informatics
Recommendation:
The Committee is asked to approve the Informatics Annual Operating Plan 2021-2022.

DIG21.34a Informatics Annual Operating Plan 21-22.docx

DIG21.34b 2021.22 Informatics Annual Operating Plan.pdf

2.3 10:16 - DIG21/35 Informatics Assurance report

Dylan Williams, Chief Information Officer, Informatics
Andrea Williams, Head of Informatics Programmes Assurance and Improvement, Informatics
Recommendation:
The Committee is asked to:-
1\. To decide if the report provides them with the appropriate level of assurance\.
2\. To note the report\.

DIG21.35 2020 2021 QTR4 DIGC Assurance Report Informatics.docx

2.4 10:31 - DIG21/36 Digital Health and Care Wales (DHCW) update report

Helen Thomas, Chief Executive Digital Health and Care Wales
Recommendation:
The Committee is asked to note this report from the Digital Health and Care Wales

DIG21.36 REP - BCU Board and Committee Report DHCW June 2021 d3.docx

3 INFORMATION GOVERNANCE

3.1 10:46 - DIG21/37 Information Governance quarterly assurance report (KPI, Lessons learned and compliance report)

Justine Parry, Assistant Director of Information Governance & Risk, Corporate Office
Recommendation:
The Committee is asked to:
• Receive and note the assurance provided in compliance with the Data Protection and Freedom of Information Legislation.

DIG21.37 Information Governance KPI Report Qtr 4 2020-21 V1-Final.docx

3.2 11:01 - DIG21/38 Chair's Assurance report : Information Governance Group

Justine Parry, Assistant Director ff Information Governance & Risk, Corporate Office

DIG21.38 DIG - IGG Chairs report May2021v0.2.docx

4 11:06 - COMFORT BREAK

5 GOVERNANCE

5.1 11:11 - DIG21/39 Review of Corporate Risks allocated to the Committee - Corporate Risk Register Report

Justine Parry, Assistant Director of Information Governance & Risk, Corporate Office
Chris Stockport, Executive Director Primary & Community Care, Corporate Office
Dylan Williams, Chief Information Officer, Informatics / Andrea Williams, Head of Informatics Programmes Assurance and Improvement

Recommendation:
The Committee is asked to:
1) Review and note the progress on the Corporate Tier 1 Operational Risk Register Report;
2) CRR20-06 - Approve the completion of the actions 12422 and 12428 so they can be archived and removed from the next report, recognising that the implementation of the Centralised Access to Health Records Service and the Baseline Assessment Report of Records need to be captured as controls within the next iteration of the risk.
3) CRR20-06 - Note the extension of the due date for action 12426 due to the impact from re-aligning resources to support the management of the COVID-19 Pandemic.
4) CRR20-07 - Approve the completion of the action 13182 so it can be archived and removed from the next report, recognising that the monitoring and assurance reporting of the implementation of the Digital Strategy will become a control within a future iteration of the risk.
5) Approve the risks 1875 and 3659 being presented for escalation onto the Tier 1 Operational Risk Register.

DIG21.39a CRR DIGC cover report-V2.0.docx

DIG21.39b Appendix 1 - DIGC Corporate Risk Register Report.pdf

DIG21.39c Appendix 2 - DIGC Risk Escalation Report.pdf

5.2 11:26 - DIG21/40 Review of Board Assurance Risk allocated to the Committee - Board Assurance Framework (BAF)

Dawn Sharp, Assistant Director - Deputy Board Secretary, Corporate Office
Recommendation:
That the Committee review and note the progress on the Principal Risks as set out in the Board Assurance Framework (BAF).

DIG21.40a BAF cover report - DIGC - 18 June 2021 updated.docx

DIG21.40b Appendix 1 pdf. BAF20-18-P5-Resources-Digital Estates and Assets - LIVE.pdf

DIG21.40c Appendix 2 to BAF report - Remapping BAF risks to Annual Plan.pptx

DIG21.40d Appendix 3 BAF key field guidance.docx

5.3 11:41 - DIG21/41 Periodic updates on Limited Assurance Audit reports

To note the email circulated on 20.4.21 which included the Final Internal Audit Report - Business Continuity - Informatics.

5.4 11:42 - DIG21/42 Policies: Adoption of All Wales Information Governance Policies

Justine Parry, Assistant Director of Information Governance & Risk
Recommendation:
The Committee is asked to:
1) Endorse the All Wales policies for implementation across the Health Board.

DIG21.42a DIGC-Cover Sheet-National Policies-V1.docx

DIG21.42b Appendix 1-WIGB202103 BCUHB Policy letter.pdf

DIG21.42c Appendix 2-All Wales Internet Use Policy v3.pdf

DIG21.42d Appendix 2a-EqIA Internet Use Policy v2.1.pdf

DIG21.42e Appendix 3 -All Wales Information Governance Policy v2.pdf

DIG21.42f Appendix 3a-EqIA Information Governance Policy v2.1.pdf

DIG21.42g Appendix 4-All Wales Information Security Policy v2(1).pdf

DIG21.42h Appendix 4a-EqIA Information Security Policy v2.1.pdf

6 DIG21/43 Summary of InCommittee business to be reported in public

Recommendation: The Committee is asked to note the report for information only.

DIG21.43 Items discussed in private section 26.3.21.docx

7 11:57 - DIG21/44 Issues to inform the Chair's Assurance report

8 11:59 - DIG21/45 Date of next meeting

9 DIG21/46 Exclusion of the Press and Public

Recommendation:
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

Digital Information and Governance Committee

Date	18/06/2021
Time	9:30 - 12:30
Location	Virtual Microsoft Teams
Chair	John Cunliffe

1	**OPENING BUSINESS**
1.1	**DIG21/28 Chair's opening remarks**
9:30	
1.2	**DIG21/29 Apologies**
9:32	
1.3	**DIG21/30 Declarations of Interest**
9:34	
1.4	**DIG21/31 Draft minutes of the previous meeting held on 26.3.21**
9:36	
1.5	**DIG21/32 Matters arising and Review of Summary Action Log**
9:41	
2	**DIGITAL**
2.1	**DIG21/33 Digital Operational Plan - quarterly update**
9:46	Dylan Williams, Chief Information Officer, Informatics Andrea Williams, Head of Informatics Programmes Assurance and Improvement, Informatics Recommendation: The Committee is asked to:- 1. To decide if the report provides them with the appropriate level of assurance. 2. To note the report.
2.2	**DIG21/34 Digital Operational Plan - 2021/22**
10:01	Dylan Williams, Chief Information Officer, Informatics Andrea Williams, Head of Informatics Programmes Assurance and Improvement, Informatics Recommendation: The Committee is asked to approve the Informatics Annual Operating Plan 2021-2022.

2.3 **DIG21/35 Informatics Assurance report**

10:16 Dylan Williams, Chief Information Officer, Informatics
Andrea Williams, Head of Informatics Programmes Assurance and Improvement, Informatics
Recommendation:
The Committee is asked to:-
1. To decide if the report provides them with the appropriate level of assurance.
2. To note the report.

2.4 **DIG21/36 Digital Health and Care Wales (DHCW) update report**

10:31 Helen Thomas, Chief Executive Digital Health and Care Wales
Recommendation:
The Committee is asked to note this report from the Digital Health and Care Wales

3 **INFORMATION GOVERNANCE**

3.1 **DIG21/37 Information Governance quarterly assurance report (KPI, Lessons learned and compliance report)**

10:46 Justine Parry, Assistant Director of Information Governance & Risk, Corporate Office
Recommendation:
The Committee is asked to:
• Receive and note the assurance provided in compliance with the Data Protection and Freedom of Information Legislation.

3.2 **DIG21/38 Chair's Assurance report : Information Governance Group**

11:01 Justine Parry, Assistant Director ff Information Governance & Risk, Corporate Office

4 **COMFORT BREAK**

11:06

5 **GOVERNANCE**

5.1 **DIG21/39 Review of Corporate Risks allocated to the Committee - Corporate Risk Register Report**

11:11 Justine Parry, Assistant Director of Information Governance & Risk, Corporate Office
Chris Stockport, Executive Director Primary & Community Care, Corporate

Office
Dylan Williams, Chief Information Officer, Informatics / Andrea Williams, Head of Informatics Programmes Assurance and Improvement

Recommendation:
The Committee is asked to:
1) Review and note the progress on the Corporate Tier 1 Operational Risk Register Report;
2) CRR20-06 - Approve the completion of the actions 12422 and 12428 so they can be archived and removed from the next report, recognising that the implementation of the Centralised Access to Health Records Service and the Baseline Assessment Report of Records need to be captured as controls within the next iteration of the risk.
3) CRR20-06 - Note the extension of the due date for action 12426 due to the impact from re-aligning resources to support the management of the COVID-19 Pandemic.
4) CRR20-07 - Approve the completion of the action 13182 so it can be archived and removed from the next report, recognising that the monitoring and assurance reporting of the implementation of the Digital Strategy will become a control within a future iteration of the risk.
5) Approve the risks 1875 and 3659 being presented for escalation onto the Tier 1 Operational Risk Register.

5.2 **DIG21/40 Review of Board Assurance Risk allocated to the Committee - Board Assurance Framework (BAF)**

11:26

Dawn Sharp, Assistant Director - Deputy Board Secretary, Corporate Office
Recommendation:
That the Committee review and note the progress on the Principal Risks as set out in the Board Assurance Framework (BAF).

5.3 **DIG21/41 Periodic updates on Limited Assurance Audit reports**

11:41

To note the email circulated on 20.4.21 which included the Final Internal Audit Report - Business Continuity - Informatics.

5.4 **DIG21/42 Policies: Adoption of All Wales Information Governance Policies**

11:42

Justine Parry, Assistant Director of Information Governance & Risk
Recommendation:
The Committee is asked to:
1) Endorse the All Wales policies for implementation across the Health Board.

6 **DIG21/43 Summary of InCommittee business to be reported in public**

Recommendation: The Committee is asked to note the report for information only.

7 **DIG21/44 Issues to inform the Chair's Assurance report**

11:57

8 **DIG21/45 Date of next meeting**

11:59

9 **DIG21/46 Exclusion of the Press and Public**

Recommendation:
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.

DRAFT

Digital and Information Governance Committee
Minutes of the Meeting held on 26.03.2021
Held virtually via Microsoft Teams

Present:

Mr John Cunliffe	Independent Member – Committee Chair
Professor Nicola Callow	Independent Member

In Attendance:

Mr Liam Allsup	Business Planning & Improvement Manager, Informatics
Mrs Jody Evans	Secretariat, Corporate Governance Officer
Mr Simon Evans-Evans	Interim Director of Governance, Corporate Office
Ms Jo Flannery	Regional Programme Manager – Community Services Transformation - Denbighshire County Council {part meeting}
Mr Arpan Guha	Acting Executive Medical Director, Corporate Office
Ms Sue Hill	Executive Director of Finance (SIRO) – {part meeting}
Ms Carol Johnson	Head of Information Governance
Mrs Justine Parry	Assistant Director of Information Governance & Risk
Ms Helen Thomas	NWIS Director of Information, Information Services {part meeting}
Mr Dylan Williams	Chief Information Officer, Informatics
Ms Andrea Williams	Head of Informatics Programmes Assurance and Improvement, Informatics

Agenda Item Discussed	Action
DIG21/1 Welcome and Chair's opening remarks. **DIG21/1.1** The Committee Chair welcomed everyone to the meeting. **DIG21/1.2** An Independent Member (IM) informed the Committee of a break in her attendance from 10:30am for a brief period of time. It was noted that the comfort break would commence at that point, in order to avoid non quorum of the Committee. **DIG21/1.3** The Chair informed the Committee of two Chair's actions *scheduled to have been taken to the December meeting, which was stood down*). The two Chair's actions were taken and approved with regards to: - Information Governance Strategy Item – annual review - Item approved. - Information Governance Assurance Report item - Assurance provided regarding IG preparedness for EU Exit - Item approved. **DIG21/1.3** The Chair confirmed that the Chief Information Officer had been delegated as the delegated Lead of the Committee (on this occasion) in the absence of the Executive Director of Primary and Community Care.	

DIG21/2 Apologies for Absence **DIG21/2.1** Apologies were received from Chris Stockport, Executive Director Primary and Community Care, Jo Whitehead, Chief Executive Officer, Melanie Maxwell, Senior Associate Medical Director, Sue Hill, Executive Director of Finance [part meeting], Medwyn Hughes, Independent Member and Dave Harries, Internal Audit.	
DIG21/3 Declarations of Interest **DIG21/3.1** None received.	
DIG21/4 Draft minutes of the previous meeting held on 25.09.2020 **DIG21/4.1** The Minutes of the last meeting held on 25.09.21 were confirmed as an accurate record.	
DIG21/5 Matters arising and Review of Summary Action Log **DIG21/5.1** Updates to the summary action log were recorded therein the action log accordingly. **DIG21/5.2** Members also discussed the additional item referred from the relevant Committee. **DIG21/5.3 Documents circulated to members since the last meeting** The following items were noted that had been circulated to members since the meeting held in September: • Cyber resilience in the public sector - Circulated 14/01/2021 via email. • Audit Wales, Welsh Community Care Information System - Circulated 03/02/2021 via email.	
Digital Matters	
DIG21/6 Digital Operational plan **DIG21/6.1** The Chief Information Officer provided the Committee with an overview of the Quarter 2 and Quarter 3 reports. The Committee noted the update on the implementation of the Informatics Operational Plan – Quarter 2 and Quarter 3, and the assurances that legislative and regulatory responsibilities were being met against agreed plans. The Committee noted the key points from the reports and it was recognised that the reporting figures had been similar due to the impacts of Covid. It was noted that there had been a financial overspend due to non-achievement of savings targets. It was also recognised that there had been 2 reviews which had been updated since the previous report.	

The Committee acknowledged the slight change in format and it was raised that the formatting of appendix 2 would be updated for the next iteration. There were no further comments or questions received. **DIG21/6.2** The Committee confirmed that the reports provided the appropriate levels of assurances and agreed to note the reports.	DW
DIG21/7 Informatics Assurance Report Informatics Assurance Reports - Quarter 1 and Quarter 2 **DIG21/7.1** The Chief Information Officer presented the reports from Quarter 2 and 3 collectively and provided the overview of data relating to the quality and effectiveness of information and information systems. **DIG21/7.2** The Committee noted the HASCAS/Ockenden recommendations and the detailed update relating to the two-stage process to (1) map out the approach to baselining of priority casenote types of Acute, Mental Health Acute/Community and CAMHS Community Childrens Services, by March 2021 and (2) complete the baselining activity for all remaining casenote types, by March 2022. The output of this work make recommendations that would enable BCUHB to work towards pan-BCUHB compliance with legislation and standards for good records management across all paper patient record types. It was stated that ongoing progress was being reported through the Patient Records Group. The Chief Information Officer also confirmed that the outcomes would be shared with the Committee accordingly. **DIG21/7.3** The Head of Informatics also informed the Committee of 2 overdue audit recommendations with regards to Clinical coding, it was noted that the recommendations had not been met due to COVID and the impacts upon staffing. It was also stated that large numbers of machines had not been connected the network for long periods of time; which resulted in them being outside of compliance with scheduled updates. It was stated that once machines were switched on and connected to the BCU network, that they were then updated within the 24 hour period. Key areas relating to appendix 1 were also referred to and discussion ensued with regards to the workshop which had been cancelled. **DIG21/7.4** The Chair commented upon various areas of the report and gave particular attention to page 4: table 1 – relating to the number of overdue recommendations which had increased by 50%. It was confirmed that the Team were not able to meet the target recommendations due to Covid pressures. The Chair also queried data in relation to trends which had decreased in performance relating to coding compliance. Clarification was also discussed with regards to the results management project and of the timeline of the project to date. The Chief information Officer also informed the Committee of the barriers to progress the Attend Anywhere project and of the Business Case which was under development. The Chair also noted that the tables on page 9 had no titles and seem to be related to next section of the report. The Head of Informatics agreed to review and update the table titles in future iterations of the report.	DW AW

DIG21/7.5 Discussion ensued regarding key areas and duplication with regards to performance reporting and ongoing compliance updates. An independent member thanked the team for the report and the Committee acknowledged the level of information provided. The members noted the report and agreed that the report provided them with the appropriate levels of assurance. It was agreed to re-arrange the workshop to further discuss the future purpose and content of the report. RESOLVED: The Digital & Information Governance Committee reviewed and noted the report. It was also agreed to re-arrange the workshop to discuss the content of the assurance report going forwards.	AW/JE
DIG21/8 NWIS update report **DIG21/8.1** The Committee Chair welcomed the NWIS Interim Chief Executive Officer to the Committee who provided the report and presented a verbal presentation regarding the National Update report which outlined updates on the progress of a range of National Digital initiatives within BCU, *detail as follows*; Establishment of Special Health Authority, Digital Health and Care Wales (DHCW), Welsh Patient Administration System (WPAS), Welsh Community Care Information System (WCCIS), Data Centre Transition project, WCP & WCP Mobile, Welsh Patient Referral System (WPRS), Digitisation of Welsh Nursing Care Record, Welsh ED system (WEDS), Hospital Pharmacy and the National Data Resource (NDR). **DIG21/08.2** Further to the establishment of the DHCW, it was noted that the Special Health Authority (SHA) Legislation had passed through the Senedd in order to establish the SHA from 1st April 2021. It was noted that the SHA Board were meeting in April and that the progress was on plan. It was also confirmed that work was ongoing with regards to WPAS relating to the data transition program. A discussion took place relating to the overall metrics, movement and effects on services. It was also clarified that a timeline and plan would be informed by the end of July. It was confirmed that the detailed plan in its current form was available. It was agreed that the relevant information would be shared with the Chief Information Officer accordingly. **DIG21/8.3** The Chair referred to the WPRS system and the Committee noted the challenges relating to the planning and roll out. The challenges of discharge communication and of cross referrals were acknowledged. It was noted that NWIS had appointed a Project Support Manager who would work with BCU to develop the plan of implementation. **DIG21/8.4** Within the update report it was also confirmed that the NWIS Senior Leadership Team and BCU Informatics colleagues met in January with regards to strategic engagement discussions to ensure plans and priorities were shared and aligned. It was noted that there was a meeting planned which would include members of the BCU Executive Team, in order for the organisations to agree the joint plan for 2021/22. A discussion took place with regards to how the 2 organisations would	HT

monitor and maintain the clear strategic plan moving forwards. It was also confirmed that the Head of Informatics had been meeting with the NWIS lead on a regular basis, in order to continue to establish the clear working links. **DIG21/08.5** The Committee Chair thanked the Director of Information for the update. RESOLVED: The Digital and Information Governance Committee noted the update.	

DIG21/9 Digital Communities (Community Services Transformation workstream): Update Report **DIG21/9.1** The Committee Chair welcomed the Regional Programme Manager – Community Services Transformation - Denbighshire County Council to the Committee. **DIG21/9.2** The Regional Programme Manager provided the update report regarding the progress to date in relation to the Community Services Transformation Fund. The overview of the role was provided which highlighted joint working mechanisms, along with the promotion of support byway of electronic devices. The support mechanisms were recognised therein the update with regards to those shielding along with support to care homes and hospitals. It was also noted that Amazon echos were also being utilised. Training and development approaches were also summarised. The support of the BCUHB had also been commended along with the positive partnership working links. **DIG21/9.3** An Independent Member queried with regards to raising the levels of publicity around the initiative. It was confirmed that a phone provider had provided a number of free data sims, along with working links with the regional partnership board and of there being a number of press articles to raise awareness within the community. Ongoing revenue funding was also being discussed along with possibilities of there being an ongoing loan scheme roll out in the future. The idea of Training hubs were also noted. A discussion also took place around the assurances relating to the usage of Amazons echos. It was raised that the Regional Manager was looking into it in more detail and stressed that Information Governance would be at the forefront of any future developments. The Committee Chair thanked the Regional Manager for the update. RESOLVED: The Digital and Information Governance Committee noted the update.	
DIG21/10 Digital Strategy - Our Digital Future **DIG21/10.1** The Chief Information Officer and Head of Informatics Programmes Assurance and Improvement presented the Digital Strategy to the Committee for Approval. The Committee received the overview of the Strategy. **DIG21/10.2** It was explained that the Strategy had been developed through the 2 phased engagement approach. It was confirmed that phase 1 had commenced in October 2020 and had ceased in December 2020, which included the targeted communications campaign along with links with existing networks and focus groups. It was also noted that general question and answer sessions along with surveys had also taken place. **DIG21/10.3** Phrase 2 of the consultation had also taken place through the months of February 2021 and March 2021. It was noted that there were over 40 responses along with over 4000 comments which had been received and utilised, in order to shape the strategy to date.	

DIG21/10.4 The Head of Informatics Programmes Assurance and Improvement also informed the Committee (byway of a PowerPoint presentation) of key areas of the Strategy, it was noted that the full Equality Impact Assessment and a Socio-Economic Duty Assessment would also be completed in due course. It was also confirmed that there were 6 Key Enablers underpinning the Strategy. The need for ongoing engagement was recognised, along with strengthening links between Primary and Secondary care. It was confirmed that the Strategy would also be developed into a shorter Public version as a "Strategy on a page". It was also confirmed that the Engagement Report findings would also be published in due course. **DIG21/10.5** The Members agreed that the Strategy and Engagement Report were extremely positive. Discussion ensued in relation to the planning of Business Cases relating to the current processes and of digital involvement relating to relevant cost implications. The Committee congratulated the Head of Informatics Programmes, Assurance and Improvement on the development of the Strategy and provided their support on the clear engagement process. **RESOLVED:** The Digital and Information Governance Committee approved the Strategy.	
COMFORT BREAK	
INFORMATION GOVERNANCE	
DIG21/11 Information Governance quarterly assurance report (KPI, Lessons learned and compliance report) - Quarter 3 2020/21 Key Performance Indicators (KPI) Report **DIG21/11.1** The Assistant Director of Information Governance & Risk presented the detailed overview of the Key Performance Indicators: Quarter 3 report. The report provided the Committee with the high-level analysis, demonstrating many of the continuous improvements to date. Positively it was noted that the compliance level for responding requests within the standard of 20 days had increased from 57% to 77%. It was recognised that there had been various complaints received from the information commissioner with regards to the Holden Report which were ongoing. Figures in relation to data protection and non-clinical information had positively increased to 93%. It was also reported that HMP Berwyn had received a 100% compliance rate for the quarter. It was also noted that there had been a steady increase of incidents reported for the quarter. It was clarified that since the introduction of Office 365 the BCU email address default address book had reverted to the global address book, which had proved problematic. Training and compliance rates had been maintained to over 82% and it was stated that the positive result had been shared with the Chief Executive Officer. **DIG21/11.2** The Chair invited questions from the Members and queried with regards to inappropriate access on relevant systems and whether or not auditing of the system had been a deterrent. It was agreed that the Head of Information Governance would contact Workforce colleagues, in order to review and possibly re-issue reminders to staff.	JP

RESOLVED – The Committee received and noted the assurance provided in compliance with the Data Protection and Freedom of Information Legislation.	
DIG21/12 Chair Assurance reports : Information Governance Group **DIG21/12.1** The Assistant Director of Information Governance and Risk presented the reports and provided the highlights; in relation to key issues taken from the meetings held on the 26th November 2020 and 4th March 2021, on behalf of Dr Melanie Maxwell, Senior Associate Medical Director. **DIG21/12.2** The detail in relation to the information asset register was raised. It was noted that the Leads were working with Informatics Leads along with the Executive Director of Finance to improve reporting, it was agreed to include data within future FOI reports. **DIG21/12.3** A further discussion ensued with regards to the risk of the information asset register and General Data Protection Regulation implementations. It was confirmed that the risk was on the Information Governance Risk Register and work was being undertaken with IM&T to future proof the system. It was discussed that works had halted due to Covid and had presented as resource intensive. It was confirmed that the Information Governance Team had recruited to a band 5 position in order to work on the process. **DIG21/12.4** Discussion ensued in relation to the reported Office 365 incident and of the risks to the health board. It was agreed to review the associated risks accordingly. It was agreed for the Chair and the Assistant Director of Information Governance to consider wording which would be included within the Chairs report to the board to highlight the associated risk/s. **RESOLVED:** The Committee received and noted the IGG Chairs reports provided.	MM/JP JP/JC
GOVERNANCE	
DIG21/13 Board Assurance Framework Principal and Corporate Risk Report **DIG21/13.1** The Assistant Director, Deputy Board Secretary presented the report and asked the Committee to review and note the progress on the Principal Risk as set out in the Board Assurance Framework (BAF) and Corporate Tier 1 Operational risks presented. The overview of the report was provided and the Committee noted that the Risk Management Strategy and Policy had recently been revised, along with the recent implementation of the revised Board Assurance Framework (BAF) template reporting arrangements. It was explained that;	

• Appendix 1 highlighted the Board Assurance Framework Risks assigned to the Committee. • Appendix 2 provided the overview of all BAF risks and also included detail of the definitions of the assurance levels. • Appendix 3 highlighted the Corporate Tier 1 Risks associated with the Committee which had been reviewed and agreed at the Risk Management Group (RMG) on the 15th March 2021 and scrutinised by the Executive Team on the 17th March 2021. **DIG21/13.2** Discussions arose with regards to the 3 additional risks which had been submitted to the Risk Management Group and were reopened in relation to National Services, Cyber Security and Non delivery of the WCCIS project. It was confirmed that comments with regards to the content and the Strategy had also been forwarded to the risk management officers accordingly and it was confirmed that the detail would be included within future iterations. **DIG21/13.3** Further discussion took place in relation to the BAF document and of the change in the inherent risks, rather than scorings. Assurance levels were discussed and the defining categories were noted in relation to the 3 levels of assurances along with the level zero. Further debate took place in relation to CRR20-10. The Chair noted the requirement to further discuss risks relating to finance issues within the remit of the Finance and Performance Committee. It was noted that with regards to BAF20-18 the detail relating to the wording required updating to include Health Board wide, in order to be consistent with other BAF risks. National delays were also discussed in relation to mitigations and algorithms with regards to impacts upon services. It was agreed for the Chief information Officer and the Assistant Director of Information Governance & Risk meet to discuss themes in relation to impacts on service. **RESOLVED:** The Committee reviewed and discussed the progress in relation to the Board Assurance Framework Corporate Risk Report.	JC DW/JP
GOVERNANCE	
DIG21/14 Draft Committee Annual Report **DIG21/14.1** The Chief Information Officer presented the draft report to the Committee which had previously been reviewed by the members. **DIG21/14.2** The members reviewed the proposed Red, Amber, Green (RAG) scores against the objectives, as set out within the terms of reference. It was agreed that based on the cancellation of the Workshop that the RAG scoring for the year would have to be categorised as Amber. It was agreed for the Amber RAG status to be incorporated and the summary table be updated to reflect the Committee Assessment by the Leads. It was therefore agreed to approve the Draft Report for onward submission to the Audit Committee and take Chairs Action accordingly. **RESOLVED**: The Digital and Information Governance Committee approved the Draft Report.	JE/JC

DIG21/15 Summary of InCommittee business to be reported in public – Dylan Williams, Chief Information Officer **DIG21/15.1** The Committee noted the report. **RESOLVED:** The Committee noted the Summary of Business reported in public.	
DIG21/16 Issues to inform the Chair's Assurance report **DIG21/16.1** John Cunliffe, Chair - Recommendation - To agree the Issues.	JC
DIG21/17 Date of next meeting **DIG21/17.1** The date of the next meeting was noted as: 18th June, 2021	

BCUHB Digital and Information Governance Committee Summary Action Log – arising from meetings held in public				
Officer	**Minute Reference and Action Agreed**	**Original Timescale**	**Latest Update Position**	**Revised Timescale**
25.09.20				
Officer	**Minute Reference and Action Agreed**	**Original Timescale**	**Latest Update Position**	**Revised Timescale**
John Cunliffe	DIG20/89.3 Members discussed the additional items referred from the relevant Committee and Health Board Meetings. It was agreed that the outcomes would be advised within the Chair's Assurance report to Board accordingly.	October 2020	October 2020 Update- Chair's report to be provided to the November Health Board Meeting. December 2020 – DIG Committee stood down – feedback to be presented to the March Meeting. Update as at 26/3/2021 – Confirmed by the Chair that the items had been covered. The mechanisms of feedback are to be further explored. Update as at 10/6/21 – Confirmed by the Chair to close the item.	 26th March 2021 Ongoing. **Item to be closed.**
26.03.2021 (*actions taken from the draft set of minutes)*				
Dylan Williams	**DIG21/6.1 Digital Operational plan** Formatting of appendix 2 to be updated for the next iteration.	June 2021	Update as at 9/6/21 – No Appendix 2 in the June update. Item noted.	**Item to be closed.**
Dylan Williams	**DIG21/7.2** The Committee noted the HASCAS/Ockenden recommendations. The Chief Information Officer	TBC	Update as at 9/6/21 – Item ongoing.	

	confirmed that the outcomes would be shared with the Committee accordingly.			
Andrea Williams Jody Evans to arrange workshop	**DIG21/07 Informatics Assurance Report Informatics Assurance Reports - Quarter 1 and Quarter 2** The Chair noted that the tables on page 9 had no titles and seemed to be related to next section of the report. The Head of Informatics agreed to review and update the table titles in future iterations of the report. Work shop to be re-arranged to discuss the future purpose and content of the report.	June 2021 May 2021	Update as at 9/6/21 – Item complete. Complete **–** Workshop held on 28th May 2021.	**Action to be closed.** **Action to be closed.**
Helen Thomas / Dylan Williams	**DIG21/08 NWIS update report** **DIG21/08.2** It was confirmed that the detailed plan in its current form was available. It was agreed that the relevant information would be shared with the Chief Information Officer accordingly.	May 2021	Update 9/6/21 **–** The Chief information officer confirmed that the DHCW Board papers and plans are now public documents and we have we have access to the detailed WPAS plans.	**Action to be closed.**
Justine Parry	**DIG21/11 Information Governance quarterly assurance report (KPI, Lessons learned and compliance report) - Quarter 3 2020/21 Key Performance Indicators (KPI) Report**	June 2021	Update as at 9/6/21 - Complete Following a review of NIIAS notifications since 2016/17, the below has been confirmed and so far in 2021/22 we are continuing to see the downward trend: 2016/17 total notifications were 439	**Action to be closed.**

	DIG21/11.2 The Chair invited questions from the Members and queried with regards to inappropriate access on relevant systems and whether or not auditing of the system had been a deterrent. It was agreed that the Head of Information Governance would contact Workforce colleagues, in order to review and possibly re-issue reminders to staff.		2017/18 total notifications were 347 2018/19 total notifications were 273 2019/20 total notifications were 319 (but this year saw an increase in false positives) 2020/21 total notifications were 225 Feedback has been obtained from W&OD and this includes: • Based on experience, process is proving effective with little re-occurrence. • Process effective in managing cases to reduce timescales for dealing with the notifications. • Improves staff members understanding of accountability and responsibilities. • Improves wider lessons learnt when teams reviewing cases with their managers. Actions taken to improve compliance include: 1) NIIAS stats and guidance included in all IG Bulletins since 2020/21. 2) NIIAS notifications dealt with via W&OD Fast Track process. Further action to now consider: 1) A review of the process / sanctions for repeat or persistent offenders – completion date of December 2021.	

	DIG21/12 Chair Assurance reports : Information Governance Group	June 2021		
Melanie Maxwell / Justine Parry	**DIG21/12.2** The detail in relation to the information asset register was raised. It was noted that the Leads were working with Informatics Leads along with the Executive Director of Finance to improve reporting, it was agreed to include data within future FOI reports.		Update as at 9/6/21 - This information is being incorporated into Quarter 1 IG KPI report and a section on the Asset Register is to be incorporated into the IG Annual Report.	**Action to be closed.**
John Cunliffe / Justine Parry	**DIG21/12.4** Discussion ensued in relation to the reported Office 365 incident and of the risks to the health board. It was agreed to review the associated risks accordingly. It was agreed for the Chair and the Assistant Director of Information Governance to consider wording which would be included within the Chairs report to the board to highlight the associated risk/s.		**Complete** Incorporated into the DIGC Chairs Assurance Report to the Board.	**Action to be closed.**
	DIG21/13 Board Assurance Framework Principal and Corporate Risk Report	May 2021		
Dawn Sharp	**DIG21/13.2** Discussions arose concerning the 3 additional risks, which had been submitted to the Risk Management Group and were reopened in relation to National		Update as at 9/6/21 BAF risk 20-18 - Digital Estates and Assets reviewed, updated and features as an agenda item for the June Committee meeting.	**Item to be closed.**

	Services, Cyber Security and Non delivery of the WCCIS project. It was confirmed that comments with regards to the content and the Strategy had also been forwarded to the risk management officers accordingly and it was confirmed that the detail would be included within future iterations.			
John Cunliffe	**DIG21/13.3** The Chair noted the requirement to further discuss risks relating to finance issues within the remit of the Finance and Performance Committee. It was noted that with regards to BAF20-18 the detail relating to the wording required updating to include Health Board wide, in order to be consistent with other BAF risks. National delays also discussed in relation to mitigations and algorithms with regards to impacts upon services. It was agreed for the Chief information Officer and the Assistant Director of Information Governance & Risk meet to discuss themes in relation to impacts on service.		Update as at 10/6/21 – Chair reviewing status of action and will discuss with Chair of QSE.	
Dylan Williams/ Justine Parry			Update as at 9/6/21 - This action will be addressed at the next BAF review meeting with the Assistant Director - Deputy Board Secretary, Corporate Office.	

Jody Evans / John Cunliffe	**DIG21/14 Draft Committee Annual Report** It was agreed to approve the Draft Report for onward submission to the Audit Committee and take Chairs Action accordingly.	May 2021	7/5/21 Update – Report submitted to the Lead Executive and Independent Members to provide an opportunity to include any final additional comments by 11th May 2021 - in order for the report to then be submitted as V1.0 to the Audit Committee Workshop. 7/6/21 Update – Report Submitted to the Audit Committee as final.	**Action complete**
Jody Evans / John Cunliffe	**DIG21/16 Issues to inform the Chair's Assurance report** **DIG21/16.1** John Cunliffe, Chair - Recommendation - To agree the Issues.	May 2021	7/5/21 Update – Report complete – Now submitted for Welsh translation for onward submission to the Health Board Deadline of the 19th May.	**Action complete**

Cyfarfod a dyddiad: Meeting and date:	Digital and Information Governance Committee 18th June 2021
Cyhoeddus neu Breifat: Public or Private:	*Public*
Teitl yr Adroddiad Report Title:	Digital Operational Plan Quarter 4 Report (2020/21)
Cyfarwyddwr Cyfrifol: Responsible Director:	Chris Stockport, Executive Director Primary and Community Care
Awdur yr Adroddiad Report Author:	Dylan Williams, Chief Information Officer, et al.
Craffu blaenorol: Prior Scrutiny:	Chief Information Officer and Executive Medical Director
Atodiadau Appendices:	Appendix A

Argymhelliad / Recommendation:

The Digital and Information Governance Committee is asked to:-
1. To decide if the report provides them with the appropriate level of assurance.
2. To note the report.

Please tick as appropriate

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		**Ar gyfer Trafodaeth For Discussion**		**Ar gyfer sicrwydd For Assurance**	**X**	**Er gwybodaeth For Information**	
If this report relates to a 'strategic decision', i.e. the outcome will affect how the Health Board fulfils its statutory purpose over a significant period of time and is not considered to be a 'day to day' decision, then you must include both a completed Equality Impact (EqIA) and a socio-economic (SED) impact assessment as an appendix.						**Y/N to indicate whether the Equality/SED duty is applicable**	**N**

Sefyllfa / Situation:

The purpose of this report is to provide the Digital Information Governance Committee with:
1. An update on the implementation of the Informatics Operational Plan – Quarter 4.
2. A mechanism to gain assurance on behalf of the Health Board that legislative and regulatory responsibilities are being met by the Informatics Services and if delivery is being undertaken against agreed plans.

There has been no approved Informatics Operational Plan for 2020/21, this update is based on an extension of the 2019/20 Approved Operational Plan. This year's plan is in line with the Corporate quarterly planning process."

"The key points from this report are:
1. 19 projects are reported as being on track.
2. The Medicine, Transcribing and Electronic Discharge (MTeD) Business Case has been presented to Executive Team and agreement was received to fund via the Performance Fund. Project development and ownership will now move over to the Informatics Programmes, Assurance and Improvement service.
3. Projects are beginning to restart following COVID with a reduction in the number of projects on hold this quarter (7 in QTR4 down from 9 in QTR3).

4. There has been an increase in the number of projects reported as “Off Track” and the Committee are asked to note these for exception;

- Welsh Nursing Care Record has been delayed due to COVID and competing priorities within Informatics.
- Welsh Community Care Information System (WCCIS) will have an updated business case developed during QTR1 2021/22 reflecting the revised contractual terms.
- Welsh Patient Administration System (WPAS) Phases 3 and 4 remains of concern due to delays with Digital Health Care Wales (DHCW). Integration activities have begun to assess the viability of a West into Central instance proposal and the outcome will be reported in QTR1 2021/22.
- BCU Symphony Locally Hosted is experiencing delays due to emergency department recruitment activities and a change of scope in the project which was agreed during January 2021.
- Implement new encoding software is delayed awaiting a date for West area to be migrated onto the new server.
- New Ysbyty Glan Clwyd File Library is delayed due to the Mental Health development at Ysbyty Glan Clwyd.

5. Finances - overspend, savings target and the discretionary capital programme are covered in finance below.
7. The Capital Programme with a total value of £1.56 million is included in Appendix A.

Cefndir / Background:

The Informatics Operational Plan is a service plan that enables the delivery of BCUHB Corporate Plan. It has 7 strategic principles that all projects link to and are reported under. The plan is updated on an annual basis but the projects within may have a wider timespan for delivery.

Asesiad / Assessment & Analysis

Strategy Implications

This Operational Plan enables the Living Healthier, Staying Well strategic approach.

Wellbeing and Future Generations – the 5 ways of working:

This Operational Plan delivers on the following 5 ways of working;

Long Term – We assess digital systems to ensure that they meet future needs and can work with other existing systems.

Integration – Some of our systems that we are working on support the delivery objectives of other partners i.e. WCCIS.

Involvement – Patients, Staff and key stakeholders are involved in finding the best solutions. We ensure that we are involved when national solutions are being developed to ensure they meet the organisations/patients’ needs.

Collaboration – We work across the organisation using a collaborative approach, the systems have to meet the needs of the system owners.

Prevention – We put solutions in place that can prevent service failure i.e. text reminders to reduce the number of Did not Attends.

Financial Implications

Revenue: The year-end overspend at the 31st March 2021 is due to unachieved savings. The position includes costs of £532K related to Covid costs which have been funded by Welsh Government this financial year.

Capital: The discretionary capital programme is covered in Appendix A of the report.

Risk Analysis: There have been no significant changes to project risks during quarter 3.

Legal and Compliance: None

Impact Assessment: No overall equality impact assessment has been undertaken on the Operational Plan but we are working with the Digital Communities Wales to understand the key data and information in relation to digital inclusion for the new Strategy.

Informatics Operational Plan 2020/21: Progress Monitoring Report

Quarter 4

About this Report

This report is presented to the Digital and Information Governance Committee (DIGC), to support its remit to receive and gain assurance on the delivery of the Informatics Operational plan. The report presents:-

Summary data to highlight progress against Informatics Strategic Principles (page 4) which are detailed with the 2020/21 operational plan

Summary data that is reported directly to the Health board and used by them to monitor progress against the annual plan (page 5) for core Informatics Projects (i.e. Digital Health Programme – High Level Matrix). More detailed performance updates against the Milestones of these projects (page 6 to 8) which is used to attribute status. This is not subject to standard submission / scrutiny by the board and is provided to the committee to support their assurance activities.

The Revenue and Capital position at the end of Quarter 4 (page 9 to10)

The ratings which have been attributed to each of the Projects have been assessed by the relevant lead for the project or Milestones. All of the ratings have been reviewed and approved by the Chief Information Officer (CIO). Additional assurance is provided by the Informatics Performance and Improvement department who will request rationale for the ratings given and sample test the anticipated verses achieved milestone deliverables.

Where a red or amber rating is applied to any project in any month, a short narrative is provided to explain the reasons for this and any actions being taken to address.

To interpret this report, it is necessary to note the basis of the rating which provides a succinct forecast of delivery, combined with an assessment of relative risk (matrix below).

Feedback is welcomed on this report and how it can be strengthened. Please email Andrea.Williams30@wales.nhs.uk

RAG	Every Month End	By year end	Actions depending on RAG rating given
Red	Off track, serious risk of, or will not be achieved	Not achieved	Where RAG given is Red: - Please provide some short bullet points expaining why, and what is being done to get back on track.
Amber	Achievement as forecast; work has commenced; some risks being actively managed	N/A	Where RAG is Amber: No additional information required
Green	On track for achievement, no real concerns	Achieved	Where RAG is Green: No additional Information required
Purple	Achieved	N/A	Where RAG is Purple: No additional Information required

Informatics Operational Plan 2020/21: Monitoring of Progress against Actions and Milestones

Executive Summary

As at the end of March (Quarter 4), the Informatics Operational Plan for 2020/21 has 41 projects which are linked to and intended to deliver 7 Strategic principles and objectives, of these 29 projects are currently active.

Project Status	No of Projects	Update
Achieved	4	Welsh E-Documents Reporting (National E-docs from within the Welsh Clinical Portal) - Hep-C. E Form Clinical Requests Good Record Keeping Management Development of ICT infrastructure monitoring and reporting systems - Solar Winds & Netterain
On track for achievement, no real concerns	19	
Off track, serious risk, or will not be achieved	7	**Welsh Nursing Care Record - Digitisation of Nursing Documents** - pending business case approval by the Board and full implementation within three years. **Welsh Community Care Information System (WCCIS)** - revised completion date to be confirmed following business case approval at Finance and Performance Committee August 2021. **Welsh Patient Administration System (WPAS) Phases 3 and 4** revised completion dates are dependant on Welsh Government Funding, Phase 3 to complete May 2022 and Phase 4 to complete during the 2024/25 financial year. **BCU Symphony Locally Hosted** revised completion date for East implementation of September 2021 and Central February 2022. Fully integrated WEDS will complete after single instance (phase 4) WPAS. **Implement new encoding software,** revised completion date to be confirmed following WPAS West implementation. **New Ysbyty Glan Clwyd File Library** - this project is anticipated to complete in December 2024.
Achievement as forecast, work has commenced: some risk being actively managed	3	
On Hold	7	
Removed	1	SBAR taken to WPAS board with recommendation to delay Tracker 7 until WPAS is implemented across all BCU sites.
Not Started	2	Projects due to start in the 2021/22 financial year

Summary Progress against Strategic Principles

The Informatics Operational Plan details all of the projects that Informatics is aiming to further or deliver during 2020/21 (41). All projects are linked to strategic principles and objectives which are listed below. A high level overview of progress against each objective is also provided e.g. number of projects and project status. Further detail can be provided.

Strategic Principle	Objective	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4	Total Projects	Active	On Track	Experiencing Issues	Unmet	Closed	On Hold	Removed
Digital Roadmap	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". The building blocks of a single patient view which can be accessed by those receiving, providing or supporting patient care.	A	R	R	R	**15**	10	3	2	5	3	2	0
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.	G	A	G	G	**5**	5	5	0	0	0	0	0
Underpinning Service Transformation	Supporting services to combine technological opportunities with new business processes, that enable us to meet our Local and National responsibilities.	A	A	G	G	**7**	5	4	0	1	1	0	1
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".	G	A	A	A	**1**	0	0	0	0	0	1	0
Managing Innovation & Emerging	Learning and Innovating by providing accelerators of digital transformation. Collaborating with innovators and entrepreneurs and suppliers to encourage innovation.	G	G	G	G	**1**	1	1	0	0	0	0	0
Digital Infrastructure	Providing, developing and maintaining a secure, flexible and robust infrastructure to enable a digital future.	G	A	G	G	**9**	6	6	0	0	1	2	0
Workforce Development, Transparency, Sustainability & Standards	Nurturing a digital culture throughout the organisation to enable staff to tell us 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	G	A	A	R	**3**	1	0	0	1	0	2	0

Progress against the following projects is reported to the Board as part of annual plan progress monitoring.

Programme	Strategic Objective	Exec Lead	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
WPAS*	Phase three of Welsh Patient Administration Project (PAS) starts. It will replace the Commercial PAS system in the West and standardise processes relating to this system in other sites	MD												
WCCIS	Completion of pilot studies to learn lessons to inform wider installation and utilisation of the Welsh Community Care Information System	MD												
WEDS	Reconstitute the Welsh Emergency Department System upgrading the Emergency Department System in the West (phase 1,East (Phase 2) and extending into the Central MIU's (Phase 3) followed by the final phase to move onto a Single Integrated WEDS solution'.	MD												
Digital Health Record *	Phase 2 of a local Digital Health Record which will strengthen our investment and approach to the delivery of an electronic patient record	MD												
YGC Records Library	Support the identification of storage solution for Central Library	MD												
Good Record Keeping Management	Transition program to review the management arrangements for ensuring good record keeping across all patient record types	MD	**Pre-Formal Start**											
Information Flow	Delivery of information content to support flow/efficiency	MD	**On hold / pre-formal start**											
Digital Infrastructure	Rolling programmes of work to maintain / improve the digital infrastructure e.g. migration of telephone infrastructure from an end of life solution to one which is fully supported and capable of underpinning service change e.g. single call centre	MD												

Digital Health Programme Milestone Summary Matrix

Actions	Due	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4	Comments
WPAS						
Ways of Working / Standardisation Activity Data Migration Event 5 started (paused due to COVID-19) User Acceptance Testing Preparation started Training Plan Preparation started	Q1	A				The WPAS project restarted in June after a period of suspension due to the COVID priorities impact. Data Migration Event 5 started against the revised plan working towards a May 2021 go-live. Work was also undertaken on the remaining Ways of Working gaps. Additionally, the Go-Live, Training and User Acceptance Testing strategies were drafted.
Data Migration Event 5 Completed Data Migration Event 6 started Continued Ways of Working Activity Training Strategy Approved User Acceptance Strategy Approved Revised Business Case (Phase 4) Drafted	Q2		R			September 2020 - WPAS project is reporting a delay of approximately 7 months due to NWIS having to divert their resources in order to move national systems including the cancer system CANISC out of the Blaenavon Data Centre (BDC) at short notice as the supplier is ceasing services there. The CANISC system is also end of life so this has accelerated the need for NWIS to implement the Velindre WPAS project in order to de-risk the situation. NWIS have indicated a possible restart of the BCU phase 3 from May 2021, however this has not been confirmed or agreed yet. There is also a current issue which affects our data migration partner DXC being able to support such a date. Further discussions are needed following the most recent delay.
Data Migration Event 6 Completed Data Migration Event 7 started Continued Ways of Working Activity User Acceptance Testing Activity started Revised Business Case (Phase 4) submitted (Subject to approval)	Q3			R		September 2020 - WPAS project is reporting a delay of approximately 7 months due to NWIS having to divert their resources in order to move national systems including the cancer system CANISC out of the Blaenavon Data Centre (BDC) at short notice as the supplier is ceasing services there. The CANISC system is also end of life so this has accelerated the need for NWIS to implement the Velindre WPAS project in order to de-risk the situation. NWIS have indicated a possible restart of the BCU phase 3 from May 2021, however this has not been confirmed or agreed yet. There is also a current issue which affects our data migration partner DXC being able to support such a date. Further discussions are needed following the most recent delay.
Replanning exercise to commence to look at bringing DM activities forward to this qrt, Options being explored to address viability of pooring PiMS West data into Central WPAS.	Q4				R	The core part of the project continues to be onhold due to NWIS (DHCW) prioritising Velindre activities over BCUHB. planned Data refinement activities for this quarter have been delayed due to delays in the NWIS/Velindre Plan. Some build activities have been continued however a number of key resources have been pull by the organisation to support WIS and Attend Anyway business priorities. Integration activities has been started in this Qtr to assess the viability of a West into Central instance proposal. Outcome will be reported in next Qtr.
WCCIS						
Planning and configuration for prototype; defining new ways of working; development of reports / workflows etc. Testing of v5.2.15 Correction Planning for wider implementation.	Q1	R				Project paused. Objectives not achieved due to re-deployment of team to cover COVID 19 requirements. Also, re-deployment of Local Authority colleagues involved in the Prototype
Planning and configuration for prototype; defining new ways of working; development of reports / workflows etc. Testing of v5.2.15 Correction Planning for wider implementation.	Q2		R			Planning and configuration of the prototype continues to progress within the WCCIS workstream. The V5.2.15 release from the National Team has been delayed until early 2021 and therefore no testing has been undertaken. The Health Board team have met with the Regional and National Team to discuss re-planning of the wider implementation. The national team have agreed to work with the Health Board to review the detail of the deployment order, however a hardware and technical refresh planned by the National Team may delay this process.
Prototype implementation and support for new ways of working. Testing of new releases (bug fixes / Inpatient functionality / mobile).	Q3			R		The WCCIS Workstream (BCUHB, Gwynedd LA and Ynys Mon LA) have continued to work together to develop the security model and outline configuration requirements for the West Prototype. However, delays in receiving required detail and agreement on future ways of working from the new CRTs has seriously delayed progress (these are both still to be resolved). Added to this, the National Team have now requested payment for licences to include Health Board community staff onto the system. The Health Board is now awaiting costs from the National Team with regards to these licences.
Prototype closure:Review & evaluation of prototype. Finalise rollout plans for full implementation; readiness activities	Q4				R	An options appraisal has concluded that the project should seek to agree revised contractual terms based on functional delivery, and that these should be reflected in an updated business case, to be developed in the next quarter.

Actions	Due	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4	Comments
WEDS						
Non-Integrated WEDS (BCU Symphony) Sequencing Approved Correction Plan Approved Revenue Business Case Approved West Data Migration completed West User Acceptance Testing completed West End-user training started	Q1	A				The Correction Plan needs revising due to the change in Go Live date with the Revenue Business Case to be presented to Finance & Performance Committee at the end of July and to the Board at the end of September (via Health Board Review Team - date TBC). Data Migration testing is almost complete and is awaiting sign off. End user training for staff in the Emergency Department West is now 65% complete however, refresher training will now be required due to the Go Live date delay moving from July 2020 to a date in the Autumn yet to be finalised. User Acceptance Testing of the system is ongoing.
Correction Plan Approved Revenue Business Case approved by HBRT and F&P and submitted to Health Board meeting 24/09/2020 DM Signed off West End-user Training completed including MIUs UAT complete	Q2		R			Correction Plan no longer required as BCU will be locally hosting in the interim whilst National Team plan work in the National Data Centre. Work in progress to extend the existing contract in East. Revenue Business Case approved by Health Board Review Team and Exec Team now waiting for approval by Finance and Performance Committee on 29/10/20 . Data Migration Signed off by Project Board at the end of September. Refresher training now planned for October as Go Live Date slipped from July to November (subject to Finance and Performance Committee's Approval on 29/10/20)
West ED and MIUs complete and Go-Live Support ongoing East readiness activities commenced including 1 x MIU and 2 x MIUs in Central	Q3			A		Completed YG ED implementation 2/12/2020. Readiness activities for MIUs behind schedule due to Covid pressures.
Post West Go-Live Support East readiness activities completed Go-Live East complete including MIU	Q4				R	Some Post Go Live support in ED West continues as ED are yet to commence recruitment. Training - MIU West including LLGH was completed in February (does not include Dolgellau & Tywyn as they are currently closed). BCU Symphony successfully implemented at Ysbyty Alltwen 23/03/2021. Please note scope of Project has been amended to include Central ED as agreed by January Board.
Digital Health Record						
Development and approval by the Health Board of a full business case for the Digital Health Record which will inform the times scales for the project delivery	Q1	A				The DHR full business case (FBC) has been presented to the HBRG, who unanimously determined it as an approvable business case. Subsequent presentation to Exec Team and DIGC gave unanimous support. Funding route has been agreed with the Executive Director of Finance prior to the FBC being presented to the Finance & Performance Committee in early July. Project on track to take the FBC to Health Board on the 23rd July; if approved on to the WG via a Ministerial Brief.
To have the FBC approved by BCU Health Board; agreement to award contact from the WG - Contract Awarded.	Q2		G			The FBC was approved by the Health Board on 23rd July, and subsequently WG approved the Ministerial Brief to appoint the preferred supplier in September 2020. The 10 day Alcatel (stand still) period, which allows the unsuccessful suppliers to challenge our decision,ended on 2nd October - no challenge was received. This action is now complete.
Engagement with Supplier to agree 4 year formal Project Start Date.	Q3			G		The contract has now been completed and signed with Civica for their Cito product. The project is currently in 'Stage 0 - Pre-Start'. The Project Board has met again to workshop the benefits baselining and risks identification/management; and the Clinical Task & Finish Sub Group has held a workshop to explore the tabs structure within the product and models for delivery. Outline Project Plan anticipated for the January Project Board meeting.
Demonstrable progress against Project Plan	Q4				G	Project remains on track with key deliverables for this quarter: Project Board agreed a formal project start of 1st March 2021 with an established Project Team; Phase 2.0 Project Plan has been agreed to deliver a Minimum Viable Product and implement with two early adopters with key targets for 2021 - Infrastructure ready by late Spring, Test Environment by early Summer, Early Adopters Go Live early Autumn; Engagement with a Clinical Task & Finish Group to design and development of the Cito product for BCU delivered the folder structure; risk sub-group is established with register baselined; Data Protection Impact Assessment in place.

Actions	Due	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4	Comments
YGC Records Library						
Working with support from the Hospital Management Team, Planning and Estates department to identify an appropriate solution, development and approval by the Health Board of a single stage business case that specifies the storage and logistics requirements for long-term storage of acute patient records in Central	Q1	A				A meeting was arranged to visit the Ablett site on the 27/09/20 to scope out the area in readiness of this becoming the agreed site for the YGC File Library. Work is underway with racking suppliers to assess the best use of the space to rack and store. Since the meeting the work has been put on hold due to the workload of the Planning and Performance (Capital) Team and Estates due to covid and risk compliance work. The actions and timelines will be reviewed at the next meeting.
To have a clear steer from Planning on the availability of the option to house YGC File Library in the entire Ablett Site	Q2		A			A meeting was arranged to visit the Ablett site on the 27/09/20 to scope out the area in readiness of this becoming the agreed site for the YGC File Library. Work is underway with racking suppliers to assess the best use of the space to
To have a clear steer from Planning on the availability of the option to house YGC File Library in the entire Ablett Site	Q3			A		Meeting with SRO and planning lead was held this month with outcome that, due to the delay in the Mental Health scheme and the pressures of Covid within all Departments, work to evaluate the Ablett for Health Records use will hold until April. The Health Records Site Manager reported that risks associate with the portacabin Library are being managed and the delay is within tolerance.
Direction of travel provided by the HMT in line with the Stratgic Mental Health Business Case	Q4				R	Meeting to review the status of the Mental Health development business case is planned for April which will inform the next steps for this long standing action
Good Record Keeping Management						
To begin the baseline of the; storage, processes, management arrangements and standards compliance to work towards PAN-BCUHB Patient Records Compliance with legislation and standards in patient records management across all casenote types.	Q1	A				Pre Covid, the post of Project Manager was advertised as a 12 month secondment, however no candidates met the essential skills. The approach has been reviewed post-Covid to ensure compliance with new restrictions in the undertaking of the review, with a focus on how to progress this at pace. Work is expected to commence in Q2 with the aim to make up as much time as possible within the constraints.
(revised) Project start commenced and work underway with Mental Health Service and Community Service as a priority.	Q2		G			Task Monitoring plan has been implemented with actions delivered during quarter 2. Table top baseline audit has been completed on current knowledge with implementation of the delivery plan for the full baseline audit commencing in Quarter 3. The first service to be audited will be MHLD.
Work commenced with all other patient record custodians. Information evaluation underway with Task & Finish Group.	Q3			G		This project is now well underway under the lead of the Deputy Head of Patient Records & Digital Integration Department. There are currently 12 tasks to be completed within the Project, with good progress made in the 1st reporting period. Progress is being reported into the Patient Records Group (via a highlight report) then up to the Information Governance Group (via the Chair's Assurance Report), and to the Digital and Information Governance Committee as part of the overall summary progress from Informatics.
Present the recommendations and funding requirements: ~ Patient Records Group ~ Information Governane Group ~ Digital & Information Governance Committee ~ Executive Team ~ Finance & Performance Committee	Q4				C	The Stage 1 report is finalised with a clearly defied approach to undertaking this pan-BCU and findings from the primary scoped areas of Acute, Mental Health and CAMHS. Report will be provided to Patient Records Group, Information Governance Group and Digital and Information Governance Committee (in absence of HASCAS Improvement group). This will CLOSE this action in respect of the HASCAS recommendation for Mental Health and move activity into BAU.
Information Flow						
The majority of Information led projects are either on hold due to COVID-19 or not due to start until later in the financial year.	Q1					No update available at this stage.
The majority of Information led projects are on track for completion.	Q2		G			The majority of Information led projects are on track for completion.
The majority of Information led projects are on track for completion.	Q3			G		The majority of Information led projects are on track for completion.
The majority of Information led projects are on track for completion.	Q4				G	The majority of Information led projects are on track for completion.
Maintain/Improve Digital Infrastructure						
Deliver Capital Programme for 2020 2021 as defined within plans	Q1					
Deliver Capital Programme for 2020 2021 as defined within plans	Q2					
Deliver Capital Programme for 2020 2021 as defined within plans	Q3					
Deliver Capital Programme for 2020 2021 as defined within plans	Q4					

The year end overspend at the 31st March 2021 is due to unachieved savings. The position includes costs of £532K related to Covid costs which have been funded by Welsh Government this financial year. Overspend in ICT was compensated by under spends in other areas. Multiple projects currently in progress.

WCCIS project is currenty on hold and funding for Office 365 rollout has recently been agreed. Invest to save project funds has also been agreed for Digital Dictation. Funding also made available for Business Intelligence Unit and Access to health records. Funding also agreed for Digital Health Records. Pressure on budget will continue in 2021-22.

Revenue	Annual Budget £'000	Year to Date Budget £'000	Year to Date Actual £'000	Year to Date Variance £'000	Year End Forecast £'000		Risk
Achievement against Revenue Resource Limit	19,717	19,717	20,062	345	345		Red

Cost Improvement Programme		2019-20 Savings Target b/f £'000	2019-20 Additional Savings Target B/f £'000	2020-21 Savings Target £'000	2018-19 Recurring avings Achieve £'000	2018-19 Non Recurring Savings plans £'000	Risk
Savings Plans		-620	-447	-785	71	0	Red

Capital: The discretionary capital programme has resulted in an allocation of £1.5m for 2020/21. (Previous years were circ £3m). This decrease is principally due to Covid-19 whereby the Health Board may be required to pay for elements of expenditure to date.
Appendix A, overleaf, reflects the current agreed capital schemes within the programme with business cases now being completed. Pre-sales and procurement activities have already commenced where required.

Funding	Scheme	Values						
		Approved Allocation From CRL	Sum of Brokerage	Approved Budget	Expenditure to Date	Budget less Spend	Estimated Out-turn	Sum of Annual Variance calc
All Wales	National Patient Administration System-Infrastructure & Hardware	423,000	73,000	496,000	-	496,000		(496,000)
	Clinical Information System-Emergency Dept-Configuration, Integration, Migration Suppliers	366,000	16,000	382,000	780	381,220	780	(381,220)
	PAS-Configuration, Integration, Migration Suppliers			-	45,079	(45,079)	45,079	45,079
	PAS-Archive & Continuity Suppliers			-	-	-		-
	PAS-Informatics Staff			-	348,819	(348,819)	348,818	348,818
	PAS-Operational Staff			-	-	-		-
	Clinical Information System-Emergency Dept-Infrastrucure & Hardware			-	363,864	(363,864)	363,864	363,864
	Clinical Information System-Emergency Dept-Informatics Staff			-	45,506	(45,506)	45,505	45,505
	Clinical Information System-Emergency Dept-Operational Staff			-	-	-		-
	Remote Access Software			-	-	-		-
	Expand Network-Field Hospitals			-	-	-	-	-
	27 Home Reporting Stations-Radiology	167,994		167,994	167,994	0	167,994	-
	Additional Laptops & printers	150,169		150,169	150,169	(0)	150,169	-
	3 Interactive Screens-Field Hospitals	17,561		17,561	17,561	0	17,561	-
	Additional Laptops for remote working Covid 19	842,000		842,000	823,884	18,116	823,884	(18,116)
	Laptops-Community Resource Teams	20,000		20,000	19,454	546	19,455	(546)
	Laptops-Community Nursing Groups	284,000		284,000	283,642	358	283,642	(358)
	LINC Hardware	40,000		40,000	-	40,000		(40,000)
	Server Hardware for Patient Communications Portal	30,000		30,000	-	30,000	-	(30,000)
		2,340,724	89,000	2,429,724	2,266,750	162,974	2,266,751	(162,974)
Discretionary	Staff Recharges			-	-	-		-
	PSBA (Wide Area Network) Circuit Upgrades			15,000	(9,220)	24,220	(9,220)	(24,220)
	Core Telephony Switch Upgrade			150,000	156,024	(6,024)	156,023	6,023
	Data Centre Design & Refit-Glan Clwyd			80,000	42,925	37,075	42,925	(37,075)
	Upgrade Perimeter Security			-	(3,300)	3,300	(3,300)	(3,300)
	Single Sign On			-	(16,237)	16,237	(16,237)	(16,237)
	Telepath Hardware & Software-Pathology			-	(24,164)	24,164	(24,164)	(24,164)
	Audio Visual System-Clinical Training Wrexham Maelor			-	-	-		-
	Upgrade Integrated Clinical Environment System-Haematology			-	(1,760)	1,760	(1,760)	(1,760)

Cyfarfod a dyddiad: Meeting and date:	Digital Information and Governance Committee 18.06.2021
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Informatics Annual Operating Plan 2021-2022
Cyfarwyddwr Cyfrifol: Responsible Director:	Chris Stockport, Executive Director Primary and Community Care
Awdur yr Adroddiad Report Author:	Liam Allsup, Business Planning and Improvement Manager
Craffu blaenorol: Prior Scrutiny:	Informatics Senior Management Team
Atodiadau Appendices:	Appendix 1 – Informatics Annual Operating plan 2021-2022

Argymhelliad / Recommendation:

The Digital Information and Governance Committee is asked to approve the Informatics Annual Operating Plan 2021-2022.

Please tick as appropriate

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval	**x**	**Ar gyfer Trafodaeth For Discussion**		**Ar gyfer sicrwydd For Assurance**		**Er gwybodaeth For Information**	
If this report relates to a 'strategic decision', i.e. the outcome will affect how the Health Board fulfils its statutory purpose over a significant period of time and is not considered to be a 'day to day' decision, then you must include both a completed Equality Impact (EqIA) and a socio-economic (SED) impact assessment as an appendix.						**Y/N to indicate whether the Equality/SED duty is applicable**	**N**

Sefyllfa / Situation:

The purpose of this report is to provide the Digital Information and Governance Committee with an overview of the projects and activities outlined within Informatics Annual Operating Plan 2021-2022.

The Annual Operating Plan is derived from our 2021/2024 Digital Strategy actions our Corporate Programme Actions and additional service actions. This plan provides a mechanism for assurance on behalf of the Health Board that legislative and regulatory responsibilities are being met by the Informatics Services and provides additional detail on what Informatics will accomplish over the coming year to support the Three-Year Plan and its long-term vision.

Cefndir / Background:

The Informatics Operational Plan is a service plan that enables the delivery of BCUHB Corporate Plan. It has 7 strategic principles that all projects link to and are reported under.

The plan is updated on an annual basis but the projects within may have a wider timespan for delivery. The yearly activities and projects that will be carried out by Informatics have been identified and will outline the projects/programmes targets to work toward fulfilling the goals and objectives set within the Digital Strategy.

Some actions will be reported annually in line with the Digital Strategy reporting requirements.

Asesiad / Assessment & Analysis

Strategy Implications

This Operational Plan enables the Living Healthier, Staying Well strategic approach.

Wellbeing and Future Generations – the 5 ways of working:

This Operational Plan delivers on the following 5 ways of working

Long Term – We assess digital systems to ensure that they meet future needs and can work with other existing systems

Integration – Some of our systems that we are working on support the delivery objectives of other partners i.e. WCCIS

Involvement – Patients, Staff and key stakeholders are involved in finding the best solutions. We ensure that we are involved when national solutions are being developed to ensure they meet the organisations/patient's needs.

Collaboration – We work across the organisation using a collaborative approach, the systems have to meet the needs of the system owners.

Prevention – We will aim to put solutions in place that can prevent service failure i.e. text reminders to reduce the number of Did not Attends.

Financial Implications

The revenue that we have secured is identified within the Digital Strategy. Not all revenue has been identified and will be subject to Business Cases and Prioritisation. Some projects are being nationally led so we do not have the costings for these yet.

Risk Analysis

The key risk's to the implementation of the Annual Operating Plan is the funding and resources required to deliver.

Legal and Compliance

None.

Impact Assessment

No overall equality impact assessment has been undertaken on the Operational Plan, but we are working with the Digital Communities Wales to understand the key data and information in relation to digital inclusion for the overarching Strategy.

Experience / Enabler	Action / Project Ref.	Risk / Regulatory / Policy Ref.	Action / Project	Output(s) / Success Measure *Please describe how you know when the action is complete*	Lead	Action / Project Qtr. Start	Action / Project Planned Qtr. End	AOP 20/21 Final Status	QTR1	QTR2	QTR3	QTR4	QTR1 Updates	QTR2 Updates	QTR3 Updates	QTR4 Updates	Digital Strategy action	Corporate Action	Annual Operating Plan
Enabled Patients and Carers	1.8		To embed a user-centred design approach into the implementation of patient focused systems.	User centre designed training delivered. Project management framework updated to reflect user centre design.	Head of PAI	2021/22	QTR4										Yes		
Enabled Patients and Carers	1.16		Promote the “Finding Health Information Online” leaflet	Patients and carers are informed of the "finding Health Information Online" leaflet to gain better awareness of the initiatives incorporated to support them.	Head of Informatio n	2021/22	TBC										Yes		
Enabled Patients and Carers	1.11		To keep up to date with the Technology Enabled Care (TEC Cymru) Centre to identify and prioritise TEC projects for care closer to home.	Bi-annual update to SMT.	Head of PAI	2021/22	QTR2 and QTR4										Yes		
Connected Staff	2.4		Implementation of the Welsh Patient Administration System - Single Instance		Head of PAI	2023/24											Y		
Connected Staff	2.7		Implementation of user centred design in the development / implementation of new systems.	User centre designed training delivered. Project management framework updated to reflect user centre design.	Head of PAI	2021/22	QTR4										Yes		
Connected Staff	2.8		Implementation of a Community Information Sharing System	Business Case approved, confirmation of funding. Go live to be added.	Head of PAI	2021/22	Quarterly updates needed. Completion needs to be determined.										Yes		
Connected Staff	2.15		Implementation of Symphony / WEDS	Phase 1 - West MIU 30th April (QTR1). Phase 2 - Wrexham and Mold MIU (QTR3).	Head of PAI	2021/22	Will need quarterly updated - Completion QTR4										Yes		
Connected Staff	2.17		Feasibility of a Digital Ward	Full review of all systems within wards.	Head of PAI	2021/22	QTR4										Yes		
Strengthened Digital Foundation	3.7		Implementation of WPAS - Single Instance	Delivery of a single patient administration system Welsh Patient Administration System (WPAS) -across BCUHB. This will streamline the care process and enable up to date accurate information to be available for service delivery across the Health Board. Improve the ability to manage patient pathways seamlessly throughout the hospitals within the Health Board.	Head of PAI	2023/24											Y		
Strengthened Digital Foundation	3.8		Implementation of a system that enables sharing patient data with our key partners	Agreed information sharing agreement	Head of PAI	2021/22	QTR3										Yes		
Strengthened Digital Foundation	3.11		Undertake integration assessments when implementing any new systems	WPAS integration assessment	Head of PAI	2021/22	QTR1										Yes		
Strengthened Digital Foundation	3.12		Develop a business case to develop a pilot for integration between Primary Care and Secondary Care Systems.	Business Case developed	Head of PAI	2021/22	QTR4										Yes		
Strengthened Digital Foundation	3.24		Undertake a review of the usage of our key systems and provide staff with the support to use the systems better.	Review key systems and guide.	Head of PAI	2021/22	QTR4										Yes		
Strengthened Digital Foundation	3.28		Work collaboratively with NWSSP to strengthen procurement processes, use Value Based Procurement where appropriate and to gain maximum value from our contracts (including Social Value)	Increase knowledge of value based procurement. Review procurement process. Collate value gained from contracts.	Head of PAI	2021/22	QTR4										Yes		

Experience / Enabler	Action / Project Ref.	Risk / Regulatory / Policy Ref.	Action / Project	Output(s) / Success Measure *Please describe how you know when the action is complete*	Lead	Action / Project Qtr. Start	Action / Project Planned Qtr. End	AOP 20/21 Final Status	QTR1	QTR2	QTR3	QTR4	QTR1 Updates	QTR2 Updates	QTR3 Updates	QTR4 Updates	Digital Strategy action	Corporate Action	Annual Operating Plan
Strengthened Digital Foundation	3.29		Develop a whole lifecycle relationship management model (includes contract management)	Risk assess contracts, relationship management model developed.	Head of PAI	2021/22	QTR4										Yes		
Strengthened Digital Foundation	3.3		Annually develop a joint plan for the year ahead with DHCW	Agreed plan is in place and is scrutinised.	Head of PAI	2021/22	QTR1										Yes		
Digital Organisation	3.1		Baseline our Digital Maturity (includes Leadership & Capabilities)	Identify and agree and digital maturity model. Baseline against the agreed model.	Head of PAI	2021/22	QTR4										Yes		
Digital Organisation	5.5		Develop a Communication Plan to raise awareness of the Strategy	Strategy branding and Approve communication plan.	Head of PAI	2021/22	QTR1										Yes		
Digital Organisation	5.6		Re-brand the Informatics Service	Staff engagement plan for rebranding and then implementation of rebranding.	Head of PAI	2021/22	QTR3										Yes		
Digital Organisation	5.8		To integrate the Digital Standards Wales into the Programmes / Project documentation	Corporate approval of digital standards Wales. Review of project management engagement.	Head of PAI	2021/22	QTR4										Yes		
Digital Organisation	5.10		Implement a Management of Portfolio approach which includes a full review of governance of Digital Programmes / Projects	Approve portfolio management strategy.	Head of PAI	2021/22	QTR2										Yes		
Digital Organisation	5.13		Review of Project Management Framework to become more agile	Provision of staff training on agile working and an updated framework.	Head of PAI	2021/22	QTR4										Yes		
Digital Organisation	5.14		Develop and Implement a Programme Management Framework	Programme management framework and all appropriate staff trained.	Head of PAI	2021/22	QTR4										Yes		
Digital Organisation	5.15		Implementation of Management of Portfolio	Provision of staff training on agile working and an updated framework.	Head of PAI	2021/22	QTR2										Yes		
Digital Organisation	5.16		Develop and fully implement a Benefits Realisation Framework (including training and support)	Pilot, training and full approval of a benefits realisation framework.	Head of PAI	2021/22	QTR2										Yes		
Digital Organisation	5.17		Undertake research on the impact of systems on patient safety and outcomes and integrate the findings into the Benefits Realisation Framework	Research paper provided.	Head of PAI	2021/22	QTR2										Yes		
Digital Organisation	5.18		Develop an Informatics 5 year Workforce Planning Strategy and implement	Gain approval and implementation of a workforce planning strategy.	Head of PAI	2021/22	QTR3										Yes		
Digital Organisation	5.19		Fully assess the level of staff engagement in all project engagement and communication plans	Review project health check list and incorporate review of engagement and communications.	Head of PAI	2021/22	QTR4										Yes		
Digital Organisation	5.22		Set up a virtual digital patient group	Engagement with patients to feed into a collaborative plan for wider patient engagement with the Patient Engagement Team.	Head of PAI	2021/22	QTR4										Yes		
Strong Partnerships	6.2		Project Staff to attend training and provided with support to work co-productively	Project staff have been given the necessary training to support them working co-productively.	Head of PAI	2021/22	QTR4										Yes		
Strong Partnerships	6.3		Allocate a Partner Lead from Informatics	A partner lead to be assigned from Informatics.	Head of PAI	2021/22	QTR4										Yes		
Digital Inclusion	7.4		Develop a Digital Inclusion Impact Assessment utilising the Digital Inclusion Checklist	Digital Inclusion Impact Assessment utilising the Digital Inclusion Checklist	Head of PAI	2021/22	QTR4										Yes		
Digital Inclusion	7.5		Develop a Digital Inclusion Impact Assessment for all digital service changes that we make	A Digital Inclusion Impact Assessment is completed for all digital service changes that we make.	Head of PAI	2021/22	QTR4										Yes		

Experience / Enabler	Action / Project Ref.	Risk / Regulatory / Policy Ref.	Action / Project	Output(s) / Success Measure *Please describe how you know when the action is complete*	Lead	Action / Project Qtr. Start	Action / Project Planned Qtr. End	AOP 20/21 Final Status	QTR1	QTR2	QTR3	QTR4	QTR1 Updates	QTR2 Updates	QTR3 Updates	QTR4 Updates	Digital Strategy action	Corporate Action	Annual Operating Plan
Digital Inclusion	7.6		Further develop the relationship with Digital Communities Wales and report on what work they are doing with the Health Board as a way of sharing good practice.	Collaborative working to engage with Digital Communities Wales to determine best practice that is being carried out.	Head of PAI	2021/22	QTR4										Yes		
			Implementation of MTeD - Medicine, Transcribing and Electronic Discharge (WCP)	Medicines Transcribing will improve medicines management by allowing hospital pharmacists to transcribe patient medications electronically, so taking the information from the drug chart at the bottom of the bed and putting this on the Welsh Clinical Portal. This will support the patients from admission to discharge.	Head of PAI	2021/22	QTR4												Yes
			Welsh Patient Referral Service (National On-line Electronic Referral System also known as WAP)	The WPRS (Welsh Patient Referral Service) provides an electronic solution for the management of outpatient referrals from their creation by GP's through the Admin roles carried out in secondary care and on to the appropriate clinicians for e-prioritisation.	Head of PAI	2021/22	QTR4												Yes
			GP Out Of Hours - Welsh System Implementation (All Wales 111 Service System Implementation)	All Wales will be using the 111 service system which will provide health advice and an information service available 24 hours a day, every day.	Head of PAI	2021/22	QTR4												Yes

Experience / Enabler	Action / Project Ref.	Risk / Regulatory / Policy Ref.	Action / Project	Output(s) / Success Measure *Please describe how you know when the action is complete*	Lead	Action / Project Qtr. Start	Action / Project Planned Qtr. End	AOP 20/21 Final Status	QTR1	QTR2	QTR3	QTR4	QTR1 Updates	QTR2 Updates	QTR3 Updates	QTR4 Updates	Digital Strategy action	Corporate Action	Annual Operating Plan
This was an action under the recommendation of the HASCAS/Ockenden Imporvement Board that has now been transfered to the DIGC for monitoring (the reporting route is quite convoluted due to the high profile of this and the significant impact for the organisation)	1.1	HASCAS Rec 9 ICO (a9, b9, a13, c9 IA (ISS.1,ISS.2 ISS.2, HR1 PRG RR 01 HR1	Y	Support BCU's standards compliance in respect of patient records storage, processes and management arrangements pan-BCU by (i) review the progress against the recommendation actions for the areas in scope of Stage 1 Baseline Assessment and (ii) Stage 2 onwards - apply this approach as good practice in line with the work of the IG Toolkit.	Report outlining the findings and the options for mitigation to: ~ PRG ~ IGG ~ Exec Team ~ DIGC ~ F&P Committee (if funding req)	Wendy Hardman/ Nia Harrison	Qtr. 1 (April to June)	Qtr. 4 (Jan to Mar)	N/A	On Target								Yes	
This is a corporate responsibility to address the long term location of the TGC file library and is featured on other corporate plans/Datix which we have to be aware of	2.1	SRR # PRG RR 02 YGC Site RR #	Y	Consult with Estates and Planning departments on identifying suitable and 'fit for purpose' options for the long-term location for the acute patient records in Central	The library facilities in both the portacabin and Ablett locations (as a minimum) have been moved into a long-term 'fit for purpose' building on or close to the YGC Main Hospital Site	Danielle Edwards/Jane Carney	Carried over from 2019/20	Qtr. 4 (Jan to Mar)	Off Target	Off Target					*AOP 2020/21 Last Update: Meeting to review the status of the Mental Health development business case is planned for April which will inform the next steps for this long standing action*			Yes	
Connected Staff	2.3		N	To trial agile working within a shared location to create a collective base for the DHR/DDSR project teams to work from (taking account of new ways of working post-Covid)	Staff have access to hot desks within a shared location to balance alongside home and hospital site working; supporting an engaging deliver of the projects.	Danielle Edwards/Andrea Williams	Qtr. 1 (April to June)	Qtr. 3 (Oct to Dec)	N/A	On Target									Yes
Connected Staff	3.3	DS 2.14	Y	Improving Assurance of Results Management (Stopping Printing Results)	A 100% take up of 'Electronic Test Requesting' for tests in scope To have a viable application/system to manage the 4 key steps of results management; To have stopped printing results for the tests in scope of Objective 1; To have assurance on the management of results via a 'dashboard tool' in use within BCUHB that reports on un-viewed and/or non-actioned results, by speciality, clinician and test	Danielle Edwards/Angharad Wiggin	Carried over from 2019/20	Qtr. 1 2022 - 2023	Experiencing Issues	Experiencing Issues					*AOP 2020/21 Last Update: (WS1) - WCP 3.11.4 (moved on version) has been through UAT and whilst all showstoppers for RN have been addressed to a level that can be managed through SOPs, there are some other areas of the release that are still being reviewed. Business Case in process of being submitted to secure the funding required to deliver the project. (WS2) - for the 10 users that have the access (provided directy by NWIS which will in furture need to come with the Project Board agreement to ensrue readiness to govern and support) plans are being formed to test an*		Yes		

Experience / Enabler	Action / Project Ref.	Risk / Regulatory / Policy Ref.	Action / Project	Output(s) / Success Measure *Please describe how you know when the action is complete*	Lead	Action / Project Qtr. Start	Action / Project Planned Qtr. End	AOP 20/21 Final Status	QTR1	QTR2	QTR3	QTR4	QTR1 Updates	QTR2 Updates	QTR3 Updates	QTR4 Updates	Digital Strategy action	Corporate Action	Annual Operating Plan
Connected Staff	3.4	HR1 and DS 2.1	Y	Development of the acute digital health record (Cito DHR) pan-BCU	Deliver the project for the Digital Health Record (4 year project to Nov 2024)	Danielle Edwards/Angharad Wiggin	Qtr. 3 (Oct to Dec)	Beyond Qtr. 4	On Target	On Target					*AOP 2020/21 Last Update: Project remains on track with key deliverables for this quarter: Project Board agreed a formal project start of 1st March 2021 with an established Project Team; Phase 2.0 Project Plan has been agreed to deliver a Minimum Viable Product and implement with two early adopters with key targets for 2021 - Infrastructure ready by late Spring, Test Environment by early Summer, Early Adopters Go Live early Autumn; Engagement with a Clinical Task & Finish Group to design and development of the Cito product for BCU delivered the folder structure; risk sub-group is*		Yes		
Enabled Patients and Carers	3.6	DS 2.13	Y	Digitise the clinic letters for outpatients through implementation of Digital Dictation and Speech Recognition project (2 year project to June 2022)	Clinic letters are digitised and available electronically pan-BCUHB, offering the option of speech recognition and device dictation; with the product in use within the WEST prior to the migration from PIMS to WPAS in May (key dependency).	Angharad Wiggin	Carried over from 2019/21	Qtr. 1 2022 - 2023	On Target	On Target					*AOP 20/21 Last Update: Project remains on track - (West) the recovery activity for the PiMs integration is complete with the integration running well. Cancer Services, Pain Team went live 08/03 followed by the Anaesthetics Team on 15/03. The full roll out is in development with the West Operational leads, with an aim to run on a weekly go live schedule. (Central) Care of the Elderly team went live with EPRO on the 25/01, Gastro team on the 02/02, closely followed by Renal team 03/02 and Community Paediatrics planned 12/04. The Project team will take advantage of any*		Yes		
Connected Staff	3.7	DS 2.2	Y	Write the WNCR Business Case to secure funding for the roll out of the national product for the digitisation of Adult Nursing Documentation.	WNCR Business Case presented for approval to: ~ Health Board Review Group ~ Executive Team ~ Digital & Information Governance Group ~ Finance & Performance Committee ~ (possibly) Health Board	Jane Brady	Carried over from 2019/22	Qtr. 3 (Oct to Dec)	Off Target	Experiencing Issues					*AOP 20/21 Last Update: Due to pressures with the Nursing Lead supproting IPC (Covid) and other competing priorities within the Informatics team this was delayed, however work has picked back up with this to complete over the next few weeks as a draft for review, but will roll into next AOP year.*		Yes		

Experience / Enabler	Action / Project Ref.	Risk / Regulatory / Policy Ref.	Action / Project	Output(s) / Success Measure *Please describe how you know when the action is complete*	Lead	Action / Project Qtr. Start	Action / Project Planned Qtr. End	AOP 20/21 Final Status	QTR1	QTR2	QTR3	QTR4	QTR1 Updates	QTR2 Updates	QTR3 Updates	QTR4 Updates	Digital Strategy action	Corporate Action	Annual Operating Plan
Connected Staff	2.9		CPAWP: Full roll out of Office 365 Phase 1 (E-mail and office migration)	This will fulfil the requirements of the Business Case.	Head of ICT	2020/21	QTR1										Yes		
Connected Staff	2.10		CPAWP: Roll out of the Office 365 Applications Suite (productivity) Phase 2	Fulfilled the requirements of the Business Case. Successful replacement of business and clinical processes utilisation the Microsoft 365 application suite to achieve standardisation and automation where possible across the Health Board.	Head of ICT	2021/22	QTR4										Yes		
Connected Staff	2.11		CPAWP: Implementation of Single Sign on	Clinical staff will only require to sign into a device once to then be granted access to the multiple clinical applications they use to carry out their clinical role. Once implemented this will increase efficiency and save time to clinical staff to carry out their clinical duties.	Head of ICT	2021/22	Awaiting feedback										Yes		
Strengthened Digital Foundation	3.1		Using Optical Spectrum Access (OSA) technology over dedicated optical fibre circuits to increase bandwidth and resilience between Data Centres and District General Hospitals.	This will allow the Health Board to virtualise its two strategy key data centres allowing them to be treated as a single logical entity increasing resilience and high availability across technologies.	Head of ICT	2021/22	QTR2										Yes		
Strengthened Digital Foundation	3.2		Increasing bandwidth to Community Hospitals and Health Centres utilising Welsh Government funding made available via the North Wales Economic Ambition Board Local full fibre network (LFFN).	It will Improve the performance and availability of the business and clinical applications as they consume increased bandwidth.	Head of ICT	2021/22	QTR4										Yes		
Strengthened Digital Foundation	3.3		Continuously building additional WiFi capacity and extended coverage for improved corporate and patient access	This programme of work will provide improved access to technology from any site, from any medium providing business critical WiFi with enhanced availability and performance. This will further benefit the increased use of mobile applications at bedside.	Head of ICT	2021/22	QTR4										Yes		
Strengthened Digital Foundation	3.4		Finalise migration of PC and Laptop estate to Microsoft Windows 10 and reduce hardware lifecycle to enhance user experience and productivity	Ongoing replacement programme	Head of ICT	2021/22	QTR4										Yes		
Strengthened Digital Foundation	3.5		Develop software deployment methods to enable rapid roll-out of PC's, Laptops, Tablets and Mobile Phones	Ongoing replacement programme	Head of ICT	2021/22	QTR4										Yes		

Strengthened Digital Foundation	3.6		Continued roll-out of Microsoft Office 365 to further support collaboration.	Improved communication and agile capability with better utilisation of mobile devices such as Laptops, Smartphones and Tablets. Providing the underlying support for bring your own device (BYOD).	Head of ICT	2021/22	QTR4										Yes		
Strengthened Digital Foundation	3.13		Completion of move to fully virtualised server architecture to support hybrid cloud infrastructure.	Provide hybrid cloud infrastructure enabling the Health Board to consume services to meet changing service requirements.	Head of ICT	2021 - 2024	QTR4										Yes		
Strengthened Digital Foundation	3.14		Employ Storage Virtualisation technologies to create a demand responsive and resilient storage architecture	Provide hybrid cloud infrastructure enabling the Health Board to consume services to meet changing service requirements.	Head of ICT	2021/22	QTR4										Yes		
Strengthened Digital Foundation	3.19		Further develop mobile application deployment and device management to better support mobile workforce. AOP Action [L]Review and Roadmap Mobile Device Management Strategy (Year 2 of 3)	Improved communication and agile capability with better utilisation of mobile devices such as Laptops, Smartphones and Tablets. Providing the underlying support for bring your own device (BYOD).	Head of ICT	2021/22	QTR4										Yes		
Strengthened Digital Foundation	3.20		Develop customer engagement.	Customer engagement team working directly with services to fully capture technology requirements in order to inform and align ICT service delivery and meet customer expectations	Head of ICT	2021/22	QTR4										Yes		
Strengthened Digital Foundation	3.21		Develop ICT support processes to achieve Service Desk Institute (SDI) accreditation in order to consistently deliver industry best practice ICT service management	SDI accreditation will be achieved.	Head of ICT	2021/22	QTR3										Yes		
Strengthened Digital Foundation	3.23		Upgrade WLIMS	National project, does this need to be captured?	Head of ICT	2021/22											Yes		
Strengthened Digital Foundation	3.25		Achieve Cyber Essentials (CE), IASME and ISO 27001 Certification	Achievement of relevant accreditations.	Head of ICT	2021 - 2023	QTR4										Yes		
Strengthened Digital Foundation	3.26		Put in place the necessary requirements to fulfil the statutory Network & Information Systems Regulations Directive (NIS-D)	This can only be achieved by approval and appointment of a Cyber Security Team as detailed in corporate risk register.	Head of ICT	2021/22	QTR4										Yes		
Strengthened Digital Foundation	3.27		Regular internal vulnerability assessments and external Penetration Tests to provide assurance of the Health Boards security posture.	Regular programme of internal self assesmnets and external scrutiny by Welsh Government - Cyber resilience Team.	Head of ICT	2021/22	QTR4										Yes		
			Replacement of Informatics Portal	Undertake options appraisal to explore and consider migrating the Informatics Portal to a new robust, functional and easy to use software platform being resilient by design.	Head of ICT	2021/22	QTR4												Yes

Experience / Enabler	Action / Project Ref.	Risk / Regulatory / Policy Ref.	Action / Project	Output(s) / Success Measure *Please describe how you know when the action is complete*	Lead	Action / Project Qtr. Start	Action / Project Planned Qtr. End	AOP 20/21 Final Status	QTR1	QTR2	QTR3	QTR4	QTR1 Updates	QTR2 Updates	QTR3 Updates	QTR4 Updates	Digital Strategy action	Corporate Action	Annual Operating Plan
Enabled Patients and Carers	1.5		MDP: Development of digital letters and text reminders through NeoPost (Interim until WPAS is live)	Patients able to access hospital (i.e. referral acknowledgement, appointment) letters digitally	Head of Information	2021/22	QTR3										Yes		
Information To Improve	41		Develop a Business Case for the Health Analytics Unit	Business Case will provide justification, support and capacity for the Health Analytics Unit to be delivered.	Deputy Head of Information	2021/22	QTR4										Yes		
Information To Improve	4.2		Increase the use of BI Dashboards	A self-service tool to support staff to easily access data with increased effciency to review relevant real-time data.	Deputy Head of Information	2021/22	QTR4										Yes		
Information To Improve	4.4		Review of Power BI and IRIS	Power BI will be the default for the majority of reports published. Programme of replacement for existing IRIS reports suitable for Power BI (influenced by dataset availability in the new warehouse (DW2))	Deputy Head of Information	2021/22	QTR4										Yes		
Information To Improve	4.5		Pilot Robotic Process Automation	A pilot will be populate WPAS with ethnicity and mobile telephone numbers from WIS to provide up to date patient detail. Increased population of mobile numbers will allow greater use of text reminder services.	Deputy Head of Information	2021/22	QTR3										Yes		
Information To Improve	4.7		Increased Automation of Clinical Coding	Kathryn to Discuss with Dafydd Ap Gwyn	Head of Information	2021/22	?										Yes		
Information To Improve	4.8		Establish a Real-Time Messaging Framework	This will increase the frequency of updates / refreshes to IRIS allowing for closer to real-time reporting for key datasets Frame work in place (build in BCU for national use) Pilot with WAST and C&V Data Extend pilot to BCU / WAST Data	Head of Information	2021/22	QTR2										Yes		
Strengthened Digital Foundation	4.1		Provide access to modern data toolkits to support advanced analytics	Will provide better way of working through standardisation to support staff.	Head of Information	2021/22	QTR4										Yes		
			Quality Assurance Framework	Needs discussion	Head of Information	2021/22	QTR4												Yes

Cyfarfod a dyddiad: Meeting and date:	Digital and Information Governance Committee 18th June 2021
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Informatics Quarterly Assurance Report; Quarter 4
Cyfarwyddwr Cyfrifol: Responsible Director:	Chris Stockport, Executive Director Primary and Community Care
Awdur yr Adroddiad Report Author:	Dylan Williams, Chief Information Officer, *et al*.
Craffu blaenorol: Prior Scrutiny:	Chief Information Officer and Executive Medical Director
Atodiadau Appendices:	Appendix 1

Argymhelliad / Recommendation:

The Digital and Information Governance Committee is asked to:-

1. Note compliance with legislative and regulatory responsibilities which relate to the Informatics Services and
2. To advise the service of any additional metrics required to improve assurance.

Please tick as appropriate

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		**Ar gyfer Trafodaeth For Discussion**		**Ar gyfer icrwydd For Assurance**	**x**	**Er gwybodaeth For Information**	
If this report relates to a 'strategic decision', i.e. the outcome will affect how the Health Board fulfils its statutory purpose over a significant period of time and is not considered to be a 'day to day' decision, then you must include both a completed Equality Impact (EqIA) and a socio-economic (SED) impact assessment as an appendix.						**Y/N to indicate whether the Equality/SED duty is applicable**	**N**

Sefyllfa / Situation:

The purpose of this report is to:

1. Provide the Digital and Information Governance 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.
2. For DIGC to discuss the content of further assurance reports.

This is the final report for the 2020/21 financial year and highlights the impact of Covid-19 upon Informatics core business. It is evident, that COVID has and continues to create further demand for Informatics services over and above what was in current operational plans and priorities.

Overall informatics has maintained a level of compliance with existing measures and actions. However, there are some issues of significance that have affected performance:

- Clinical coding has 2 overdue audit recommendations due to COVID and its impact on staffing, it was anticipated that these would be resolved during QTR4 but unfortunately due to an increase in COVID pressures this was not possible.

- The National Target for Compliance Audit has been postponed to 2021 to due to COVID. There was no external audit on Electronically Coded Data during 2020.
- There remain delays with a number of national system projects;
    - The WPAS project continues to report a delay however integration activities have commenced to assess the viability of a West into Central instance proposal.
    - WCCIS remains a high-risk project and an updated business case is being developed.
- Significant progress has been made upgrading machines to Office 2016 during quarter 4 and the Windows 7 upgrade programme has recommenced post COVID.

Cefndir / Background:

This report 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.

The Informatics Quarterly Assurance Report is an evolving document that will continue to be developed to meet the needs of the committee. The committee is encouraged to advise of any additional requirements.

This is the final Assurance report of the 2020/21 financial year.

Asesiad / Assessment & Analysis

Strategy Implications
This Operational Plan enables the Living Healthier, Staying Well by providing assurance on the work of Informatics.

Financial Implications
Each audit recommendations and projects will have their own financial implications.

Risk Analysis
The risk of not providing appropriate level of assurance to DIGC.

Legal and Compliance
This report provides assurance in meeting legal and compliance related requirements as detailed in the report.

Impact Assessment
No impact assessment has been undertaken.

Informatics Quarterly Assurance Report – 2020/21 Quarter 4

The purpose of this report is to provide the Digital and Information Governance 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

Contents

This report will continue to evolve to meet the requirements of the committee based upon direction provided

1. National Audit Office Reports

The majority of recommendations that were specified as part of the **Wales Audit Office 2014 & 2018 Clinical Coding Audit** have now been implemented. Table 1 details the total number of recommendations provided and classifies their position over the past four quarters.

Table 1; Status of Clinical Coding 2014 & 2018 recommendations.

Summary of status	Total Number of Recommendations	Implemented	In Progress	Overdue	Superseded
Qtr4	13	10	0	2	1
Qtr1	13	10	0	2	1
Qtr2	13	10	0	2	1
Qtr3	13	10	0	2	1
Qtr4	13	10	0	2	1

Whilst progress continues, the table also highlights that two recommendations are overdue. Both overdue recommendations have been delayed due the coding departments reduced staffing and coding completeness prioritisation during the COVID crisis.

Recommendations which are overdue are to: -

1. "Introduce a single coding policy and procedure across the heath board which brings together all practices and processes to ensure consistency. The policy and procedure should include ensure coding practices are well described". This recommendation had an initial deadline of 18.11.2019 (2018 rec2a)

Unfortunately, the COVID crisis has prevented further progress with this recommendation. However, a revised policy is scheduled for initial review at Informatics Senior Management Team on the 9th June 2021 and will progress through the process for approval at the Digital and Information Governance Committee (DIGC) meeting scheduled for 10th September 2021.

2. Introduce a single coding policy and procedure across the Heath Board which brings together all practices and processes to ensure consistency. These should address variations in practices across the three sites.

All Standard Operating Procedures which supplement the policy are listed for review and approval once the coding policy has been approved and is live following DIGC on the 10th September 2021, these will be reviewed and implemented.

2. Compliance

2.1 Clinical Coding; National Coding Targets exist for clinical coding completeness and clinical coding accuracy. They form part of the Welsh Government NHS delivery framework, this details how NHS Wales will measure and report performance.

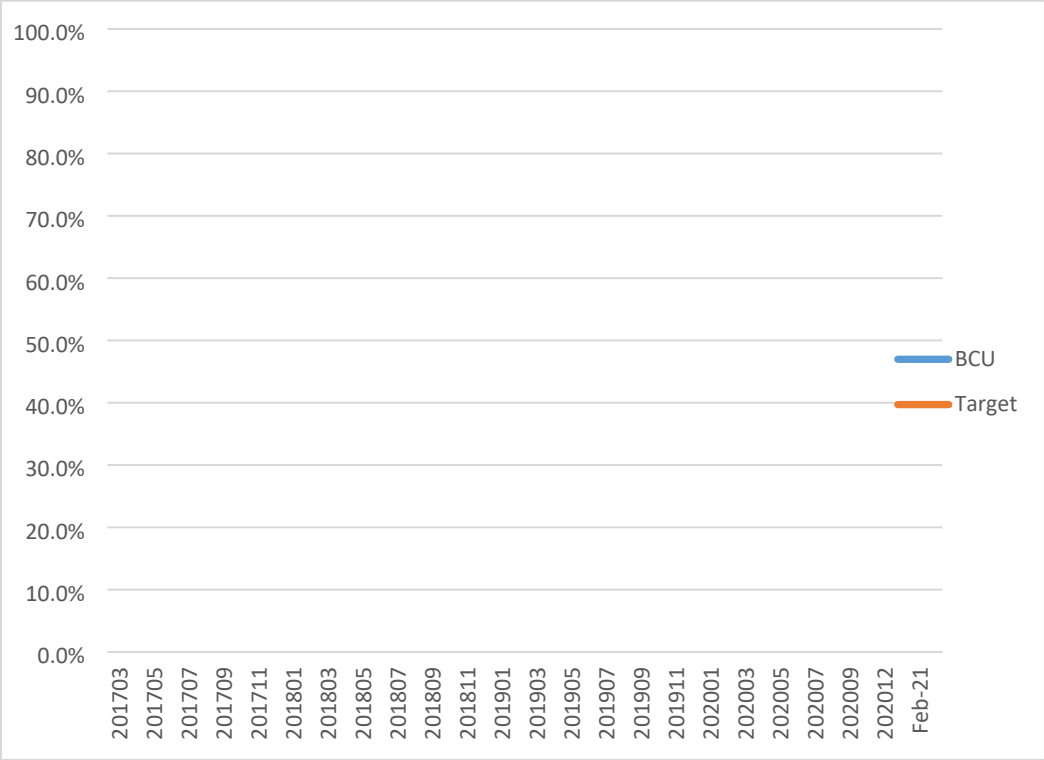
There are several reasons as to why clinical coding completion in a timely manner is vital. Examples provided by Welsh Government include to allow monitoring of treatment effectiveness and clinical governance, to monitor public health trends and to enable assessment and scrutiny in delivering the condition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

The coding completeness in BCU for February 2021 was 94.8% against the National target of 95%. (This target measures the

percentage of clinically coded episodes within 1 month of episode end date).

The following graph depicts how the Health Board has improved its compliance since March 2017 to reach National target compliance.

Figure 1; BCU's Coding Compliance.



In addition to the benefits of timely coding highlighted by the Welsh Government, the improvement in coding completeness enables the Health Board to work with timely data to support Freedom of Information requests, Costings, Mortality data and Internal Audit.

An increase in the level of Sickness Absence along with Coding posts becoming vacant has resulted in the department narrowly missing the 95% coding completion during QTR 4. Staff that were on sickness absence have returned and vacancies are out to advert on TRAC currently.

As previously reported, the second National Target of Coding Compliance requires an improvement in the accuracy score attained in the annual National Clinical Audit Program. The National Audit Programme for coding which is conducted by NWIS to review accuracy and compliance with National coding standards commenced their scheduled reviews in BCU at the end of Qtr.2 in 2019. The review concluded that the Health Board achieved the Tier 1 measure target of improving the overall accuracy scoring. The Clinical Coding accuracy increased by 3.41% to 93.03% in the 2019 audit in comparison with 89.62% accuracy scoring in 2018. The 2020 audit has been postponed due to COVID, and it has been confirmed by NHS Wales Informatics Service that the national coding audit program will resume in 2021. It was anticipated that an external audit on electronically coded data would be conducted during 2020, however we are still awaiting confirmation of a date from NWIS for this audit, however this will not replicate the Tier 1 target audit.

We are currently meeting one of the two Tier 1 targets however, due to the 2020 audit being postponed the second Tier 1 target is not applicable at this time.

COVID-19 Coding: As of the 18th March 2021, the coding department have coded 91% of COVID related discharges.

2.2 Patient Records; are subject to a tier 1 risk - *There is a risk that the right patient information is not available when 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 a failure to support clinical decisions for safer patient outcomes and an inability to meet our legislative duties.*

The control and mitigation of this risk will be delivered through the 'Patient Record Transition Programme', the latest updates are:

2.2.1 Digital Health Record (DHR) Project: Status (Green) – *The aim is for a single view of the patient record supporting integration with local and national systems in Wales and beyond.*
Project remains on track with key deliverables for this quarter: Project Board agreed a formal project start of 1st March 2021 with an established Project Team; Phase 2.0 Project Plan has been agreed to deliver a Minimum Viable Product and implement with two early adopters with key targets for 2021 - Infrastructure ready by late Spring, Test Environment by early Summer, Early Adopters Go Live early Autumn; Engagement with a Clinical Task & Finish Group to design and development of the Cito product for BCU delivered the folder structure; risk sub-group is established with register baselined; Data Protection Impact Assessment in place.

2.2.2 Results Management Project: Status (Amber) – *The aim is to address the low assurance by*; *digitising the full results management process, stopping printing results, increasing digital test requesting, providing opportunities for mobilisation of the process and providing assurance reports on the tests not viewed and results not actioned*.
Welsh Clinical Portal (WCP) 3.11.4 (moved on version) has been through User Acceptance Testing and whilst all showstoppers for RN have been addressed to a level that can be managed through Standard Operating Procedures, there are some other areas of the release that are still being reviewed. Business Case in process of being submitted to secure the funding required to deliver the project. (Workstream2 (WS2)) - for the 10 users that have the access (provided directly by NWIS which will in future need to come with the Project Board agreement to ensure readiness to govern and support). Plans are being formed to test an 'Acceptable Use statement to ensure safe practice. (WS3) ETR - improved forms that have been developed by NWIS with local Subject Matter Expert engagement will be available in WCP 3.12. (WS4) Radis 2.4 upgrade planned for later in Spring.

2.2.3 Digital Dictation/Speech Recognition (DDSR) Project: Status (Green) - *aim of delivering a DDSR solution, which will modernise the production and sign off of clinic letters and will be a key contributor to the achievement of a cohesive digitised patient record.*
Project remains on track - (West) the recovery activity for the PiMs integration is complete with the integration running well. Cancer Services, Pain Team went live 08/03 followed by the Anaesthetics Team on 15/03. The full roll out is in development with the West Operational leads, with an aim to run on a weekly go live schedule. (Central). Care of the Elderly team went live with electronic patient reported outcomes (EPRO) on the 25/01, Gastro team on the 02/02, closely followed by Renal team 03/02 and Community Paediatrics planned 12/04. The Project team will take advantage of any gaps to the West roll out plan by seizing the opportunity to address the soft roll out list for Central if and when possible.

2.2.4 (National) Welsh Nursing Care Record (WNCR) Project: Status (Red) – *The admission form and 4 risk assessments have been successfully standardised across Wales. This project will initially (i) roll out these standardised forms and (ii) pilot the national application on adult wards.*
Due to pressures with the Nursing Lead supporting IPC (Covid) and other competing priorities within the Informatics team this was delayed, however work has picked back up with this to complete over the next

few weeks as a draft for review but will roll into next year's Annual Operating Plan.

2.2.5 Access to Health Records Project (ICO Recommendation): Status (Amber) –*This will not only ensure a standardised response to Access to Health Record requests within BCUHB but will digitise the process to ensure future compliance with all aspects of GDPR and the DPA 2018.*

The team has now stabilised with significant improvements tested and now are now working as business as usual. The backlog has been completely cleared and Breaches are in single figures where occurring in the month. Roll out to West has been successfully carried out with all requests for copies of patient records now being managed through the ATHR Service. Two new Band 2 Trainee ATHR officers started in March which was funded by surplus revenue centrally following the submission of an SBAR. Last remaining step to be undertaken was to transfer the scanning of patient's paper record from the site Health Records teams to the centralised service – recruitment to the posts to manage this task as been completed as stated above. Budget for these additional B2's was centrally financed last year and is a cost pressure for 2021/22, with a mitigation to over-staff the budget if funding is not supported by the accrual from staff turn-over (vacancies not being filled). This action is now CLOSED - next action for 2021/22 annual operating plan is to monitor to ensure change has embedded.

2.2.6 Baseline PAN-BCU Project: Status (Closed) – *In response to the HASCAS/Ockenden recommendations, there has been a portfolio change so that <u>all</u> patient records (circa. 25 types beyond 'acute') are now under the responsibility of the Executive Medical Director. This will require (i) a full baseline of all patient records held to measure their compliance against legislation and standards of good record keeping, and (ii) develop recommendations to deliver this in the future.*

The Stage 1 report is finalised with a clearly defined approach to undertaking this pan-BCU and findings from the primary scoped areas of Acute, Mental Health and CAMHS. Report will be provided to Patient Records Group, Information Governance Group and Digital and Information Governance Committee (in absence of HASCAS Improvement group). This will close this action in respect of the HASCAS recommendation for Mental Health and move activity into business as usual.

2.2.7 Update on Other Key Compliance Issues:

National Infected Blood Inquiry (IBI) - *Whilst IBI Project Board is satisfied that controls are effectively in place to manage the responses to the inquiry, there is a significant storage issue due to the embargo on the destruction of any casenote types for the period of the inquiry (est. 5 years).*

This issue remains in good control and is cited for visibility as a live issue. Highlight reports for the management of off-site storage arrangements to cope with the embargo on destruction are provided to the Patient Records Group.

Relocation of the YGC File Library – *The YGC File Library Programme Board needs to develop a single business case for a new pan-central file library to relocate (as a minimum) the acute records from both the Ablett and the portacabin – taking account of the plans for a DHR, by April 2021 in line with the Mental Health Service Business Case.*

Meeting to review the status of the Mental Health development business case is planned for April which will inform the next steps for this longstanding action

2.3 National System Project Updates

2.3.1 WPAS West Project: Status (Amber) – *Phase 3 of the Welsh Patient Administration Programme. This will replace the Commercial PAS system in the West and standardise processes relating to this system in other sites.*

The core part of the project continues to be on hold due to NWIS / Digital Health Care Wales (DHCW) prioritising Velindre activities over BCUHB. Planned Data refinement activities for this quarter have been delayed due to delays in the NWIS/Velindre Plan. Some build activities have been continued however a number of key resources have been pull by the organisation to support WIS and Attend Anyway business priorities. Integration activities has been started in this Qtr to assess the viability of a West into Central instance proposal. Outcome will be reported in quarter 1.

2.3.2 WEDS Project: Status (Amber) – *Phase 1 of the Welsh Emergency Department (ED) System is to implement a non-integrated stand-alone version of the system (BCU Symphony) in BCU West including the minor injury units (MIU's). Phase 2 will upgrade the BCU East System including MIU with further extensions to include Central MIU's (phase 3) before a final phase to move all areas onto the fully integrated WEDS solution.*
Some Post Go Live support in ED West continues as ED are yet to commence recruitment. Training in MIU West including LLGH was completed in February (does not include Dolgellau & Tywyn as they are currently closed).

BCU Symphony successfully implemented at Ysbyty Alltwen 23/03/2021. Please note scope of Project has been amended to include Central ED as agreed by January Board.

2.3.3 Welsh Community Care Information System (WCCIS): Status (Red)
An options appraisal has concluded that the project should seek to agree revised contractual terms based on functional delivery, and that these should be reflected in an updated business case, to be developed in the next quarter.

2.4 ICT Security; *is the ability to protect the confidentiality, integrity and availability of digital information assets. A range of tools and processes have and are being adopted within the Health board to support ICT security and keep our assets safe.*

2.4.1 Desktop Standardisation Project: The ICT Services Team are actively engaged in a Desktop Standardisation Project with the following aims;

- To deploy Microsoft Windows 10 version 1903 to all devices where it has not been possible to upgrade to Windows 10 previously.
- To establish a rolling replacement programme, alongside an update process that keeps the estates within 6 months of the latest operating system release, as well as patched to the correct level at the application, operating system and driver.
- To have a standardised desktop, with drive and printer mappings the same across the organisation.
- For all staff to have the same experience using BCUHB ICT services regardless of which location they are accessing them from.

2.4.2 Windows 10 Migration: Please note: The project re-started August 2020 with the upgrade schedule progressing well, however reduced access to clinical areas and staff working from home will limit the number of devices that can be upgraded.

"On the 14th January 2020 Microsoft stopped updating and providing support for Windows 7, as such this is considered "end of life". An agreement has been reached with Microsoft for NHS Wales until January 2021 that they will continue to provide security patches releases only. The desktop replacement programme aims to ensure migration from Windows 7 in line with these timescales. The table

below shows the number of devices within BCUHB on each operating system at the end of each quarter for the current financial year.

Throughout quarter 4 we were able to accelerate the migration from Windows 7 to Windows 10 and over 1,000 devices were either upgraded or replaced. Work continues to work through the remainder of the migrations in conjunction with upgrading the Windows 10 estate to later feature releases

Table 1; QTR4 Operating System data.

Operating System	QTR1	QTR2	QTR3	QTR4
XP	16	15	11	10
Windows 7	4,235	3,633	3,209	2,225
Windows 10	9,167	10,064	10,956	12,590

2.4.4 Operating Systems and Patch Management: Software which supports a computer's or servers' basic functions such as scheduling of tasks is known as its operating system. BCUHB has a several operating systems in use which are detailed in table 2. Table 2 also provides the number of devices using the operating system and where applicable our compliance with "testing and deploying" software updates released by the vendor to support "bug resolution" and security.

To note, Windows patches were not distributed to the entire Health Board during March due to a problematic patch that Microsoft released. These patches have been released in April.

The Office patching figures are still low due to the continued push to replace the older versions of software, we expect this to level out and return to normal within the next quarter. It should be noted that we are unbale to upgrade the remaining Office 2007 machines due to the requirement of PIMS software using Word 2007 for letters.

The Windows 7 programme has recommenced post COVID and work is ongoing to upgrade all machines to Windows 10 and some application dependencies have now been removed.

Table 2; QTR4 Operating Systems compliance data.
Patch Management position March 2021 updates

Operating System	Device Count	% Compliant	% Target
Windows 7	2,136	**98.40%**	90%
Windows 10	13,409	**77.26%**	90%
Office 2007	3,155	94.91%	90%
Office 2010	18	**98.72%**	**90%**
Office 2013	288	**68.77%**	90%
Office 2016	13,740	**86.08%**	90%
Servers	878	**90.1%**	90%
Average Desktop OS		**91.7%**	90%
Average Office apps		**44.1%**	90%
Average all platforms		**75.0%**	90%

2.5 ICT Service Desk; Calls logged with Informatics remain high increasing by 1% from 25,666 in quarter 3 to 25,901 in Qtr4. If we compare Qtr4 from the previous year, calls have increased 9% during the same period. Overall there has been a 20% increase in support calls logged during 2020/2021 as opposed to 2019/2020

It is felt that the ongoing increase in calls relate to the continued support for the management of Coronavirus response and the need to support more staff working from home.

2.6 National and Local System Availability
2.6.1 National Systems:

During the 3 months January to March 2021 there have been 4 incidents of national system failure that have affected BCU Operational and Informatics teams.

To date no related known incidents or harm have been reported.

System failure is categorised as:

- 1 Welsh Clinical Portal (WCP) failure
- 2 WelshPAS (WPAS) failures
- 1 LIMS Failure

Table 3; Systems unavailability (please note that not all downtime length was able to be calculated)

System	Total time of unavailability (approx)
WelshPAS (WPAS) (Community Myrddin and WPAS)	7 hours
Welsh Clinical Portal (WCP)	1 hour 45 minutes
Laboratory Information Management System (LIMS)	1 hour 48 minutes

A combined downtime log has been developed (Local and National Systems) which will be able to calculate the cost of managing system unavailability for Informatics Staff.

2.6.2. Local Systems; with the advent of the security of Network and Information Systems Regulations (NIS Regulations*) in 2018, the way in which we record unplanned outages has changed and been adapted to assist with mandatory reporting under these regulations.

In the last quarter (January 2021 – March 2021), there have been 25 incidents of user affecting unplanned outages.

- 18 Network connectivity incidents.
- 5 Server related incidents.
- 2 responses to external incidents.

***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.

Data Standards Change Notice (DSCN) and Impact Assessments (IA)

DSCN New Releases

There were 7 new DSCN's issued in quarter 4 2020-21, the details are shown in the table below

DSCN	Description	Issue Date	Implementation Date	Update	Status
2021/01	Single Cancer Pathway – Adjustments Data Set – Retirement	03/02/2021	With immediate effect	To retire the Single cancer Pathway - Adjustments data set which was first published on 18/10/2020. There is no impact on the Information Department.	Not applicable
2021/02	Inpatient and Day Case Admissions and First Outpatient Appointments Waiting Times (PP01W) Data Set - Retirement	08/02/2021	With immediate effect	To retire the formal reporting of the Inpatient and Day Case Admissions and First Outpatient Appointment Waiting Times (PP01W) data set. Information Department provided support to the Mental Health service by continuing to report the PP01 locally. We have liaised with colleagues in Performance and Mental Health and developed an alternative report that is now published on IRIS and will be used locally to monitor BCUHB adult mental health waits from April 2021.	Compliant
2021/03	National Cancer Data Standards for Wales – Site Specific – Brain & Central Nervous System (CNS)	08/02/2021	Cancer Informatics Solution (CIS) with immediate effect but no action for HB's	To introduce a new standard for site-specific cancer minimum reporting requirements for tumour site - brain & central nervous system (CNS). The immediate use of this mandate will be used as a framework for the development of the CIS, therefore services/data providers should continue with 'business as usual' in terms of the data being collated and reported. There is no impact on the Information Department.	Not applicable
2021/04	111 Service Final Outcomes	05/03/2021	September 2021	These two DSCN's outline the new standards for 'Final Outcomes' and 'Relationship to Caller' within the newly	Not applicable

				procured NHS 111/ OOH Wales system that will replace the existing Clinical Assessment Software (CAS) and multiple Adastra systems. There is no impact on the Information Department	
2021/05	111 Service Relationship to Caller	05/03/2021	September 2021		Not applicable
2021/06	National Cancer Data Standards for Wales – Site Specific – Skin	25/03/2021	Cancer Informatics Solution (CIS) with immediate effect but no action for HB's	To introduce a new standard for site-specific cancer minimum reporting requirements for tumour site - Skin. The immediate use of this mandate will be used as a framework for the development of the CIS, therefore services/data providers should continue with 'business as usual' in terms of the data being collated and reported. There is no impact on the Information Department.	Not applicable
2021/07	28 days Specialist Child and Adolescent Mental Health Services (sCAMHS) waiting time data collection	31/03/2021	01/04/2021	This DSCN formalises the existing data collection that monitor the performance against the 28-day waiting time target for patients waiting for a first appointment for specialist Child and Adolescent Metal health Services (sCAMHS). Information Department have liaised with key operational staff to confirm the figures they report remain compliant with the DSCN and will submit via the new proforma from May 2021.	Compliant

Impact Assessments (IA)

There were x7 new IA's issued during quarter 4 2020/21, the details are shown in the table below:-

Issued	Description	Deadline	Feedback Provided	Update	Status
13/01/2021	Welsh Emergency Care Data Set - Phase 1:1	27/01/2021	27/01/2021	To obtain feedback regarding the retirement of 'Triage Score' and the proposed changes to 'Triage Category'. Emergency Department colleagues were asked to provide the response that Information Dept made to this IA.	Submit without a response from Wrexham Maelor Hospital
29/01/2021	Recording Group Activity (Clinics and Consultations)	19/02/2021	19/02/2021	This impact assessment aims to explore the approaches taken by health board areas, and to understand whether or not activity meeting the definition of Group Clinics is already being carried out, and if so, to understand how this is being delivered and recorded. The response that was submit was provided by BCUHB operational colleagues.	Submit
02/02/2021	Cardiac Component Waits	16/02/2021	16/02/2021	There is a need to implement a new approach to support cardiac patients to ensure that those most at risk are seen as quickly as possible. This will require the pathway to be managed differently, and the purpose of this impact assessment is to assess the proposed changes, to review the proposed definitions, and to determine whether NHS Wales are capable of adopting this change.	Submit
23/02/2021	SPC - GP Referrals	10/03/2021	09/03/2021	This Impact Assessment seeks to capture feedback regarding two proposals that have been made to allow identification of Cancer Referrals via the Outpatient Referral Dataset. Health Board feedback will help establish how Welsh Government move forward to achieve this requirement.	Submit

01/03/2021 & 24/03/2021	Risk Stratification	15/03/2021 & 01/04/2021	15/03/2021 & 01/04/2021	Monitoring of risk prioritisation, through the local patient administration systems, is now required to provide both internal and external assurance around the safe management of patient pathways. Two new measures are being proposed to capture the number of records at treatment stage that have a risk code applied, and of those categorised as P2, the number and % who are still waiting at the end of the month over their deferred target of 4 weeks. A dataset and associated definitions to support the monitoring of the two new proposed measures is also required, and re-introduction and modification of the retired Elective Admission List Data Set (EAL Ds) is proposed.	Submit
04/03/2021	Deaths Subject to a Universal Mortality Review - Retirement of standard	19/03/2021	04/03/2021	Welsh Government have requested that the standard for Deaths Subject to a Universal Mortality Review (UMR) be retired. This impact assessment requires Health Board's to confirm that they have no additional requirement for the standard.	Submit
11/03/2021	OP MDS	02/04/2021	09/04/2021	It is felt that the existing Outpatient Data Set (OP Ds) is no longer fit for purpose because it supports the traditional OP model which has evolved over recent years. This IA is the first step in work that aims to gain an understanding of stakeholder' use of Data Items in the existing OP Ds and OPR Ds (eg if they are utilised, how and where) and identify any modifications required. There is also a need to consider any changes to the existing scope of these datasets to accommodate those requirements. There is also a requirement for Health Boards to nominate a representative from each of the following departments to sit on a sub group that will support this work: Information & Performance, Operational & Planning, Finance & Clinical.	Submit within the NWIS approved x1 week extension period with insufficient data

The Information team continues to work with colleagues in the services to improve reporting compliance.

Cyfarfod a dyddiad: Meeting and date:	Digital Information and Governance Committee 18/06/2021
Cyhoeddus neu Breifat: Public or Private:	*Public*
Teitl yr Adroddiad Report Title:	Digital Health and Care Wales update to BCUHB Digital and Information Governance Committee
Cyfarwyddwr Cyfrifol: Responsible Director:	Dr Chris Stockport – Executive Director Primary & Community Care
Awdur yr Adroddiad Report Author:	Helen Thomas, Chief Executive Digital Health and Care Wales
Craffu blaenorol: Prior Scrutiny:	Copied to Chief Information Officer and Executive Director responsible.
Atodiadau Appendices:	None

Argymhelliad / Recommendation:							
The Committee is asked to note this report from the Digital Health and Care Wales.							
Ticiwch fel bo'n briodol / Please tick as appropriate							
Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		**Ar gyfer Trafodaeth For Discussion**		**Ar gyfer sicrwydd For Assurance**		**Er gwybodaeth For Information**	✓
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable						**N**	

Sefyllfa / Situation:

Digital Health and Care Wales (DHCW) works with Betsi Cadwaladr University Health Board as well as other Health Boards and Trusts in NHS Wales to deliver digital health and care services which will enable more effective, efficient, and safer decision-making by providing access to content-rich, person-focused health and care data and information.

Cefndir / Background:

This paper updates the Committee on progress of a range of national Digital initiatives in BCU.

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications

N/A

Opsiynau a ystyriwyd / Options considered

N/A

Goblygiadau Ariannol / Financial Implications
N/A

Dadansoddiad Risk / Risk Analysis
N/A

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

N/A

Asesiad Effaith / Impact Assessment

Project	Update
Establishment of Special Health Authority, Digital Health and Care Wales (DHCW)	1. Digital Health and Care Wales was established as a Special Health Authority from 1st April 2021. 2. The interim Chair of DHCW, Bob Hudson, is in post for a 12 month period until November 2021. Welsh Government have recently advertised for the substantive of Chair of DHCW. 3. Appointments have been made for 6 Independent Members, who were in place by 1st April. 4. The Executive posts of Chief Executive, Director of Finance and Clinical Director have been appointed. The new leadership structure for DHCW, which will include the remaining Director posts, is currently in development, and will be progressed by the Board over the summer period.
Welsh Patient Administration System (WPAS)	1. The joint planning assumption is to implement BCU West in May 2022 by adding to the existing BCU Central WPAS implementation. 2. WPAS Technical Oversight Group established which includes DHCW, BCU, Velindre and Cwm Taf Morgannwg. The group is meeting regularly to help coordinate planning of WPAS implementations across NHS Wales, as these implementations are mutually dependent on the same technical resources. 3. All partners are working with WG to strengthen the core capacity of WPAS data migration & integration.

Data Centre Transition Project	1. A Data Centre Transition Project is in place to transition data centre infrastructure currently held in the Blaenavon Data Centre, to a hybrid of a new data centre location and Cloud services. The new data centre is CloudCentres Data Centre (CDC). Some functionality will be migrating to Cloud, such as our Test and Development Systems and Internet Facing Services (DMZ). 2. PSBA Network connectivity has been installed at the new site and services are being physically and logically migrated to a replacement Data Centre through July to September 2021. 3. The physical moves have been scheduled to ensure that they do not impact the WPAS go live that precedes BCU West WPAS. 4. DHCW are working with the Data Centre providers, NHS Wales system suppliers, Cloud providers and Infrastructure suppliers, to enact the migration activity.
WCP & WCP Mobile	1. Results Management project: WCP 3.12.1 includes functionality improvements specifically required by BCU to forward results to a colleague and the recording of action(s). This will be implemented in secondary care later in 2021 which will mean that Pathology results will no longer be printed. 2. A roll out of WCP Mobile application is likely to be planned once WCP 3.11.4 is rolled out.
Welsh Patient Referral System (WPRS)	1. NWIS have appointed a Project Support Manager who will work with BCU to develop a plan to implement WPRS. 2. Kick off meetings have occurred in April & May 2021. 3. BCU are preparing an internal business case as the next step in agreement to take WPRS forward. 4. The implementation plan for WPRS will have technical and resource inter dependencies on the BCU WPAS implementations.
Digitisation of Welsh Nursing Care Record	1. BCU taking WNCR project through local business change and approval process, awaiting final approvals.
Welsh ED system (WEDS)	1. BCU are currently implementing standalone Symphony across the health board. 2. BCU expected to re-join the national WEDS implementation with associated integration, once WPAS single instance complete. 3. Wider WEDS roll out across Wales is being considered for accelerated by WG.

Hospital Pharmacy	1. The roll out of the new Hospital Pharmacy system across NHS Wales has completed to plan in Aneurin Bevan, Cwm Taf Morgannwg and Hywel Dda. 2. BCU were to be the third health board to go live in April 2021 but requested more time to complete readiness activities. 3. The revised go live date is expected to be in Q4.
National Data Resource (NDR)	1. NDR Environment created. Focus areas: • National Data Store initial architecture created • Use of Azure Cloud Collaboration • Laboratory data sets • Social Care data • WAST data • Datix data 2. The NDR programme is also leading on the Open architecture, developing vision and plans for each of the architectural building blocks and will procure and deliver API Management capabilities throughout 21/22.

Strategic engagement

The then NWIS senior leadership team and Informatics colleagues from BCU met in January in the first round of strategic engagement discussions to ensure plans and priorities are shared and aligned. The next meeting will include members of the BCU Executive team, and will enable the two organisations to agree our joint plans.

Cyfarfod a dyddiad: Meeting and date:	**Digital and Information Governance Committee 18th June 2021**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Information Governance Quarter 4 2020/21 Key Performance Indicators (KPI) Report
Cyfarwyddwr Cyfrifol: Responsible Director:	Simon Evans-Evans, Interim Director of Governance
Awdur yr Adroddiad Report Author:	Carol Johnson, Head of Information Governance
Craffu blaenorol: Prior Scrutiny:	Reviewed and approved by • Interim Director of Governance • Data Protection Officer • Information Governance Group *27th May 2021*
Atodiadau Appendices:	Appendix 1 - Key Performance Indicators: Quarter 4 - January 2021 to March 2021.

Argymhelliad / Recommendation:

The Digital and Information Governance Committee is asked to:

- Receive and note the assurance provided in compliance with the Data Protection and Freedom of Information Legislation.

Please tick as appropriate

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		**Ar gyfer Trafodaeth For Discussion**	√	**Ar gyfer sicrwydd For Assurance**	√	**Er gwybodaeth For Information**	
If this report relates to a 'strategic decision', i.e. the outcome will affect how the Health Board fulfils its statutory purpose over a significant period of time and is not considered to be a 'day to day' decision, then you must include both a completed Equality Impact (EqIA) and a socio-economic (SED) impact assessment as an appendix.						**Y/N to indicate whether the Equality/SED duty is applicable**	**N**

Sefyllfa / Situation:

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.

The continuous negative impact on the Health Board`s resources, strategy, tactics and operations following the Covid-19 situation underlines the need for maintaining and improving its information governance practice. This does not only put effective information governance compliance at the heart of the Health Board`s approach to managing Covid-19, but to also move to more dynamic and different ways to working to ensure the safe delivery of its operations, business sustainability and financial viability.

Quarter 1 of 2021/22 will include key indicators for the Assessment of the Asset Register within the report and will be presented to the D&IG meeting in September 2021. This delay is due to reporting timeframe requirements within the legislation and the agreed Committee meeting dates.

Cefndir / Background:

The term 'Information Governance' is used to describe how organisations manage the way information is handled. It covers the requirements and standards that Betsi Cadwaladr University Health Board (BCUHB) needs to achieve to fulfil its obligations that information is handled legally, securely, efficiently, effectively and in a manner which maintains public trust.

Information Governance applies the balance between privacy and sharing of personal confidential data and is therefore fundamental to the health care system, both providing the necessary safeguards to protect personal information and an effective framework to guide those working in health to decide when to share, or not to share.

Asesiad / Assessment & Analysis

Strategy Implications

There is a comprehensive and complex range of national guidance and legislation within which BCUHB must operate, and this KPI report includes compliance with:

- Freedom of Information Request Profile
- Data Protection Act – Subject Access Request Profile
- Information Governance Incidents and Complaints
- Requests for access to information systems (IG10)
- Information Governance Training
- Information Governance Service Desk (IG Portal)
- National Intelligent Integrated Auditing Solution (NIIAS) notifications
- Information Governance Compliance Audits
- Sharing of information
- Data Protection Impact Assessments (DPIAs)

This report provides a high-level analysis, highlighting any trends or issues of significance. Action taken to address the issues of significance and drive continuous improvement is also summarised.

Options Considered

No other options have been considered as compliance is a legal requirement.

Financial Implications

Non-compliance with the legislation can lead to significant fines imposed by the Information Commissioners office.

Risk Analysis

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.

Legal and Compliance

It is a statutory requirement to comply with Data Protection and the Freedom of Information Legislation.

Impact Assessment

Due regard of any potential equality/quality and data governance issues have been addressed during the production of this report.

Appendix 1 - Key Performance Indicators: Quarter 4 - January to March 2021

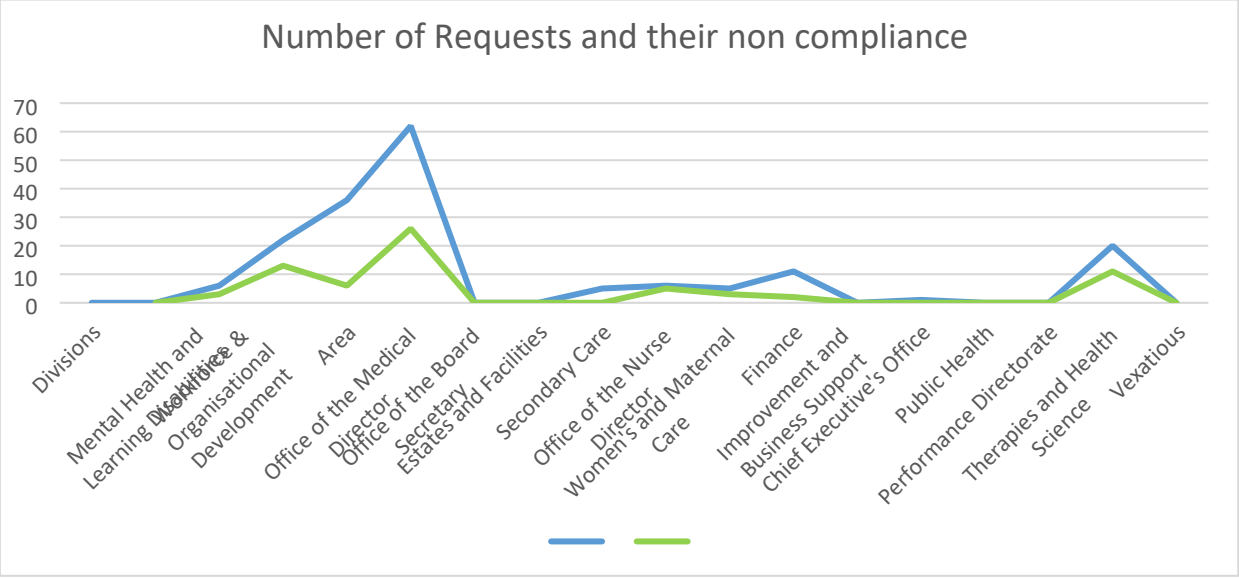
In line with the feedback received from the Digital and Information Governance Committee (D&IG) all future KPI reports will be for the full quarter data.

1) Freedom of Information Requests (FOIs)

The compliance level for responding to a request within the standard of 20 days has decreased to 61% from 77% in quarter 3.

We are continuing to see an increase in the amount of complex requests received into the Health Board resulting in the reduced compliance figures. Some of the ongoing work and lessons being learnt from these complex cases will enable us to deal with similar cases more swiftly in the future. The Health Board is exploring ways to be more open and transparent especially around the publication of commissioned reports and other reports which can be routinely published on our Internet such as waiting times etc. and other corporate information. We are hopeful that this will reduce the amount of FOIs received into the Health Board. The IG Team are continuing to look at ways to streamline the FOI process internally and to try to work closer with our FOI leads in order to improve the number of non-compliant requests in their areas. We also have representatives attending a FOI networking group with Cheshire and Merseyside NHS Trusts to share best practices.

Total number of requests received in Q4: **174** Total number of requests delayed in Q4: **68**

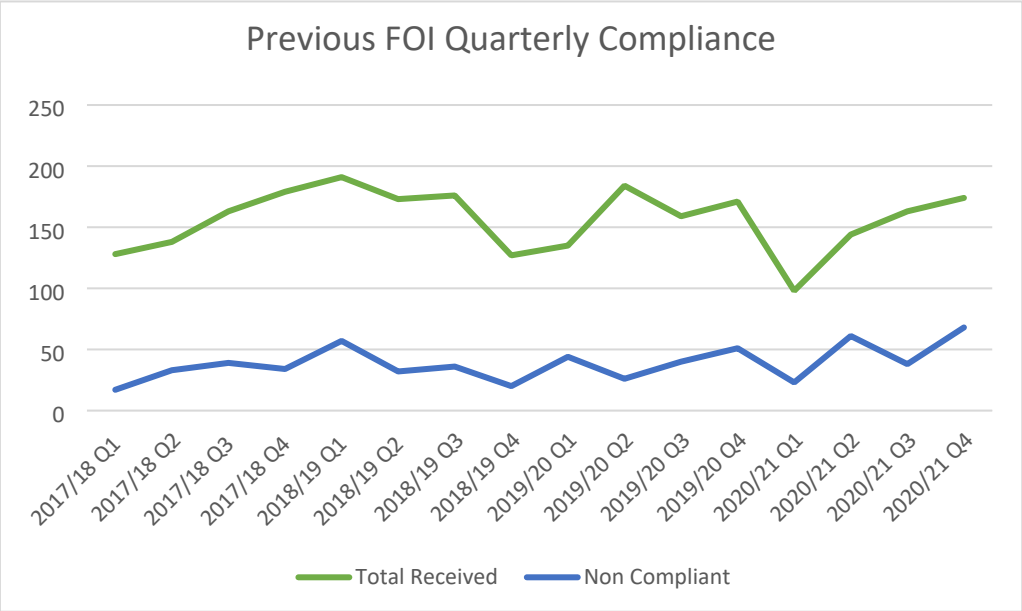


Below is the list of reasons for the delays:

- 42 Delays in obtaining/receiving information from FOI Leads. The top three divisions with the highest amount of delays were:
  - Office of the Medical Director
  - Therapies and Health Sciences
  - Workforce and Organisational Development
- 3 Delays due to Formulation of the response by IG due to complexity.

- 23 Delays due to the late approval by Executive Lead due to the number of complex requests and the validity of the data.

The below chart shows requests received by the Health Board on a quarterly basis, mapped against non-compliance:



FOI Exemption and internal reviews
Please note due to the timeframe permitted under the Act for applicants to request an internal review, some reviews may not be captured in time for this report, however they will be captured within the Information Governance Annual Report.

For quarter 4, please see table below for this detailed breakdown:

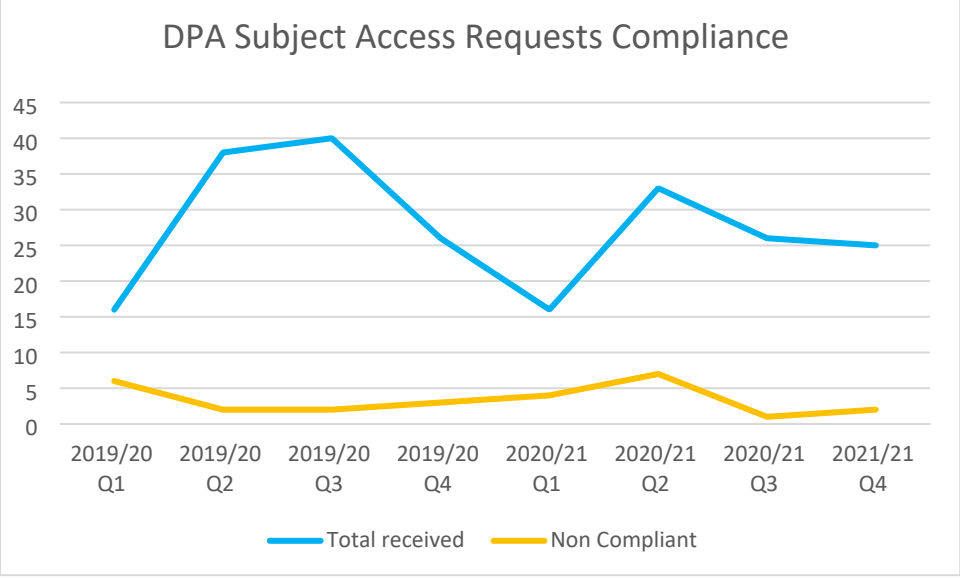
Exemption	Exemption Category	Total	Internal Review	Upheld/ Overturned
Section 10 and 11 of Data Protection Act – Prevent Processing and Marketing	Absolute – No Public Interest Test Required	1	0	N/A
Section 12 – Cost Limit Exceeded	Absolute – No Public Interest Test Required	14	0	N/A
Section 21 - reasonably accessible to an applicant by other means.	Absolute – No Public Interest Test Required	2	0	N/A
Section 40 - Personal Information	Absolute – No Public Interest Test Required	6	0	N/A
No Exemption	N/A	N/A	2	1 x overturned and 1 x outstanding
Total		23	2	

The IG team are currently completing a data cleanse in our reporting tool Datix and we expect the above number of exemptions used in the last quarter to increase due to the way this has been reported previously, this will be reported accurately to the D&IG Committee on the 18th June 2021.

Information Commissioners Office – FOI Complaints
During Quarter 4, the Health Board did not receive any complaints from the ICO in regards to FOIs. The complaint received in quarter 3 is still awaiting an outcome from the ICO with regards to a decision.

2) Data Protection
Subject Access Requests for non-clinical information
The compliance level for responding to a request within the standard of 28 days has decreased slightly this quarter to **92%** from 93% in quarter 3, this is due to the number of email searches we have been have asked to perform which have been vast in their requests and time consuming.

Requests	Total
SAR	15
Verbal SARs	0
Total	**15**
Requests from 3rd Parties	
Solicitors / Local Authority	0
Police	7
Other	3
Total	**10**
Total Requests Received	**25**
Total number of breaches (dealt with outside 28 day timeframe)	**2**
Compliance	**92%**

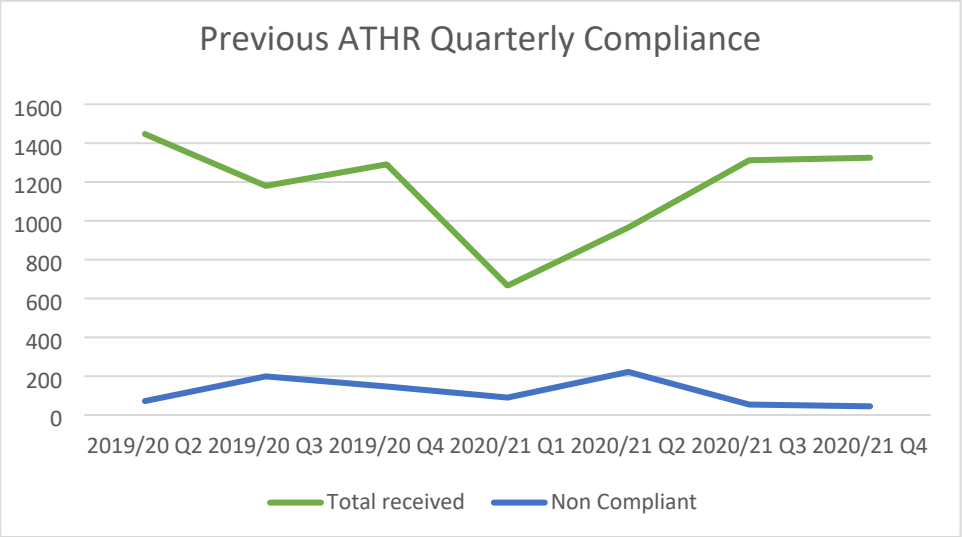


Subject Access Requests (SAR's) for clinical information and requests from third parties

During Quarter 4 we have continued to see a significant improvement in the number of SAR's completed within the DPA timescales from 93% to 97%, however we have seen a slight decrease in Access to Deceased Records requested by 0.2% on the last quarter (100% compliance). It should be noted that there has been an increase in SAR request from Quarter 1 to Quarter 4 of 23%.

Following the approval of the SBAR in quarter 3, additional funding has been received to increase the resource within the Centralised Service and all recruitment processes have now been completed, with one vacancy remaining to be filled, with a start date confirmed for May 2021. This will then provide the Centralised ATHR Service with a full complement of staff. In this quarter the Centralised Service has taken on the final phase of the project, taking on the requests of West, which now brings us in line with the ICO recommendation that all requests for copies of patient records are managed within a centralised service. A communication has been circulated to the Health Board via the corporate bulletin to advise staff that the Centralised ATHR Service is now the central contact for all subject access requests for patient records.

Access to Health Records (ATHR) Requests	**Total**
Type of SAR	
Data Protection Act (Live Patients)	787
Verbal Request	0
* Access to Health Records Act (Deceased Patients)	38
Total	**825**
Requests from 3rd Parties	
Court	280
Police	214
GMC	2
Chargeable Requests (insurance Companies)	4
Total	**500**
Total Requests Received	**1325**
Total number of breaches (dealt with outside 28 day timeframe)	**45**
Compliance %	**97%**



There was a total of 7 subject access requests whereby the ATHR Officers located commingled information in patient records (a total of 8 record types). This was most commonly found in the General Acute records however was also found in Mental Health, CAMHS, and Maternity records.

Following the transfer of scanning clerks to the centralised team in Llandudno, we will be able to more effectively record comingled information at the point of scanning, in addition to the Quality Assurance stage. This will therefore provide better reporting from Quarter 1 of 2021/2022. We will also begin targeted communications to record custodians to advise of comingled information to ensure this is rectified within the patient records and refiled in the correct patient record.

Complaints and lessons learnt ATHR
During quarter 4 there has been 12 concerns received into the ATHR Service.

These included;

- 3 x Delays in processing SAR
- 8 x Missing information from SAR
- 1 x Rectification Request of personal data

Lessons Learnt:
In all cases apologies were sent to the applicant for any distress caused and the need for raising a concern with the Health Board.

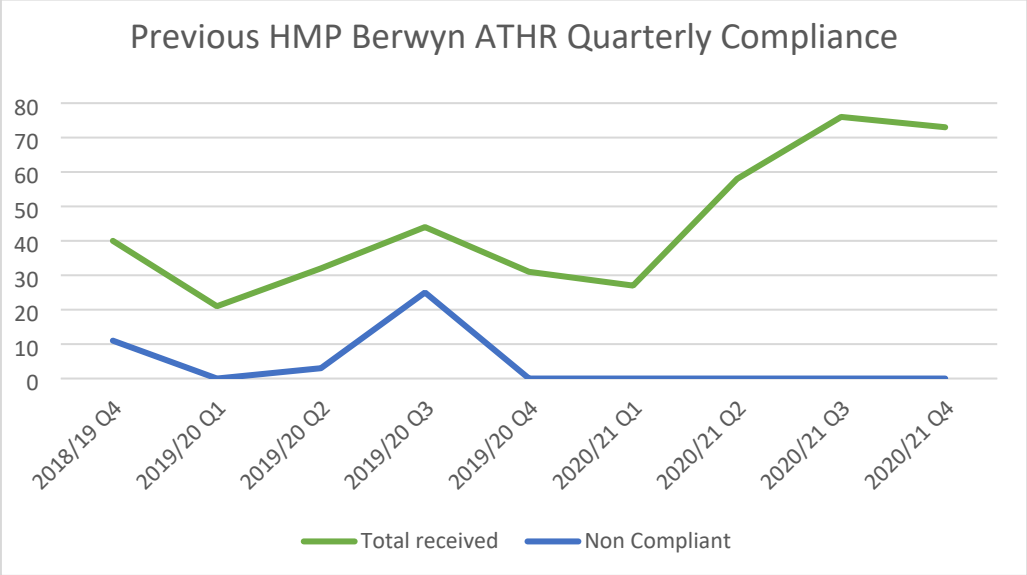
(i) With regards to concerns to delays in responses, a generic acknowledgement is provided to all applicants to advise of the strain on resources due to the pandemic and to pre-empt some minor delays during the time when the Service did not have sufficient resource.

(ii) In all cases where it was believed there was missing information from the SAR, thorough investigations were completed to identify if there was any missing information whether that be searching records, including ICT systems etc. And in cases where casenotes were missing the service areas leads were notified to complete a thorough search in line with HR1c procedure. Once verified as missing it is logged on Datix and the patient is notified.

(iii) In all cases where an individual would like their personal information rectified, a thorough investigation is completed by the ATHR Service and relevant healthcare professionals contacted to undertake a review of the patients request. In all cases apologies were sent to the applicant for any distress caused and the need for raising a concern with the Health Board.

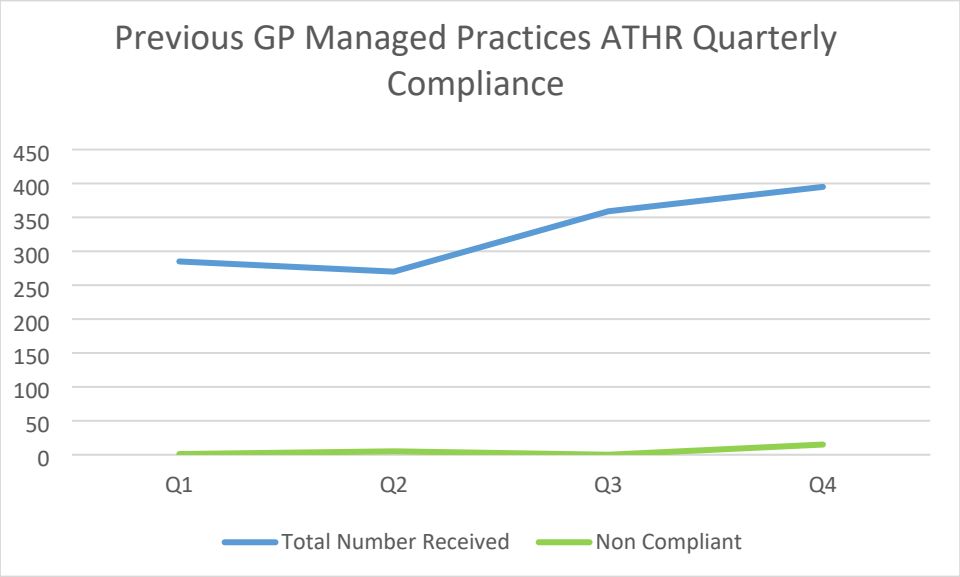
Figures provided in the table below are for requests received by HMP Berwyn. These figures are recorded separately as HMP Berwyn manage their own ATHR requests.

HMP Berwyn	Total
Solicitors Requests	26
Patient Requests	53
Total Requests received	**73**
Total number of breaches (dealt with outside 28 day timeframe)	**0**
Compliance	**100%**
Requests from third parties	
Police	**7**
Court *(Date Req. Set by Court)*	**0**
Incidents	
Confidentiality Breach (External)	**0**



GP Managed Practices
All 14 GP Managed Practices returned data to be included for this quarter:

GP Managed Practices Requests	Total
Type of SAR	
Data Protection Act	195
Requests from 3rd Parties	
Solicitors	102
Police	19
GMC	0
Other (Armed forces, DVLA, medical reports, insurance, DWP/Capita)	79
Total Requests Received	**395**
Total number of breaches (dealt with outside 28 day timeframe)	**15**
Compliance %	**96%**



3) Incidents and Complaints

All incidents are reported using the Health Board's Datix system. There have been **104** incidents reported this quarter which is a continued increase compared to 84 last quarter and complaints have remained the same as last quarter at **4**. All serious incidents risk assessed as a category Level 2 or above in line with the Health Board's Notification of Information Security Breach Procedure are reported to the ICO and WG. For this quarter, there has not been any incidents categorised at level 2 or above and therefore we have not self-reported any incidents to the ICO.

Category	Sub Category	Number of incidents	Self-Reported to ICO / WG	Number of complaints
Non-compliance with policy/ procedure (5)	IG02 Records Management	1	0	0
	IG13 Confidentiality code of conduct	1	0	0
	IG15 Safe storage & transport of PPI	2	0	0
	IG16 Disclosing PPI	1	0	2
Confidentiality Breach (External) (73)	Data Loss	5	0	0
	Email	36*	0	0
	External Mail	21*	0	2
	Fax	1	0	0
	Other	4	0	0
	Records	6	0	0

IM&T Security (26)	Confidentiality Breach (Internal)	4	0	0
	Data Loss	4	0	0
	Email	9	0	0
	Other	1	0	0
	PPI in public place	5	0	0
	Records	3	0	0
Total	**104**		**0**	**4**

* The IG team has seen an increase in incidents in these areas this quarter, we have reminded all staff in our IG Bulletin the importance to maintain confidentiality at all times, including staff privacy as well as a patients privacy and restrict the amount of personal information sent in emails and to encrypt where necessary. Staff have also been instructed to ensure that when folding patient letters, only the address details are visible in the window of the envelope.

Near Misses
There have been **3** near misses reported this quarter, all relating to incorrect patients details being in the system or in the patients notes but they were identified by staff before a breach of confidentiality could have taken place.

Complaints
4 data protection complaints were received during quarter 4 as detailed below, 2 of the complaints have been investigated and closed and 2 are still being investigated and ongoing:

- Patient believes her details have been inappropriately accessed by a staff nurse. (Closed no inappropriate access proven)
- Results sent to wrong address despite patient request to update address more than once. (Closed- Proven)
- Patient received letter with another patients details enclosed. (Open)
- Patients information sent to wrong individual. (Open)

Lessons Learnt/Actions Taken
- Staff have been reminded in GP Practices to record all Incidents on Datix, this is to ensure that there is a clear record of the error, how it happened and most importantly, to identify lessons learned to provide assurance that a similar incident does not reoccur.
- Staff have been reminded to double check email address before sending personal information.
- Outlook settings have been changed in BCU to search BCU first and not the All Wales global address book to support the reduction of incorrect email applicants outside of BCU.

- Staff are reminded to encrypt where necessary.
- Staff are reminded in our bi-monthly bulletin about inappropriate access to records.

Complaints received from the ICO
During quarter 4 we have received **5** complaints direct from the ICO all of which have been investigated and closed.

- 1 dissatisfied with their Access to Health Record request.
- 3 dissatisfied with their Data Protection Subject Access request.
- 1 Dissatisfied with response to internal review i.e. upholding decision to use S36, S40 & S41 of the FOI Act.

Personal Injury Claims
We have received 4 personal injury claims in quarter 4, all of which are alleged breaches of confidentiality and all are ongoing with the Health Boards Claims Team.

We have also been informed of a previous claim being settled:

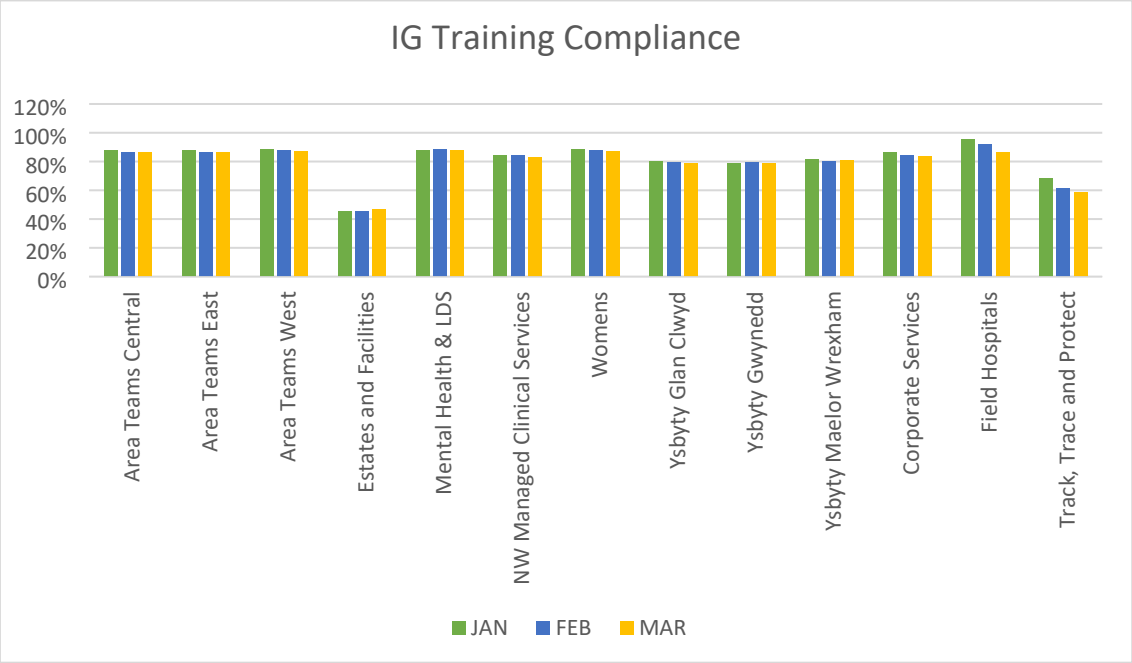
- Data Breach / Misuse of Private information - Client's medical records accessed without her permission and / or a legitimate interest – Awarded £5,600.

We have continued to see an increase in Personal Injury Claims coming into the Health Board and during quarter 4 our corporate bulletin reminded staff the importance of adhering to IG policies so that we can try and learn lessons from these claims. We are monitoring these claims closely and have now implemented a log within the IG team to track this activity level.

4) IG10 – Process for requesting, approval and review of information systems accessed by an employee
The IG10 procedure is to ensure that the correct and appropriate request and approval process is in place for access to information systems that are used by staff members as part of a serious untoward incident, investigation or a disciplinary matter. During the last quarter, the IG team have received **8** IG10 requests all of which were approved, these consisted of the following audits / access:

- 4 access to email and hard drive storage
- 4 access to CCTV

5) Training
Information Governance training is firmly embedded in all mandatory training days as well as mandatory clinician and nurse training days that are organised by the Post Graduate centres. It is a requirement within the National Skills for Health Framework that this is refreshed every two years. The training includes Data Protection, Confidentiality, Information & IT Security, Information Sharing and Records Management.



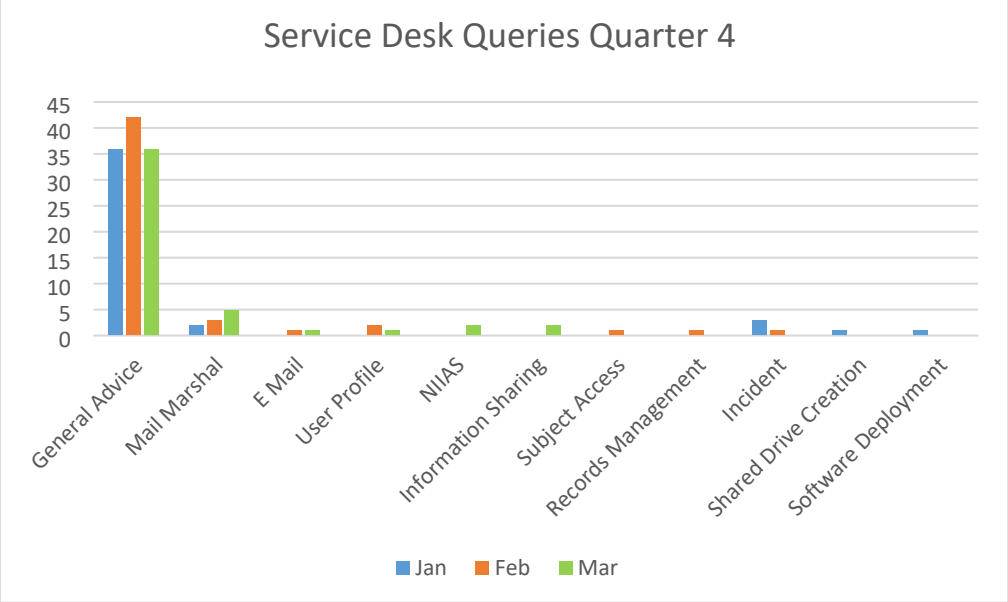
There have been no face to face training sessions this quarter due to Covid-19. However, **2,211** staff have completed their training via E-Learning. We are commencing with our first training session virtually on Teams on the 12th May 2021 and these will continue 3 times a month for the foreseeable future.

The compliance of mandatory IG training in all divisions is monitored by the Information Governance Group and if needed targeted reminders will be issued to encourage completion of the mandatory training via E-Learning or use of the recorded video mentioned above.

The current compliance of mandatory IG training across BCUHB has decreased slightly to 80% for this quarter. We are continually looking at ways to improve our compliance rates amongst some staff categories, including targeting our Information Governance Leads in these areas to assist with improving the compliance rate through a variety of different resources such as workbooks, pre-recorded training video and inviting them to our newly launched virtual sessions. We are also looking at carrying out IG workshop sessions which would be for drop in advice and are beginning to hold additional Corporate Records training with Workforce and Organisational Development being the first division to receive.

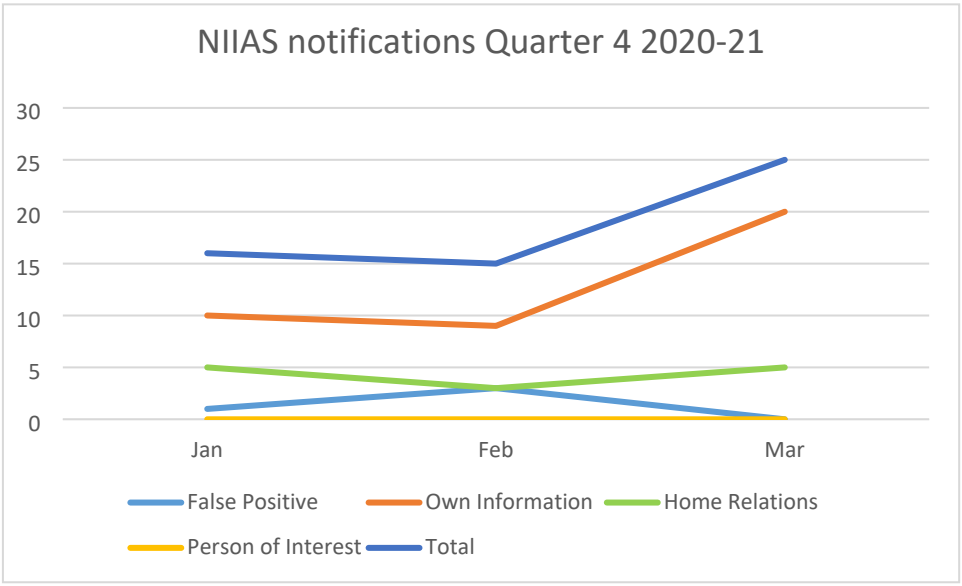
6) Service Desk – IG Portal

During Quarter 4 2020/21 the number of calls received into the Information Governance Service Desk increased from 126 to **141** (12% increase). During quarter 1 2021/22 we will look at the catergories in our service desk to try and limit the number of general advice queries to specific areas of advice so we can analyse the requests that are receieved and target areas with advice and tailored training if required.



7) NIIAS (National Intelligent Integrated Auditing Solution)

During Quarter 4 of 2020/21 the number of NIIAS notifications received decreased to 56 down from 75 in quarter 3 (25% decrease). There were 39 incidents of accessing own health information, 13 accessing relatives information and 4 false positives. These are all reported to the line manager of the individual and Workforce to establish next steps and lessons learnt.



8) Information Governance Compliance Audit Findings

As part of the Health Board's requirement to ensure compliance with legislation, national and local standards, compliance checks are essential to provide assurance that the information is being safeguarded; areas of good practice are identified and areas of weaknesses are addressed via the production of an action plan. During quarter 4 there have been no compliance checks undertaken due to the COVID-19 situation. It is envisioned that the compliance checks will resume when it is safe to do so and as instructed by the Health Board. The IG Team are still looking at ways to carry out compliance audits and is reported on our IG Operational Workplan, due to resources this has not

moved forwards. However we are expecting a full cohort of staff from July onwards and it is envisioned we will be able to make progress in this area.

9) Caldicott Guardian Decisions/Authorisations on behalf of the Board
As part of the role of the Calidicott Guardian there is a requirement for operational decisions or, as the delegated officer, to authorise information sharing on behalf of the Health Board where services or systems involve patient information. During this quarter there have been **4** authorisations signed by the Caldicott Guardian which comprised of the following:

3 x Data Disclosure Agreements
1 x Information Sharing Agreement

10) Data Protection Impact Assessments (DPIAs)
Patients have an expectation that their privacy and confidentiality will be respected at all times, during their care and beyond. It is essential therefore, when considering or implementing any new initiatives, that the impact of the collection, use and disclosure of any patient information is considered in regards to the individual's privacy. Carrying out a data protection impact assessment (DPIA) is a systematic way of doing this.

During Quarter 4 – We have received 28 DPIAs this quarter, 8 of those have been approved, 15 are currently ongoing pieces of work which are going through assurance processes and 5 after being scrutinised have been withdrawn or are no longer required. Please see the following table for those which have been approved:

Name	Description	Outcome
Huma	Application for managing cardio issues	Approved
Myzone remote	Prehabilitation – getting patients fitter prior to major cancer surgery. Need to supervise patients exercising at home while they self- isolate.	Approved
Clinical Musculoskeletal Assessment and Treatment Service	To facilitate staff members working from home to help with social distancing and the pressures of the service, particularly in relation to transcribing clinical correspondence from dictation tapes.	Approved
Child Health Record movement for home working	During the Covid-19 pandemic, and with the constraints in relation to adhering to social distancing, under exceptional circumstances (where clinical interaction with patients or professionals can be affected by not having a hard copy of notes), it has been agreed that clinicians can take patient casenotes to their home address. On this basis, clinicians must adhere to the SOP and DPIA attached to this agreement and embedded below.	Approved

Amat	Audit tracker for tier 1 and 2 screening question returned nos. met with service and no need for a full DPIA to be carried out as no PPI - refered back to ICT	Approved
Online Welsh Language Awareness Training Pack	screening question returned nos. met with service and no need for a full DPIA to be carried out as no PPI - refered back to ICT	Approved
Executive Daily Quality Report	The CEO has requested a daily (weekday) email alert of significant serious incidents; incidents reported to the Delivery Unit (in line with their reporting criteria) and incidents reported as a sensitive issue to Welsh Government. Also attached to the email summary is a report, taken from the datix system of all incidents reported in the previous 24 hours. This email and attachment is sent to the CEO, Board members, Governance leads, BCUHB safety leads, HMT, Divisions and Area Management Teams.	Approved
Covid Recognition	The Board and our Executive group would like to recognise the efforts of staff (permanent, agency, contractors, Bank etc) for their efforts throughout the Covid 19 Pandemic. They would like to issue a 'Thank you card' in the post to the home addresses that we have on file. There is a desire to have these delivered for the 23rd March to mark the one year anniversary since we first went in to lockdown.	Approved

There has also been been **7** PIDs approved during quarter 4 and 0 pathway reviews which is a decrease in comparison to 14 PIDs and 3 Pathway Reviews approved in quarter 3.

It was noted in the most recent D&IG Committee that they would like to see detail in relation to the information asset register reported each quarter. The information governance team will look at ways to incorporate this into Quarter 1 of 2021/22.

Digital & Information Governance Committee 18th June 2021	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:	27th May 2021
Name of Chair:	Mrs Justine Parry, Assistant Director of Information Governance and Risk / Data Protection Officer (Chair)
Responsible Director:	Mr Simon Evans-Evans, Interim Director of Governance
Summary of business discussed:	The Information Governance Group (IG) met on the 27th May 2021. The Group was quorate with good representation including from Managed GP Practices. It was noted that there was no representative from Informatics in attendance, and papers from the ICT Governance and Security Group were not provided. This report summaries the activity of the IG Group and members noted: 1. **Use of keynotes / alerts** - Discussions took place regarding a gap in accountability for the management of patient keynotes and alerts within the clinical systems. It was recognised that there is work being undertaken nationally to standardise this workflow, however local responsibility and guidance needs to be addressed. It was agreed to invite the national team to the next IGG to understand next steps. 2. **Terms of Reference** - A slight revision to job titles and the strengthening of sending deputes who have the authority to act on behalf of the lead representative. The Group approved the revised terms of reference 3. **CCTV** – Assurance on the management of CCTV remains an outstanding issue, however guidance and updates to sections within IG Procedures now cover CCTV disposal. 4. **Office 365** – Members discussed the previous incident involving public SharePoint sites and that the Information Commissioner Office has closed the incident with no regulatory action at this stage. LP reported it was the intention from ICT to develop a strategy and user guides to support the implementation of Teams and SharePoint sites. Further Office365 programmes and functionality were discussed and how those would be managed. A further update would be provided to the next meeting. 5. **IG Workplan Q4** – The final quarter 4 report for 2020/21 was presented noting out of the 46 actions on the

	operational work plan, 28 had been fully completed and 10 were on target to complete but were not due yet. The remaining 8 would be carried over to 2021/22 work plan. The areas of shortfall were in connection with CCTV, 3rd party notification processes when personal information has been updated, Asset Register data flow mapping and follow up actions on areas of non-conformity, and site compliance audits. These risks are being monitored as part of the IG Work plan and divisional risk registers. Despite the impact from Covid and a reduction in staff during the year, it was positive to see the volume of activity that had been achieved, including a significant increase in supporting new ways of working 6. **Information asset register** – Following previous development concerns with the register, meetings have taken place with Informatics and Finance to discuss future requirement plans. Activity is continuing with the register including contacting Information Owners to complete outstanding actions / gaps, and working through the high risk areas to ensure mitigating controls are in put in place. Meetings will continue with Informatics to ensure the register can deliver on all requirements. The development of the register has been identified on the IGG Risk Register and currently being managed at the Tier 2 Divisional level with oversight by the Deputy Chief Executive Officer. 7. **The IG Business Continuity Plan** - Was presented and had been approved by the Deputy Chief Executive / Executive Director of Nursing and Midwifery for implementation. The intention is to implement the plan over the next month and include on the 2021/22 IG work programme to test the plan in 6 months' time. 8. **Confidential Waste** – The new contract has been awarded and in place since April. Improved reporting and contract monitoring is taking place, including the bar coding of all consoles for future management and maintenance. 9. **Mandatory Training** – Low compliance rates within Estates and Facilities, Medical, Dental and Students was discussed, noting the need for IG to undertake some targeted contact with the Divisional Leadership Team to support the improvement in rates in these areas. W&OD that work is ongoing to look at the possibility of accessing the training without having to go through ESR, as this could make the training more accessible. It was also agreed to look into providing direct access for the IG Team to compliance records to support with the delivery of targeted training sessions. 10. **IG Toolkit** - The group received an update on the IG toolkit submission from March 2021 and noted the self-assessment achieved a 79% compliance score. Areas of low compliance were noted in the management of corporate

	records and CCTV. This was a positive assessment, and outstanding compliance areas will be incorporated into local work plans. The Toolkit Group will continue to meet throughout the year to ensure progression of actions and to be ready for next year's submission. Further work was ongoing nationally to develop quality assurance checking of future submissions and undertaking a comparison of scoring across Wales. A separate assurance report for the DIG Committee has been requested and will be provided in September 2021. **11. Information Governance Risk Register** - Was presented and reviewed. It was agreed to further link Health Record risks with the Information Governance risks. **12. Digital Health Records Cito System** – A presentation was provided. Improved governance and assurance around the management of the electronic patient record was discussed, and it was noted this would be implemented on a phased approach over the next 4 years given the significance of the project. Stakeholders have been identified and will be included as the project develops, for example the Concerns and Access to Health Records services. **13. Disclosing Personal Information Guidance** – Was agreed subject to a minor amendment regarding the inclusion to consider verbal requests for information and will be updated on the intranet for staff to use. **14. Management of Patient Records** – Confirmation of completion of the Phase 1 baseline assessment was provided in line with the requirements from the HASCAS report. Actions to address areas of shortfall were being progressed with monitoring and reporting being provided to the Patient Record Group. Phase 2 covering community records will commence this year and will be overseen by the Patient Record Group. Strengthened arrangements on the quality assurance for responses to access to health records requests have been implemented and this should reduce the volume of co-mingled records or incorrect third party information being released under a health records request. This is reported as part of the quarterly IG KPI reports. Also additional funding has been secured to implement the medical examiners service requirements. Chairs' reports were received and discussed from: **15.** Patient Record Group (PRG). **16.** Information Governance Management Advisory Group (IGMAG).

Key assurances provided at this meeting:	• Submission of the IG Toolkit Self-Assessment on time and an achieved compliance rating score of 79%. • Continued progression of the IG Work Programme. • Development of the Asset Register and stakeholder engagement for future development. • Development and implementation of the IG Business Continuity Plan. • Strengthened arrangements for quality assuring data protection access to the health record requests. • Improved timeframe compliance with data protection Health Records requests.
Key risks including mitigating actions and milestones	• Compliance with legislation is a Tier 2 risk on the IG Risk Register and the current score with mitigations in place is being reported as 9. This is being monitored via the work programme 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	N/A
Matters requiring escalation to the Board:	• CCTV – There is no identified ownership and management of the policy in place across the Health Board and therefore limited compliance with the CCTV Code of Practice. • Management of Keynotes / Alerts – There is no identified ownership and management of the policy in place across the Health Board and therefore limited compliance with the integrity of the data held within the clinical systems. • Management and implementation of Office365 – ownership, direction and appropriate local project management implementation to enable a safe and consistent structured implementation plan.
Well-being of Future Generations Act Sustainable Development Principle	The work of the Information Governance 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 • Clinical System Demographic updates. • Presentation on the national progress with Key notes/Alerts. • Test Trace and Protect (TTP) Information Governance Updates. • IG Annual Report. • 2021/22 Quarter 1 IG KPI Report. • Network Information Security Directive – update report.

	• Office 365 implementation – update report. • Information Asset Register – update report. • IG Risk register – update report. • IG Toolkit – action progress report.
Date of next meeting:	19th August 2021

Cyfarfod a dyddiad: **Meeting and date:**	Digital and Information Governance Committee 18th June 2021
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Corporate Risk Register Report
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Simon Evans-Evans, Interim Director of Governance
Awdur yr Adroddiad **Report Author:**	Justine Parry, Assistant Director: Information Governance and Risk
Craffu blaenorol: **Prior Scrutiny:**	Risk Management Group on the 15th March 2021 Executive Team meeting on the 12th May 2021
Atodiadau **Appendices:**	Appendix 1 – DIGC Corporate Tier 1 Operational Risk Report Appendix 2 – DIGC Corporate Risk Escalation Report

Argymhelliad / Recommendation:

The Committee is asked to:

1) **Review and note** the progress on the Corporate Tier 1 Operational Risk Register Report;
2) CRR20-06 **- Approve** the completion of the actions 12422 and 12428 so they can be archived and removed from the next report, recognising that the implementation of the Centralised Access to Health Records Service and the Baseline Assessment Report of Records need to be captured as controls within the next iteration of the risk.
3) CRR20-06 **- Note** the extension of the due date for action 12426 due to the impact from re-aligning resources to support the management of the COVID-19 Pandemic.
4) CRR20-07 **- Approve** the completion of the action 13182 so it can be archived and removed from the next report, recognising that the monitoring and assurance reporting of the implementation of the Digital Strategy will become a control within a future iteration of the risk.
5) **Approve** the risks 1875 and 3659 being presented for escalation onto the Tier 1 Operational Risk Register.

Please tick as appropriate

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval	✓	**Ar gyfer Trafodaeth For Discussion**	✓	**Ar gyfer sicrwydd For Assurance**	✓	**Er gwybodaeth For Information**	

Y/N to indicate whether the Equality/SED duty is applicable

N

Sefyllfa / Situation:

The Corporate Risk Register (CRR) demonstrates how the Health Board is robustly mitigating and managing high rated risks to the achievement of its operational objectives.

The design of both the Board Assurance Framework (BAF) and CRR emphasises their distinctive roles in underpinning the effective management of both strategic and operational risks respectively,

as well as underlining their symbiotic relationship as both mechanisms have been designed to inform and feed-off each other, the BAF is now be reported separately.

Each Corporate Risk has been reviewed and updated.

Appendix 1 highlights the Corporate Tier 1 Risks associated with this Committee which have been reviewed and agreed at the Risk Management Group (RMG) on the 15th March 2021 and scrutinised by the Executive Team on the 12th May 2021.
Appendix 2 details the operational risks approved by the Executive Team on the 12th May 2021 for escalation.

Cefndir / Background:

The implementation of the revised Risk Management Strategy underlines the Health Board's commitment to placing effective risk management at the heart of everything it does while embedding a risk-based approach into its core business processes, objective setting, strategy design and better decision making. This includes the evaluation, monitoring and review of progress, accountability and oversight of the Principal Risks and the high-level operational risks that could affect the achievement of the Health Board's agreed Priorities.

Teams reporting to the Lead Director (who is the Senior Responsible Officer for the risk) locally own and manage risks with support from the corporate risk team. The Risk Management Group has oversight of all risks and is scrutinised by the Executive Team who make the proposals for changes to the CRR to Board and Committees.

Corporate Risk Register:
The Corporate Risk Management Team continue to deliver the RM03 - Risk Management Training Plan for 2021/22 that commenced, in line with the plan in April. This training includes the management of risk in line with the Risk Management Strategy for managers and also practical training for developing, managing and reporting risks for risk handlers. Following the delivery of the training in April to June 2021, feedback will be collated and used to influence further training from June 2021 onwards.

In addition to the above, the Corporate Risk Management Team also attend existing meetings and networks in place to deliver the training, for example: Junior Doctors meetings or Consultant's meetings.

During the Executive Team meeting on the 12th May 2021, the current tier 1 risks for DIG Committee oversight were reviewed (full details of the risks and progress can be found in Appendix 1) and it was agreed to escalate the following operational risks (as set out in Appendix 2) onto the Corporate Tier 1 Risk Register:

Risk Title	Inherent risk rating	Current risk rating	Target risk rating	Movement*
CURRENT RISKS – Appendix 1				
CRR20-06 – Informatics – Patient Records pan BCU	16	16	12	Unchanged
CRR20-07 – Informatics infrastructure capacity, resource and demand	20	16	12	Unchanged

ESCALATED RISKS – Appendix 2				
1875 – National Infrastructure and Products	20	20	12	Re-opened risk
3659 – Cyber Security	25	20	15	N/A

*movement in risk score is measured from the last presentation to Board, and not necessarily reflective of the latest committee decisions

Please note: following agreement at the DIGC on the 26th March 2021, the below risk has been de-escalated and is now being actively managed by the Executive Director of Primary and Community Care at the Tier 2 level:

- **CRR20-10 – GP Out of Hours IT System**.

Below is a heat map representation of the corporate current risk scores for this Committee:

Current Risk Level		**Impact**				
		Very Low - 1	Low - 2	Moderate - 3	High - 4	Very high - 5
Likelihood	Very Likely - 5					
	Likely - 4				CRR20-06 CRR20-07	
	Possible - 3					
	Unlikely - 2					
	Rare - 1					

Asesiad / Assessment & Analysis

Strategy Implications
The implementation of the Risk Management Strategy and Policy aligns with the Health Board`s strategy to embed effective risk management in fostering its culture of safety, learning to prevent recurrence and continuous improvements in patient, quality and enhanced experience.

Options considered
Continuing with Corporate Risk Register.

Financial Implications
The effective and efficient mitigation and management of risks has the potential to leverage a positive financial dividend for the Health Board through better integration of risk management into business planning, decision-making and in shaping how care is delivered to our patients thus leading to enhanced quality, less waste and no claims.

Risk Analysis
See the individual risks for details of the related risk implications.

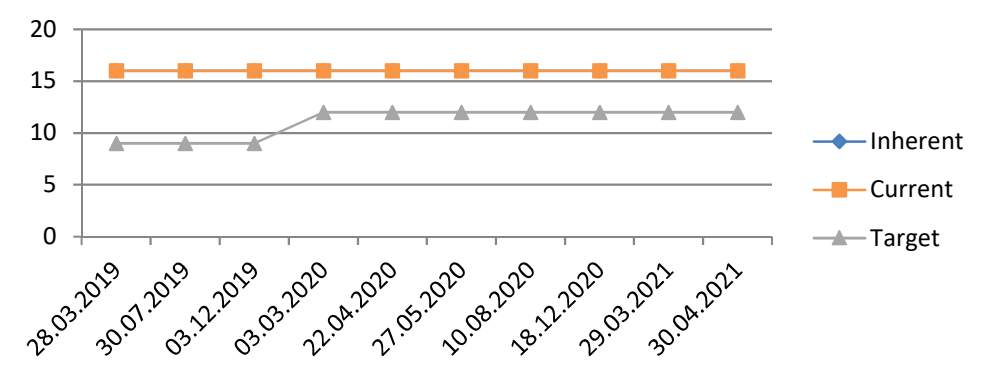
Legal and Compliance
There are no legal and compliance issues associated with the delivery of the Risk Management Strategy and Policy.

Impact Assessment
No specific or separate EqIA has been done for this report, as a full EqIA has been completed in relation to the new Risk Management Strategy and Policy to which the CRR reports are aligned.

Due regard of any potential equality/quality and data governance issues has been factored into crafting this report.

Appendix 1 - DIGC Corporate Risk Register Report

CRR20-06	**Director Lead:** Director of Primary and Community Care	**Date Opened:** 28 March 2019
	Assuring Committee: Digital and Information Governance Committee	**Date Last Reviewed:** 30 April 2021
	Risk: Informatics - Patient Records pan BCU	**Date of Committee Review:** 26 March 2021
		Target Risk Date: 30 September 2024
There is a risk that patient information is not available when and 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 could result in substandard care, patient harm and an inability to meet our legislative duties.		



	Impact	Likelihood	Score
Inherent Risk Rating	4	4	16
Current Risk Rating	4	4	16
Target Risk Score (Risk Appetite – *low level)*	4	3	12
Movement in Current Risk Rating Since last presented to the Board in January 2021	unchanged		

Controls in place	**Assurances**
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. Chairs reports from Patient Record Group. 2. ICO Audit. 3. HASCAS Audit.

Links to	
Strategic Priorities	**Principal Risks**
Effective use of our resources	BAF20-18 BAF20-28

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	12422	Enable actions to meet the regulatory recommendations from the ICO, HASCAS/Ockenden and Internal Audit reports.	Mrs Danielle Edwards, Head of Digital Records	31/03/2021	Action Closed - 29/03/2021 All actions are complete. The only recommendation not delivered to the expectation of the ICO is with regards to 'verbal requests' for a patient's information (handling a SAR request from a patient by ANY member of staff working in the Health Board) in the context of a large organisation and the risks this would introduce. Managed and controlled actions have been put in place to meet verbal request in a safe way e.g. directing to the centralised ATHR team where they are handled over the phone rather than a form being sent out; update to web-pages to give advice on recognising a verbal SAR request and signposting to the team to fulfil; new agreement in place to actively encourage the provision of Clinic Letters/Results at the point of patient care when requested (or directly following). Analysis will be undertaken in Q4 to catch any recommendations not already covered.	Complete

	12423	Development of a local Digital Health Records system	Mrs Danielle Edwards, Head of Digital Records	30/09/2024	UPDATE Mar 2021 - Project remains on track with key deliverables for this quarter: Project Board agreed a formal project start of 1st March 2021 with an established Project Team; Phase 2.0 Project Plan has been agreed to deliver a Minimum Viable Product and implement with two early adopters with key targets for 2021 - Infrastructure ready by late Spring, Test Environment by early Summer, Early Adopters Go Live early Autumn; Engagement with a Clinical Task & Finish Group to design and development of the Cito product for BCU delivered the folder structure; risk sub-group is established with register baselined; DPIA in place.	On Track
	12424	Improve the assurance of Results Management	Mrs Danielle Edwards, Head of Digital Records	30/09/2021	UPDATE Mar 2021 - (WS1) - WCP 3.11.4 (moved on version) has been through UAT and whilst all showstoppers for RN have been addressed to a level that can be managed through SOPs, there are some other areas of the release that are still being reviewed. Business Case in process of being submitted to secure the funding required to deliver the project. (WS2) - for the 10 users that have the access (provided directly by NWIS which will in future need	On Track

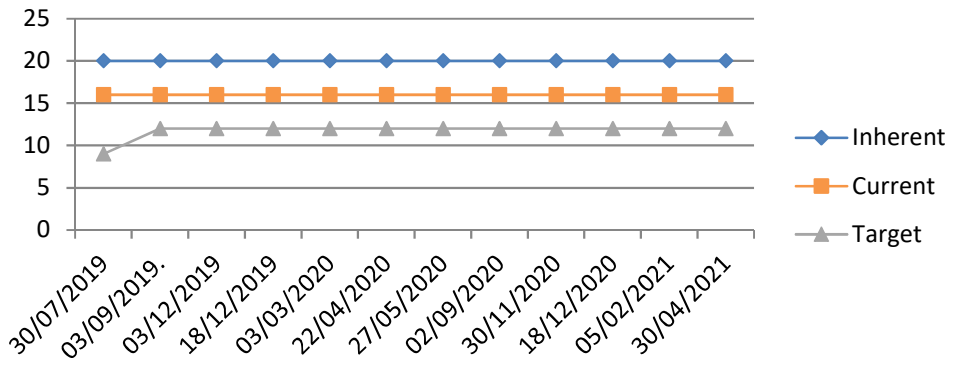
					to come with the Project Board agreement to ensure readiness to govern and support) plans are being formed to test an 'Acceptable Use statement to ensure safe practice. (WS3) ETR - improved forms that have been developed by NWIS with local SME engagement will be available in WCP 3.12. (WS4) Radis 2.4 upgrade planned for later in Spring.	
	12425	Digitise the clinic letters for outpatients	Mrs Danielle Edwards, Head of Digital Records	30/06/2021	UPDATE Mar 2021 - Project remains on track - (West) the recovery activity for the PiMs integration is complete with the integration running well. Cancer Services, Pain Team went live 08/03 followed by the Anaesthetics Team on 15/03. The full roll out is in development with the West Operational leads, with an aim to run on a weekly go live schedule. (Central) Care of the Elderly team went live with EPRO on the 25/01, Gastro team on the 02/02, closely followed by Renal team 03/02 and Community Paediatrics planned 12/04. The Project team will take advantage of any gaps to the West roll out plan by seizing the opportunity to address the soft roll out list for Central if and when possible.	On Track

	12426	Digitise nursing documentation through engaging in the WNCR	Mrs Danielle Edwards, Head of Digital Records	31/05/2021	UPDATE Mar 2021 - Due to pressures with the Nursing Lead supporting IPC (Covid) and other competing priorities within the Informatics team this was delayed, however work has picked back up with this to complete over the next few weeks as a draft for review, but will roll into next AOP year.	Delay
	12428	Baseline the; storage, processes, management arrangements and standards compliance	Mrs Danielle Edwards, Head of Digital Records	31/03/2021	Action Closed - 29/03/2021 UPDATE Mar 2021 - The initial report is now complete covering (i) the approach to measuring standards for this priority stage 1 areas and onwards for BAU and (ii) presenting the audit recommendations for Acute, Mental Health, CAHMS. The report has been signed off by the Head of Patient Records & Digital Integration Department and is being reviewed for sign off by the CIO, prior to being presented to the Patient Records Group (PRG), Information Governance Group (IGG) and finally the DIGC (June). This all aligns with the IG toolkit compliance requirements for all NHS providers. Progress against actions will be monitored by the PRG and exception reporting to the IGG and DIGC. This closes this action handing over the	Complete

					ongoing reviews and progress monitoring to the PRG.	
	12429	Engage with the Estates Rationalisation Programme to secure the future of 'fit for purpose' file libraries for legacy paper records.	Mrs Danielle Edwards, Head of Digital Records	31/05/2021	UPDATE Mar 2021 - Meeting to review the status of the Mental Health development business case is planned for April which will inform the next steps for this long standing action.	On Track

CRR20-07	**Director Lead:** Director of Primary and Community Care	**Date Opened:** 28 March 2019
	Assuring Committee: Digital and Information Governance Committee	**Date Last Reviewed:** 30 April 2021
	Risk: Informatics infrastructure capacity, resource and demand	**Date of Committee Review:** 26 March 2021
		Target Risk Date: 15 December 2021

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
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score (Risk Appetite – *moderate level)*	4	3	12
Movement in Current Risk Rating Since last presented to the Board in January 2021	unchanged		

Controls in place	**Assurances**
1. Governance structures in place to approve and monitor plans. Monitoring of approved plans for 2019 2020 (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 decision making e.g. Local hosting v's National hosting for WPAS etc. 5. National Infrastructure Review (Independent Welsh Government Review undertaken by Channel 13).	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 DIGC (for Governance).

Links to	
Strategic Priorities	**Principal Risks**
Effective use of our resources	BAF20-18 BAF20-20 BAF20-28

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	12379	Review workforce plans and establish future proof informatics/digital capability and capacity.	Ms Andrea Williams, Head of Informatics Programmes, Assurance and Improvement	30/09/2021	The development of a Workforce Planning Strategy will take into account the service capability and capacity to deliver on the Digital Strategy.	On Track
	12380	Review governance arrangements e.g. DTG whose remit includes review of resource conflicts has not been replaced.	Ms Andrea Williams, Head of Informatics Programmes, Assurance and Improvement	30/06/2021	This will be undertaken now the Digital Strategy has been approved and will ensure appropriate governance arrangements are in place to monitor implementation of the strategy.	On Track
	13182	To develop a Digital Strategy	Ms Andrea Williams, Head of Informatics Programmes, Assurance and Improvement	31/03/2021	Action Closed - 31/03/2021 This high level digital strategy will set the strategic direction and support the prioritisation of work which will support and make the case for capacity and resources. It will also influence the governance and mapping to clinical services requirements.	Complete

Appendix 2 – DIGC Corporate Risk Escalation Report

1875	**Director Lead:** Director of Primary and Community Care	**Date Opened:** 23 October 2017
	Assuring Committee: Digital and Information Governance Committee	**Date Last Reviewed:** 9 April 2021
	Risk: National Infrastructure and Products	**Date of Committee Review:** Re-opened Risk
		Target Risk Date: 31 March 2022

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 when 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.
g) DHCW Lack of alignment with BCUHB planning cycles and an understanding from a DHCW perspective.
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.

To be populated following approval

	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score (Risk Appetite – *select low, moderate or high level)*	4	3	12
Movement in Current Risk Rating Since last presented to the Board in – to be populated following approval	Re-opened Risk		

Controls in place	**Assurances**
1. Scrutiny of DHCW by DIGC who escalate any areas of concern to the Health Board. 2. Project Management Framework with strong governance. 3. Technical Oversight Group for WPAS and other National Programme Groups.	1. Public Accounts Committee Review of NWIS. 2. Reports from the Digital Transformation Group to IGIC / EMG. 3. WAO - review.

	4. National Architecture and Informatics Governance Reviews.

Links to	
Strategic Priorities	**Principal Risks**
Effective use of our resources	BAF20-18

Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve target risk score	15284	A joint digital plan to be developed with Digital Health and Care Wales for 2021/22 which will include all projects and upgrades	Ms Andrea Williams, Head of Informatics Programmes, Assurance and Improvement	30/04/2021	Having an agreed plan in place will enable better monitoring of delivery and scrutiny by DIGC.	Delay
	15285	To meet with DHCW on a quarterly basis to review delivery of agreed plan	Ms Andrea Williams, Head of Informatics Programmes, Assurance and Improvement	31/03/2022	This will enable performance management of the plan and escalations can be made sooner.	On Track
	15286	Action Plan to be scrutinised by DIGC quarterly	Ms Andrea Williams, Head of Informatics Programmes, Assurance and Improvement	30/06/2021	Increased performance management of supplier to reduce the likelihood of the risk.	On Track
	15287	To strengthen the governance by agreeing escalation levels within existing and new national projects	Ms Andrea Williams, Head of Informatics Programmes, Assurance and Improvement	31/03/2022	Having agreed escalation levels will result in issues being dealt with quicker.	On Track

	15474	CCIO & CIO to influence the National Strategic Direction through National Groups	Mr Dylan Williams, Assistant Director of Informatics	31/03/2022	Influencing the National Strategy should increase alignment with BCUHB Digital Plans.	On Track

3659	**Director Lead:** Director of Primary and Community Care	**Date Opened:** 28 September 2020
	Assuring Committee: Digital and Information Governance Committee	**Date Last Reviewed:** 13 April 2021
	Risk: Cyber Security	**Date of Committee Review:** New Risk
		Target Risk Date: 12 December 2022

There is a risk of cyber security attacks due to a lack of assurance around cyber security threats and lack of a dedicated Cyber Security Team which could lead to a total loss of all Health Board data stored on BCU servers.

This could impact patient care, Health Board reputation, confidentiality, breaches of legislation, financial impact (fines and cost of recovering data). If this risk is not addressed it could lead to the organisation not meeting legislative requirements such as GDPR and NIS-D.

We could also be open to Civil suits should patient safety incidents occur as a result of a cyber attack.

To be populated following approval

	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	5	4	20
Target Risk Score (Risk Appetite – *select low level)*	5	3	15
Movement in Current Risk Rating Since last presented to the Board in - to be populated following approval	New Risk		

Controls in place	**Assurances**
1. Engagement with National Cyber Security intelligence sharing, the National Cyber Security Centre (NCSC) as well as undertaking Cyber threat assessments and an external review have ensured that best practice is being adhered to wherever possible. 2. There is a single member of staff who works to mitigate known threats in addition to their day job and continued attention is paid to implementing security products and services to reduce threats and monitor for malicious software. Due to this member of staff being overstretched they are unable to undertake resilience management. 3. Communications campaigns to raise staff awareness have also been undertaken however there is a concern that not all staff have access to the bulletin, and we are unable to monitor the uptake of these campaigns due to a lack of manpower to run phishing exercises.	1. Risk is regularly reviewed at the Service Quality and Safety or Senior Managers Meetings. 2. Internal audit report.

4. There is Cyber Security training available however it is not mandatory within the Health Board at last count 33 staff had undertaken the training which equates to approximately 0.2% of the organisation. 5. We have deployed a number of advanced technologies to protect the organisation however these are all individual controls for each different type of threat. Each control provides a limited amount of protection. 6. The current controls in place to protect against ransomware only offer limited assurance against ever evolving threats. 7. Stratia report ongoing implementation of recommendations to improve compliance. 8. The Stratia report informed the creation of a Security Improvement Plan (SIP) for each Health Board in Wales. BCU had 24 actions and whilst we have completed 12 actions with a further 5 partially completed these are ever evolving actions and therefore completion may only be temporary.	

Links to	
Strategic Priorities	**Principal Risks**
Safe, secure & healthy environment for our people	BAF20-18

Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve target risk score	15314	Implementation of Cyber Essentials Plus.	Mr John Thomas, Deputy Head of ICT	03/01/2022	Improve standards across the Health Board to reduce the likelihood of the risk occurring.	On Track
	15315	To implement and compliance with ISO27001 Standards.	Mr John Thomas, Deputy Head of ICT	03/01/2022	Improving quality standards across the Health Board to reduce the likelihood of the risk occurring.	On Track

	15316	Implementation of the NIS Responsibilities.	Mr John Thomas, Deputy Head of ICT	03/01/2022	Meeting regulatory requirements will reduce the impact of any financial penalty for non-conformance. Maximum penalty is £15million per breach of regulations.	On Track
	15317	The Health Board to provide funding for a dedicated in-house Cyber Security team.	Mr Dylan Williams, Assistant Director of Informatics	14/06/2021	Provide dedicated staff to ensure the Health Board meets its legal obligations and prevent fines up to £15million. Removes the single point of failure and allows for greater resilience. Allow for improved planning and proactive management as opposed to reactive management.	On Track
	15590	Continue to work on implementation of Stratia recommendations.	Mr John Thomas, Deputy Head of ICT	12/12/2022	By completing the outstanding actions we will reduce the opportunity for malware to exploit vulnerable systems.	On Track
	15591	Developing supplier relationships to create a Cyber Incident Response Plan.	Mr John Thomas, Deputy Head of ICT	12/07/2021	It will formulate how BCU responds to a Cyber Security Incident and improve our speed and effectiveness when responding to Cyber Security Incidents. Speed and effectiveness are critical when responding to incidents to minimise the impact on BCU services.	On Track

Cyfarfod a dyddiad: **Meeting and date:**	Digital and Information Governance Committee 18 June 2021
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Board Assurance Framework (BAF)
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Louise Brereton, Board Secretary
Awdur yr Adroddiad **Report Author:**	Dawn Sharp, Assistant Director: Deputy Board Secretary
Craffu blaenorol: **Prior Scrutiny:**	Executive Team meeting on 9 June 2021
Atodiadau **Appendices:**	Appendix 1 – BAF Report Appendix 2 - Remapping of BAF risks to Annual Plan Appendix 3 – Key field guidance

Argymhelliad / Recommendation:

That the Committee review and note the progress on the Principal Risks as set out in the Board Assurance Framework (BAF).

Ticiwch fel bo'n briodol / Please tick as appropriate

Ar gyfer penderfyniad /cymeradwyaeth **For Decision/ Approval**	✓	**Ar gyfer Trafodaeth** **For Discussion**	✓	**Ar gyfer sicrwydd** **For Assurance**		**Er gwybodaeth** **For Information**	

Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol **Y/N to indicate whether the Equality/SED duty is applicable**	**N**

Sefyllfa / Situation:

The revised Risk Management Strategy and Policy was implemented on the 1st October 2020, and on the 21st January 2021, the Board approved the implementation of the revised Board Assurance Framework (BAF) template reporting arrangements.

This new design captures the work undertaken by the Board on the identification of its Priority Areas to support the effective management of the agreed Principal Risks that could affect the achievement of its agreed Priorities. This has led to streamlining and re-design of the Corporate Risk Register (CRR), which more effectively demonstrates how the Health Board is robustly mitigating and managing high rated risks to the achievement of its operational objectives.

Each BAF risk has since been reviewed and updated.

Appendix 1 highlights the Board Assurance Framework Risk assigned to this Committee.

Appendix 2 shows the remapping of the BAF risks to the Annual Plan.

Appendix 3 provides details of the key field guidance

Cefndir / Background:

The design of both the new BAF and CRR emphasises their distinctive roles in underpinning the effective management of both strategic and operational risks respectively, as well as underlining their symbiotic relationship as both mechanisms have been designed to inform and feed-off each other. This includes the evaluation, monitoring and review of progress, accountability and oversight of the Principal Risks and also the high level operational risks which could affect the achievement of the Health Board's agreed Priorities. These are being monitored by regular review with respective leads and oversight by the Risk Management Group and Executive Team.

Board Assurance Framework

Oversight and co-ordination of the BAF has transferred to the Office of the Board Secretary from the Corporate Risk Management Team, with the risk management system and process continuing to be managed by the Corporate Risk Team.

It is worth emphasising that ownership of the BAF rests with the Board with individual Executives being responsible for the management of their respective risks, not the Board Secretary. Engagement with risk leads continues to progress well and work continues to refine and further develop the BAF to ensure it becomes a tool to ensure strategic risks are visible to the Board and Committees.

The Board has updated its strategic priorities as set out within the 2021-22 Annual Plan. Due to the revised strategic priorities, some principal risks do not lend themselves to direct mapping, and have subsequently been mapped to an 'enabler'. The remapped BAF risks were shared with Members of the Audit Committee at a workshop held on 25th May and are attached as Appendix 2.

The BAF is a 'live' document which continues to evolve, and has progressed with the engagement and support of the full Board. This serves well going forward as the Health Board progresses and refreshes *'Byw'n iach, Aros yn iach/Living Healthier, Staying Well'* and all underpinning strategies. With this refresh there will need to be greater focus and consideration of strategic risks in the BAF as the Health Board looks to the future in delivering its strategies. A revision of the BAF will then need to take place to link to the strategic objectives as defined in the refreshed strategy with any operational BAF risks being managed as part of the Corporate Risk Register going forward.

Key progress on the BAF risk assigned to this Committee is detailed below (this information is also reflected within the BAF risk sheet):-

BAF20-18 - Digital Estates and Assets

Key progress: - Actions updated to reflect approval of the Digital Strategy by the Board, with additional action added regarding formal launch of the Strategy.

- Date in relation to the Management of Portfolio approach amended to align with the proposed Governance Structure Review implementation.
- Mitigations updated to reference regular meetings with Digital Health Care Wales (DHCW) together with extensions to action timeframes.

- Implementation of the Digital Strategy together with the resources to deliver it will be the actions that have the most material impact on the risk. Resource structure had been developed however decision taken not to fund cost pressures for additional capacity which will necessitate a review of existing resources against current projects.
-

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol /Strategy Implications
The implementation of the Board Assurance Framework and the revised Risk Management Strategy and Policy aligns with the Health Board`s strategy to embed effective risk management in fostering its culture of safety, learning to prevent recurrence and continuous improvements in patient, quality and enhanced experience.

Opsiynau a ystyriwyd / Options considered
Not applicable.

Goblygiadau Ariannol / Financial Implications
The effective and efficient mitigation and management of risks has the potential to leverage a positive financial dividend for the Health Board through better integration of risk management into business planning, decision-making and in shaping how care is delivered to our patients thus leading to enhanced quality, less waste and no claims.

Due to the improved and increased reporting frequency arrangements, the management of the BAF is resource intensive and so additional resources may be required.

Dadansoddiad Risk / Risk Analysis
See the individual risks for details of the related risk implications.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance
There are no legal and compliance issues associated with the delivery of the Board Assurance Framework or the Risk Management Strategy and Policy.

Asesiad Effaith / Impact Assessment
No specific or separate EqIA has been done for this report, as a full EqIA has been completed in relation to the new Risk Management Strategy and Policy to which the BAF and CRR reports are aligned.
Due regard of any potential equality/quality and data governance issues has been factored into crafting this report.

Board Assurance Framework 2020/21

Strategic Priority 5: Effective Use of Resources

Risk Reference: BAF20-18		Risk Rating	Impact		Likelihood		Score		Appetite
Digital Estate and Assets									
There is a risk that Informatics cannot implement digital solutions due to available resource not keeping step with an organisational wish to become more digitally focused. This could impact on the safety of our patients, service efficiency and the reputation of the Health Board, the ability to recruit and retain staff or impact on compliance with legislation resulting in significant financial penalties.		Inherent Risk	4		5		20		Moderate to High 8 - 15
		Current Risk	4	↔	5	↔	20	↔	
		Target Risk	4		3		12		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Monthly budget reviews take place with finance. Finance attendance at Informatics Senior Management Team (SMT) on a monthly basis as part of the Cycle of Business.	1	Contribution to national informatics programmes through representation both informatics and clinical i.e. Virtual Consultations, Digital Services for Patients and the Public Programme.	3	1) Development of a Digital Strategy - approved by the Board on 20 May 2021. 2) Formal launch of Digital Strategy	Complete 1 September 2021
Quarterly review of Operational Plan at SMT with Digital and Information Governance Committee (DIGC) oversight of the delivery of the Informatics Operational Plan and budget on a quarterly basis.	2	Review of required business cases through the Business Case Review Group and to the Finance & Performance Committee (F&P) Committee for approval.	2	Implementation of the Digital Strategy Year 1 to 2.	1 March 2022
Capital and Revenue Programmes are in place and are reported through the DIGC on a quarterly basis.	2	Resource risks are identified and go through the escalation process as documented in the Risk Management Strategy. This governance includes SMT, DIGC and Risk Management Group.	2	Established resource structure submitted, together with revenue and capital requirements for 21/22 - decision taken by ET not to fund cost presssure for additional capacity. Accordingly a review of the current projects is being undertaken which will be presented in due course to the Executive Team.	30 June 2021
		Programmes and Projects are managed using agreed standard methodologies (Tailored Prince2) and have governance structures.	1	Development of an established resource structure and revenue and capital requirements in line with the strategy delivery from 22/23.	1 December 2021
		Regular meetings with Digital Health Care Wales in place to discuss local and national priorities and challenges.	3	Development a Management of Portfolio approach so that all digital solution change initiatives are well governed, controlled and prioritised. Implementation of the Management of Portfolio Approach.	31 October 2021
				Meeting with Digital Health Care Wales has taken place to discuss the BCUHB Priorities and Risks and plan currently in development to take account of the challenges.	30 June 2021

Review comments since last report: Actions updated to reflect approval of the Digital Strategy by the Board, with additional action added re formal launch of the Strategy. Date in relation to the Management of Portfolio approach amended to align with the proposed Governance Structure Review implementation. Mitigations updated to reference regular meetings with DHCW together with extensions to action timeframes. Implementation of the Digital Strategy together with the resources to deliver it will be the actions that have the most material impact on the risk. Resource structure had been developed however decision taken not to fund cost pressures for additional capacity which will necessitate a review of existing resources against current projects.

Executive Lead:	**Board / Committee:**	**Review Date:**
Chris Stockport, Executive Director of Primary and Community Services	Digital and Information Governance Committee	21 May 2021

Linked to Operational Corporate Risks:
CRR20-06 - Informatics - Patient Records pan BCUHB
CRR20-07 - Informatics infrastructure capacity, resource and demand

Appendix 2 – Remapping BAF Risks to Annual Plan

- Remapping of BAF risks to the revised strategic priorities and enablers as set out within the Draft Annual Plan for 2021-22: -
  - **Priorities**
    - 1 Covid19 response
    - 2 Strengthen our wellbeing focus
    - 3 Primary and community care
    - 4 Recovering access to timely planned care pathways
    - 5 Improved USC pathways
    - 6 Integration and improvement of MH Services
  - **Key enablers:-**
    - Making effective and sustainable use of resources
    - Transformation for improvement
    - Effective alignment of our people

Remapped BAF Risks

New BAF Ref.	New priority alignment	20-21 Plan Priority	Previous BAF Ref.	Title
N/A Archived	5 Improved USC Pathways	1 Safe USC	20-01	Surge/ Winter Plan
21-01	**5 Improved USC Pathways**	**1 Safe USC**	**20-02**	**Safe and Effective Management of Unscheduled Care (formerly titled Emergency Care Review Recommendations)**
21-02	2 Strengthen our wellbeing focus	2 Essential Services and Planned Care	20-03	Sustainable Key Health Services
21-03	3 Primary and Community Care	2 Essential Services and Planned Care	20-04	Primary Care Sustainable Health Services
21-04	**4 Recovering access to timely planned care pathways**	**2 Essential Services and Planned Care**	**20-05**	**Timely Access to Planned Care**

Remapped BAF Risks continued

New BAF Ref.	New priority alignment	20-21 Plan Priority	BAF Ref.	Title
21-05	**6 Integration and Improvement of MH Services**	**3 Mental Health Services**	**20-07**	**Effective Stakeholder Relationships**
21-06	6 Integration and Improvement of MH Services	3 Mental Health Services	20-08	Safe and Effective Mental Health Delivery
21-07	6 Integration and Improvement of MH Services	3 Mental Health Services	20-09	Mental Health Leadership Model
21-08	6 Integration and Improvement of MH Services	3 Mental Health Services	20-10	Mental Health Service Delivery During Pandemic Management
21-09	**2 Strengthen our wellbeing focus**	**4 Safe and Secure Environment**	**20-11**	**Infection Prevention and Control**
21-10	**2 Strengthen our Wellbeing focus**	**4 Safe and Secure Environment**	**20-12**	**Listening and Learning**

Remapped BAF Risks continued

New BAF Ref.	New priority alignment	20-21 Plan Priority	Prev. BAF Ref.	Title
21-11	**2 Strengthen our wellbeing focus**	**4 Safe and Secure Environment**	**20-13**	**Culture – Staff Engagement**
21-12	**2 Strengthen our wellbeing focus**	**4 Safe and Secure Environment**	**20-14**	**Security Services**
21-13	2 Strengthen our wellbeing focus	4 Safe and Secure Environment	20-15	Health and Safety
21-14	**1 Covid 19 response**	**4 Safe and Secure Environment**	**20-16**	**Pandemic Exposure**
21-15	**NB aligned to key enabler – Making effective and sustainable use of resources**	**5 Effective Use of Resources**	**20-17**	**Value Based Improvement Programme**
21-16	**NB aligned to key enabler – Transformation for Improvement**	**5 Effective Use of Resources**	**20-18**	**Digital Estate and Assets**

Remapped BAF Risks continued

New BAF Ref.	New priority alignment	20-21 Plan Priority	BAF Ref.	Title
21-17	NB aligned to key enabler – Making effective and sustainable use of resources	5 Effective Use of Resources	20-20	Estates and Assets Development
21-18	NB aligned to key enabler – Effective alignment of our people	5 Effective Use of Resources	20-21	Workforce Optimisation
21-19	1 Covid 19 response	2 Essential Services and Planned Care	20-25	Impact of COVID-19
21-20	NB aligned to key enabler – Making effective and sustainable use of resources	5 Effective Use of Resources	20-26	Development of Annual Operational Plan 2021-22
21-21	NB aligned to key enabler – Making effective and sustainable use of resources	5 Effective Use of Resources	20-27	Delivery of a Planned Annual Budget
21-22	NB aligned to key enabler – Making effective and sustainable use of resources	5 Effective Use of Resources	20-28	Estates and Assets

Board Assurance Framework Key field guidance/ definitions of assurance levels

BAF Template Item		Please refer to the Risk Management Strategy and Policy for further detailed explanations
Risk Reference		Board Assurance Framework reference number, allocated by the Board Secretary
Risk Description		An uncertainty that something could or may happen that will have an impact on the achievement of the Health Board's Priority. There are 3 main components to include when articulating the risk description (cause, event and effect):
		- There is a risk of / if ….
		- This may be caused by ….
		- Which could lead to an impact / effect on ……
Risk Ratings	Inherent	Without taking into consideration any controls which may be in place to manage this risk, what is the likelihood that this risk will be realised, and if it did, what would be the consequence
	Current	Having considered the key controls and key mitigation measures in place, indicate what the current risk grading is. Note – this should reduce as action is taken to address the risk.
	Target	This is the level of risk one would expect to reach once all controls and key mitigation measures are in place.
Risk Impact		The consequence (or how bad) if the risk were to be realised, in line with the NPSA Grading Matrix an impact of 1 is a Negligible (very low), with a 5 as Catastrophic (very high)
Risk Likelihood		The probability (frequency or how often) would this happen if the risk were to be realised. In line with the NPSA Grading Matrix a likelihood of 1 is this will probably never happen / recur, with a 5 being that it will undoubtedly happen, recur, possibly frequently
Score		Impact x Likelihood of the risk happening
Appetite	Definition	Is defined as the amount and type of risk the Health Board is willing to take on, pursue or retain in order to achieve its priorities.
	Low	Cautious with a preference for safe delivery options (Score 1 to 6)
	Moderate	Prepared to take on, pursue or retain some risks as a result of the Health Board taking opportunities to improve quality and safety of services (Score 8 to 10)
	High	Open or willing to take on, pursue or retain risks associated with innovation, research and development consistent with the Health Board's Priorities (Score 12-15)

Board Assurance Framework Key field guidance/ definitions of assurance levels

Control	Definition	These are measures/interventions implemented by the Health Board to reduce either the likelihood of a risk and/or the magnitude/severity of its potential impact were it to be realised. A collection of strategies, policies, procedures and systems - to control the risks that would otherwise arise and ensure that care and services are delivered by competent staff who are aware of how to raise concerns [NHS WALES Governance e-manual - http://www.wales.nhs.uk/governance-emanual/risk-management] A measure that maintains and/or modifies risk (ISO 31000:2018(en))
	Examples include, but are not limited to:	- People, for example, a person who may have a specific role in delivery of an objective - Strategy, policies, procedures, SOP, checklist in place and being implemented which ensures the delivery of an objective - Training in place, monitored and assurance reported - Compliance audits - Business Continuity plans in place, up to date, tested and effectively monitored - Contract Management in place, up to date and regularly monitored
Mitigation	Definition	This refers to the process of reducing risk exposure and minimising its likelihood and/or lessening or making less severe its impact were it to materialise. Types of risk mitigations include the 5Ts (treat, tolerate, terminate, transfer or take opportunity).
	Examples include, but are not limited to:	- Service or Pathway Redesign - Business Case Development - Staff Training - Risk Assessment - Evidential data sets - Taking out insurance
Assurance Levels	1	The first level of assurance comes from the department that performs the day to day activity, for example the data is available
	2	The second level of assurance comes from other functions in the Health Board who have internally verified the data, for example quality, finance and H/R assurance
	3	The third level of assurance comes from assurance provided from outside the Health Board, for example WG, HIW, HSE etc.

Cyfarfod a dyddiad: **Meeting and date:**	Digital and Information Governance Committee 18th June 2021
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Adoption of All Wales Information Governance Policies
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Simon Evans-Evans, Interim Director of Governance
Awdur yr Adroddiad **Report Author:**	Justine Parry, Assistant Director: Information Governance and Risk
Craffu blaenorol: **Prior Scrutiny:**	Executive Team meeting on the 26th May 2021 Information Governance Group 4th March 2021 Wales Information Governance Board 14th January 2021
Atodiadau **Appendices:**	**Appendix 1 -** WIGB202103 BCUHB Policy Letter **Appendix 2 -** All Wales Internet Use Policy V3 **Appendix 2a** – All Wales Internet Use Policy EQIA **Appendix 3 -** All Wales Information Governance Policy V2 **Appendix 3a** – All Wales Information Governance Policy EQIA **Appendix 4 -** All Wales Information Security Policy V2 **Appendix 4a** – All Wales Information Security Policy EQIA

Argymhelliad / Recommendation:

The Committee is asked to:

1) Endorse the All Wales policies for implementation across the Health Board.

Please tick as appropriate

Ar gyfer penderfyniad /cymeradwyaeth **For Decision/ Approval**	✓	**Ar gyfer Trafodaeth** **For Discussion**		**Ar gyfer sicrwydd** **For Assurance**		**Er gwybodaeth** **For Information**	

Y/N to indicate whether the Equality/SED duty is applicable

Y

Sefyllfa / Situation:

The National Information Governance Management Advisory Group (IGMAG), representative of the information governance leads from all NHS Wales Health Boards and Trusts, have completed a review of a number of existing national information governance related policies.

The Health Board are now required to approve the policies for implementation and provide assurance to the Chair of the WIGB that this action has been completed.

Cefndir / Background:

As part of the role and terms of reference for the National Information Governance Management Advisory Group (IGMAG), there is a requirement to develop a suite of policies for adoption by Health Boards and Trusts in Wales to ensure a consistent approach to monitoring and maintaining good information governance practice. A policy sub-group reporting into IGMAG was established to drive forward with the development of these national policies, with a selection of representatives from Health Boards and Trust across Wales. BCUHB are represented at this Policy Sub-Group.

The below policies were reviewed and updated during 2020/21 and have been developed in consultation with the Welsh Partnership Forum. Equality impact assessments have also been conducted by the NHS Wales Informatics Service. These policies were approved during the Wales Information Governance Board (WIGB) on the 14th January 2021 for adoption across Wales:

- All Wales Internet Use Policy V3 – this is an update to the previous version implemented by the Health Board in 2018.
- All Wales Information Governance Policy V2 – this is an update to the previous version implemented by the Health Board in 2018
- All Wales Information Security Policy V2 – this is an update to the previous version implemented by the Health Board in 2018.

A letter from the Chair of WIGB was issued on the 1st March to all CEO to adopt and implement these policies, please refer to Appendix 1. The BCUHB Information Governance Group have reviewed the policies on the 4th March 2021 and identified a requirement to remove “Executive” from the position of the Chief Information Officer in the roles and responsibilities section in the Information Governance Policy. Not all NHS organisations across Wales could comply with this statement. The Executive Team were presented with the Policies for approval on the 26th May 2021 and no further concerns were returned.

Further to the approval of these policies, and in order for them to become standard policies within the NHS in Wales, it is a requirement for the Health Board to ensure the updated policies are formally adopted within BCUHB.

Once approved, the Information Governance Department will make arrangements for the existing policies to be replaced with the new ones and ensure that they are communicated and made available to all staff within BCUHB, in addition to monitoring the implementation and embedding of the policies across the whole Health Board.

Asesiad / Assessment & Analysis

Strategy Implications
The implementation of these policies align with the Health Board`s aims and objectives to enable and maintain compliance with data protection legislation and its Information Governance responsibilities and duties. The policies have been developed taking into consideration the updated legislation, best practice and guidance, and support the BCUHB Information Governance Strategy. All of which will support improvements in the handling and security of data across the Health Board, with regular compliance monitoring reported as part of the overarching Information Governance Key Performance Indicators.

Options considered
Continuation with local policies was an option, however this will not support the national drive for consistency across Wales. It would also not improve efficiency or reduce the duplication of resources required within each organisation to produce local documentation.

Financial Implications
Non-compliance with data protection legislation can lead to significant fines imposed by the Information Commissioners office.

Risk Analysis
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. There are currently six Information Governance risks being managed and monitored by the Information Governance Group. The below four Tier 2 risks also have oversight by the Deputy Chief Executive / Executive Director of Nursing and Midwifery:

Risk Title	**Inherent risk rating**	**Current risk rating**	**Target risk rating**	**Movement**
Failure to comply with the Data Protection Legislation / Freedom of Information Act 2000	9	9	6	Unchanged
Failure to develop and make improvements to the Information Asset Register	9	9	4	Unchanged
Management of Corporate Records	9	9	6	Unchanged
MS Office 365 - Management of Health Board Records	12	8	6	Decreased

Legal and Compliance
It is a statutory requirement to comply with Data Protection Legislation and these policies will assist the Health Board in meeting its legal obligations. They will also assist partnership working with other Health Boards and Trusts across Wales as we will be working to common standards.

Impact Assessment
These policies have been Equality Impact Assessed by the National Wales Informatics Service as part of the National Information Governance Policy working group.

Wales
Information Governance
Board

GIG CYMRU NHS WALES
Gwasanaeth Gwybodeg Informatics Service

Chair, WIGB
C/o NHS Wales Informatics Service

1st March 2021

Dear Jo

I write as Chair of the Wales Information Governance Board (WIGB).

You will be aware that the Board is a high level board providing advice and assurance to the Cabinet Secretary for Health, Well-being and Sport; and to health and social care organisations.

The WIGB recognise the need for consistent information governance policies across NHS Wales organisations as the benefits are realised when providing a consistent messages to staff who may work in a variety of functions and disciplines across NHS Wales and its services.

On behalf of the WIGB, the Information Governance Management Advisory Group (IGMAG), representative of the information governance leads from all NHS Wales Health Boards and Trusts, have recently completed a review of a number of existing national information governance related policies as follows:

- All Wales Internet Use Policy
- All Wales Information Governance Policy
- All Wales Information Security Policy

I can confirm, all these policies have now been approved by the WIGB, at its meeting held on the 14th January 2021. Prior to presentation for formal approval at the WIGB, the Welsh Partnership Forum was consulted. An equality impact assessment has been conducted by the NHS Wales Informatics Service.

Further to the approval of these policies, and in order for these to become standard policies within the NHS in Wales, I would now be grateful if you would make arrangements for the policies to be adopted by your Board (or sub committee) and implemented at the earliest opportunity. Individual organisations will need to consider, in partnership, their own implementation arrangements including the development of joint training programmes and awareness raising for staff at all levels.

We request that you notify the Board once this process is completed.

The policies will be reviewed on a two yearly basis, and can only be amended with the agreement by the WIGB.

If you have any queries, please feel free to write to me at the below address, or contact Andrew Fletcher, Lead for Supporting the Information Governance Assurance Framework at the NHS Wales Informatics Service on Andrew.Fletcher2@wales.nhs.uk.

We look forward to hearing from you soon.

Yours Sincerely

Chair of the Wales Information Governance Board

NHS Wales
Internet Use Policy

Author: Information Governance Management Advisory Group Policy Sub Group
Approved by: Information Governance Management Advisory Group
Approved by: Wales Information Governance Board
Version: 3
Date: 14th January 2021
Review date: 13th January 2023

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Contents

1. Introduction

This document is issued under the All Wales Information Governance Policy Framework and maintained by the NHS Wales Informatics Service (NWIS) on behalf of all NHS Wales organisations.

2. Purpose

This policy provides assurance that NHS Wales internet facilities are being used appropriately to assist in delivering services.

The policy also sets out the responsibilities of all users when using the internet. These responsibilities include, but are not restricted to, ensuring that:

- The confidentiality, integrity, availability and suitability of information and NHS computer systems are maintained by ensuring use of internet services is governed appropriately;
- All individuals as referenced within the scope of this policy are aware of their obligations.

This policy must be read in conjunction with relevant organisational procedures.

3. Scope

This policy applies to the workforce of all NHS Wales organisations including staff, students, trainees, secondees, volunteers, contracted third parties and any persons undertaking duties on behalf of NHS Wales.

For the purpose of this policy 'NHS Wales Organisations' will include all NHS Wales organisations including all Health Boards and NHS Trusts.

The policy describes the principles which must be adhered to by all in the use of the internet, the NHS Wales Network (which is defined as a corporate Intranet) and other affiliated sites.

The terms "internet access" or "internet use" encompass any use of any resources of the internet including social media / social networking, browsing, streaming, downloading, uploading, posting, "blogging", "tweeting", chat and email. The NHS Wales Social Media Policy provides information on the appropriate use of social media.

This policy applies to all staff that make use of the NHS network infrastructure and / or NHS equipment to access internet services regardless of the location from which they accessed and the type of equipment that is used including corporate equipment, third party and personal devices.

4. Roles and responsibilities

The Chief Executive is responsible for ensuring the highest level of organisational commitment to the policy and the availability of resources to support its implementation and any associated legal requirements. Specific responsibilities will be delegated to the Data Protection Officer, Senior Information Risk Officer and the Caldicott Guardian or an Executive Director as appropriate.

Managers are responsible for the implementation of this policy within their department/directorate. In addition, they must ensure that their staff are aware of this policy, understand their responsibilities in complying with the policy requirements and are up to date with mandatory information governance training. Breaches of the policy must be reported via local incident reporting processes and dealt with in line with the All Wales Disciplinary Policy where appropriate.

The workforce must familiarise themselves with the policy content and ensure the policy requirements are implemented and followed within their own work area. Mandatory information governance training must be undertaken at least every two years. Breaches of this policy must be reported via local incident reporting processes.

5. Policy

5.1 Position Statement

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

The NHS Wales workforce should become competent in using internet services to the level required for their role in order to be more efficient and effective in their day-to-day activities.

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

5.2 Conditions & Restrictions

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

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

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

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

It is each user's responsibility to ensure that their internet facilities are used appropriately. Managers are reminded that, as an NHS Wales resource, the internet is in many ways similar to the telephone systems and should be managed accordingly.

5.3 Personal Use

NHS Wales organisations allow staff reasonable personal use of internet services providing this is within the bounds of the law and decency and compliance with policy.

Personal use should be incidental and reasonable. As a threshold, NHS Wales defines this as a maximum of thirty minutes in one calendar day and before or after normal working hours, or during agreed break times. These limitations are also necessary due to network demands and therefore local restrictions may apply dependent on the duration of access and the capacity of resources available. In addition to this, users must not stream or download large volumes of data (e.g. streaming audio or video, multimedia content, software packages) as these may have a negative impact on network resources.

Where local organisations have provided patients and staff with access to public Wi-Fi services, employees are encouraged to use these facilities by default on personally-owned devices instead of using NHS equipment. Local agreements will be in place for the use of and availability of these facilities.

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

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

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

At no time should access to the internet be used by any individual for personal financial gain (E.g. using eBay or any other auction sites).

6. Training and Awareness

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

Staff who need support in understanding the legal, professional and ethical obligations that apply to them should contact their local information governance department.

The NHS Wales workforce should become competent in using internet services to the level required of their role in order to be efficient and effective in their day-to-day activities.

7. Monitoring and compliance

NHS Wales trusts its workforce.

NHS Wales reserves the right to monitor work processes to ensure the effectiveness of the service. This will mean that any personal activities that the employee practices in work may come under scrutiny. NHS Wales

organisations respect the privacy of its employees and does not want to interfere in their personal lives but monitoring of work processes is a legitimate business interest.

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

Staff should be reassured that NHS Wales organisations take a considered approach to monitoring, however it reserves the right to adopt different monitoring patterns as required. Monitoring is normally conducted where it is suspected that there is a breach of either policy or legislation or when a manager has concerns around employees performance, (e.g. excessive internet usage). Furthermore, on deciding whether such analysis is appropriate in any given circumstances, full consideration is given to the rights of the employee.

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

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

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

8. Review

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

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

9. Equality Impact Assessment

This policy has been subject to an equality assessment.

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

Appendix A - Inappropriate use

For the avoidance of doubt, inappropriate use includes, but is not limited to:

- Excessive personal use.
- Allowing access to NHS Wales internet services by anyone not authorised to access the services, such as by a friend or family member.
- Communicating or disclosing confidential or sensitive information via the internet without authorisation or without the appropriate security measures being in place.
- Downloading or communicating any information or images which are unlawful, or could be regarded as defamatory, offensive, abusive, obscene, hateful, pornographic, violent, terrorist, indecent, being discriminatory in relation to the protected characteristics,; or using the email system to inflict bullying or harassment on any person.
- Downloading, uploading, transmitting, viewing, publishing, storing or distributing defamatory material or intentionally publishing false information about NHS Wales or its staff, clients or patients.
- Knowingly accessing, or attempting to access internet sites that contain obscene, hateful, pornographic, violent, terrorist, racist or otherwise illegal material. This will include such pages on social media sites.
- Knowingly and without authority view, upload, or download material that may bring NHS Wales into disrepute; or material that could cause offence to others.
- Sending or saving information or images which could be considered defamatory, obscene, hateful, pornographic, violent, terrorist, racist or otherwise illegal material.
- Downloading or installing or distributing unlicensed or illegal software.
- Downloading software without authorisation or changing the configuration of existing software using the internet without the appropriate permissions.
- Breaching copyright or Intellectual Property Rights (IPR).
- ‘Hacking’ into others accounts or unauthorised areas.
- Deliberately attempting to circumvent security systems protecting the integrity of the NHS Wales network.
- Any purpose that denies service to other users (for example, deliberate or reckless overloading of access links or switching equipment).
- Intentionally introducing malicious software such as Viruses, Worms, and Trojans into the NHS Wales network.
- To access sites with the intention of making a personal gain (for example - running a business).
- Access to internet based e-mail providers such as Gmail, Hotmail, Yahoo etc is prohibited for reasons of security with the exception of:

    - Access to email services provided by a recognised professional body or a trade union recognised by the employer;
    - Any UK university hosted e-mail account (accounts ending in .ac.uk);
    - Any email account hosted by a body which the employee contributes to in conjunction with their NHS role, such as a local authority or tertiary organisation.

- Altering any of the system settings on a NHS Wales owned PC or trying to change the access server in an attempt to avoid the restriction imposed by the filtering software. This will be deemed as a breach of this policy and will be dealt with under the All Wales Disciplinary Policy.

Annex 1: Policy Development - Version Control

Revision History

Date	Version	Author	Revision Summary
26/06/2018	2	Andrew Fletcher (Chair of the IGMAG policy sub group)	Original policy as approved.
1/12/2020	2.1	Andrew Fletcher (Chair of the IGMAG policy sub group)	Policy with incorporated comments
14/01/2021	3	Andrew Fletcher (Chair of the IGMAG policy sub group)	Final Policy

Reviewers

This document requires the following reviews:

Date	Version	Name	Position
1/12/2020	2.1	IGMAG Policy sub group	Sub group of the Information Governance Management and Advisory Group
4/01/2021	2.1	Information Governance Management and Advisory Group	All Wales Information Governance Leads
4/01/2021	2.1	Welsh Partnership Forum	All Wales workforce leads and trade unions
7/01/2021	2.1	Equality Impact Assessment	NWIS Equality Impact Assessment Group
14/01/2021	2.1	Information Governance Management and Advisory Group	All Wales Information Governance Leads
14/01/2021	2.1	Wales Information Governance Board	Advisory Board to the Minister for Health and Social Care (Welsh Government)

Approvers

This document requires the following approvals:

Date	Version	Name	Position
4/01/2020	3	Information Governance Management and Advisory Group	All Wales Information Governance Leads
14/01/2021	3	Wales Information Governance Board	Advisory Board to the Minister for Health and Social Care (Welsh Government)

Equality Impact Assessment (EQIA) Form		
Ref no:		
Name of the policy, service, scheme or project:	Service Area	
NHS Wales Internet Use Policy	Information Governance	
Preparation		
Aims and Brief Description	The policy is the product of the review of the All Wales Internet Use Policy.	
Which Director is responsible for this policy/service/scheme etc	All Wales policy developed in conjunction with Health Boards/Trusts	
Who is involved in undertaking the EQIA	Andrew Fletcher and EQIA group	
Have you consulted with stakeholders in the development of this policy?	Yes. A sub group has developed this policy with a membership consisting of information governance leads and an OSSMB representative. IM&T leads and the Wales Partnership Forum have been consulted. The NHS Wales Information Governance Management and Advisory Group have approved the text of this Policy. The policy will be approved by the Wales Information Governance Board.	
Does the policy assist services or staff in meeting their most basic needs such as; Improved Health, fair recruitment etc	Yes. The policy will stand as a single internet use policy for NHS Wales. As per the original all-Wales Policy, it removes many of the restrictions which were in place in some organisations, while strengthening the governance framework. A key driver during the process was the need to recognise that organisations needed to trust their staff.	
Who and how many (if known) may be affected by the policy?	All users of the NHS Wales internet service within the Health Boards and NHS Trusts.	
What guidance have you used in the development of this service, policy etc?	The policy is based on good practice and legal obligations as set out by the Information Commissioners Office and in the legislation. The policy has also been constructed from existing agreed principles and the corporate knowledge of its stakeholders.	
Updates to Policy:		

Equality Duties

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

Key	
✓	Yes
x	No
-	Neutral

Human Rights Based Approach – Issues of Dignity & Respect

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

Measuring the Impact

What operational impact does this **policy, service, scheme or project**, have with regard to the Protected Characteristics. Please cross reference with equality duties	
	Impact – operational & financial
Race	There is a consistent approach to IT policies across NHS Wales, this is an extension of the approach to put clear boundaries in place for staff, a revision of restrictions and identifying the need to respect and trust our staff. There is a clear statement around behaviours making it explicit that hateful and discriminatory language will not be accepted. There needs to be a wider understanding and context of trigger words. Dignity and respect of those using Internet policy as individuals and staff and clear instructions so staff know what is applicable to them.
Sex/gender	
Disability	
Sexual orientation	
Religion belief and non belief	
Age	
Gender reassignment	
Pregnancy and maternity	
Marriage and civil partnership	
Other areas	
Welsh language	
Carers	

Outcome report

Equality Impact Assessment: Recommendations Please list below any recommendations for action that you plan to take as a result of this impact assessment					
Recommendation	**Action Required**	**Lead Officer**	**Time -scale**	**Resource implications**	**Comments – updated 07/01/21**
1 Updated statement in policy	Inclusion of reference to protected characteristics rather than homophobic, bi-phobic, racist etc so inclusive of all in the statement	AF	ASAP	Time	Amended – see section 9 prior to previous issue Schedule also amended to refer to 'protected characteristics. (wording retained in current policy)
2 Communication of the changes	Make sure staff aware of the changes	AF	ASAP	Time	Original policy subject to local processes. Local communication in Velindre and NWIS NWIS communication 2/10/2018 here: https://informatics.wales.nhs.uk/news/Pages/2018/October/Policies-Approved-Sept%202018.aspx Communication on current policy conveyed to Welsh Partnership Forum. Current Policy subject to local consultation prior to implimentation.
3 Updated EQIA statement	Inclusion of reference to protected characteristics	AF	ASAP	Time	Amended – see section 9 prior to previous issue (wording retained in current policy)

Risk Assessment based on above recommendations – if policy is approved in original format refer to grading in appendix 1

Recommendation	Likelihood	Impact	Risk Grading
1	2	2	4
2	2	2	4
3	2	2	4

Is the policy etc lawful?	**Yes** ☒	**No** ☐	**Review date**
Does the EQIA group support the policy be adopted?	**Yes** ☒	**No** ☐	**3 years**

Signed on behalf of NWIS Equal Impact Assessment Group

WfOD Facilitator

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

Appendix 1

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

NHS Wales
Information Governance Policy

Author: Information Governance Management Advisory Group Policy Sub Group
Approved by: Information Governance Management Advisory Group
Approved by: Wales Information Governance Board
Version: 2
Date: 14th January 2021
Review date: 13th January 2023

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Contents

1. Introduction

This document is issued under the All Wales Information Governance Policy Framework and maintained by the Digital Health and Care Wales on behalf of all NHS Wales organisations.

2. Purpose

The aim of this Policy is to provide all NHS Wales employees with a framework to ensure all personal data is acquired, stored, processed, and transferred in accordance with the law and associated standards. These include Data Protection legislation, the common law duty of confidence, NHS standards such as the Caldicott Principles, and associated guidance issued by Welsh Government, Information Commissioner's Office (ICO), Department of Health and other professional bodies.

The objectives of the Policy are to:

- Set out the legal, regulatory and professional requirements;
- Provide staff with the guidance to understand their responsibilities for ensuring the confidentiality and security of personal data.

3. Scope

This policy applies to the workforce of all NHS Wales organisations including staff, students, trainees, secondees, volunteers, contracted third parties and any other persons undertaking duties on behalf of NHS Wales.

For the purpose of this policy 'NHS Wales Organisations' include all Health Boards and NHS Trusts.

It applies to all forms of information processed by NHS Wales organisations; and covers all business functions and the information, information systems, networks, physical environment and relevant people who support those business functions.

For the purpose of this policy, the use of the term "personal data" refers to information relating to both living and deceased individuals. Examples of key identifiable personal data include (but are not limited to) name, address, full postcode, date of birth, NHS number, National Insurance number, images, recordings, IP addresses, email addresses etc.

For the purpose of this policy "special category data" refers to the types of personal data that are defined by data protection legislation as relating to an individual's racial or ethnic origin, political opinions, religious or philosophical beliefs, trade union membership, health, sex life, sexual orientation, genetic and biometric data where processed to uniquely identify an individual. Some special category data is also protected by legislation separate to the data protection legislation. For example information relating to certain sexually transmitted diseases is subject to separate legislative provisions in certain circumstances.

4. Roles and responsibilities

The Chief Executive is responsible for ensuring the highest level of organisational commitment to the policy and the availability of resources to support its implementation and any associated legal requirements. Specific responsibilities will be delegated to the Chief Information Officer, the Data Protection Officer, Senior Information Risk Officer and the Caldicott Guardian or an Executive Director as appropriate.

NHS Wales Organisations must have the following key roles in place:

- **Chief Information Officer (CIO):** The person responsible for the management, implementation, and usability of information and computer technologies in an organisation;
- **Senior Information Risk Owner (SIRO):** An Executive Director or member of the Senior Management Board of an organisation with delegated responsibility from the CEO for an organisation's information risk policy. The SIRO is accountable and responsible for information risk across the organisation. The SIRO is accountable and responsible for information risk across the organisation;
- **Caldicott Guardian:** A senior person with delegated responsibility from the CEO for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing;
- **Data Protection Officer (DPO):** A data protection expert who is responsible for monitoring an organisation's compliance; informing and advising the organisation on its data protection obligations, and acting as a contact point for data subjects and the Information Commissioner's Office (ICO).

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

The workforce must familiarise themselves with the policy content and ensure the policy requirements are implemented and followed within their own work area. Mandatory information governance training must be undertaken at least every two years. Breaches of the policy must be reported via local incident reporting processes and dealt with in line with the All Wales Disciplinary Policy where appropriate.

5. Policy

5.1 Data Protection and Compliance

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

While the emphasis of this policy is on the protection of personal data, organisations will also own business sensitive data and provision for the security of that data will also be governed by this policy as appropriate.

5.1.1 Fair and Lawful Processing

Under data protection legislation, personal data, including special category data must be processed fairly and lawfully. Processing broadly means collecting, using, disclosing, sharing, retaining or disposing of personal data or information.

In order for the processing to be fair, NHS Wales organisations must be open and transparent about the way it processes personal data by informing individuals using a variety of methods. The most common way to provide this information is in a privacy notice. Guidance must be made available to staff to enable them to produce and make available privacy notices in line with the legislation.

5.1.2 Individual's Rights

Individuals have certain rights with regard to the processing of their personal data. NHS Wales organisations must ensure that appropriate arrangements are in place to manage these rights. Staff must follow their organisational procedures and guidance to ensure requests relating to individual rights are managed appropriately.

5.1.3 Accuracy of Personal Data

Arrangements must be in place to ensure that any personal data held by NHS Wales organisations is accurate and up to date. Staff must follow their organisational procedures and guidance to ensure that information, howsoever held is maintained appropriately.

5.1.4 Data Minimisation

NHS Wales organisations will use the minimum amount of identifiable information required when processing personal data. Where appropriate, personal data must be anonymised or pseudonymised. Staff must follow their organisational procedures and guidance to ensure the principle of data minimisation is appropriately upheld.

5.1.5 Data Protection Impact Assessment (DPIA)

All new projects or major new flows of information must consider information governance practices from the outset to ensure that personal data is protected at all times. This also provides assurance that NHS Wales organisations are working to the necessary standards and are complying with data protection legislation. In order to identify information risks a DPIA must be completed. Your information governance department will provide the required guidance and template.

5.1.6 Incident Management and Breach Reporting

NHS Wales organisations must have arrangements in place to identify, report, manage and resolve any data breaches within specified legal timescales. Lessons learnt will be shared to continually improve procedures and services, and consideration given to updating risk registers accordingly. Incidents must be reported immediately following local reporting arrangements.

5.1.7 Information Governance Compliance

NHS Wales organisations must have arrangements in place to monitor information governance compliance. Staff are required to assist in this activity when required. This may include providing evidence in relation to an investigation, or for completion of the information governance toolkit.

Any risks identified must be managed in line with local risk management arrangements.

5.1.8 Information Asset Management

Information assets will be catalogued and managed by NHS Wales organisations by using an Information Asset Register which must be regularly reviewed and kept up to date.

5.1.9 Third Parties and Contractual Arrangements

Where the organisation uses any third party who processes personal data on its behalf, any processing must be subject to a legally binding written contract which meets the requirements of data protection legislation. Where the third party is a supplier of services, appropriate and approved codes of conduct or certification schemes must be considered to help demonstrate that the organisation has chosen a suitable processor.

5.2 Information Security

NHS Wales organisations will maintain the appropriate confidentiality, integrity and availability of its information, and information services, and manage the risks from internal and external threats. Please refer to the National Information Security Policy for further details.

5.3 Records Management

NHS Wales organisations must have a systematic and planned approach to the management of records in the organisation from their creation to their disposal. This will ensure that organisations can control the quality and quantity of the information that it generates, can maintain that information in an effective

manner, and can dispose of information efficiently when it is no longer required and outside the retention period.

5.4 Access to Information

NHS Wales organisations are in some circumstances required by law to disclose information. Examples include, but are not limited to, information requested under Data Protection legislation, Access to Health Records legislation, the Freedom of Information Act, the Environmental Information Regulations.

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

5.5 Confidentiality

All staff have an obligation of confidentiality regardless of their role and are required to respect the personal data and privacy of others in line with the Common Law Duty of Confidence, and the Caldicott Principles.

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

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

5.6 Sharing Personal Data

The WASPI Framework provides good practice to assist organisations to share personal data effectively and lawfully. WASPI is utilised by organisations directly concerned with the health, education, safety, crime prevention and social wellbeing of people in Wales.

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

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

Personal data may need to be shared externally on a one-off basis in the event of an emergency, where an ISP or equivalent sharing document does not exist. The sharing of such information must be formally documented with a clear, justifiable purpose, and processed securely.

5.7 Information Assets

5.7.1 The Control Standard

The Wales Control Standard for Electronic Health and Care Records describes the principles and common standards that apply to shared electronic health and care records in Wales, and provides the mechanism through which organisations commit to them.

5.7.2 Asset Registers

A register of core national systems is maintained by the Digital Health and Care Wales and sets out how shared electronic health and care records are held within National Systems. NHS Wales organisations will also have local information asset registers. Staff must follow their organisational procedures and guidance to ensure information asset registers are regularly updated.

5.8 Data Quality

NHS Wales organisations process large amounts of data and information as part of their everyday business. For data and information to be of value they must be of a suitable standard.

Poor quality data and information can undermine the organisation's efforts to deliver its objectives and for this reason, the NHS in Wales is committed to ensuring that the data and information it holds and processes is of the highest quality reasonably practicable under the circumstances. All staff have a duty to ensure that any information or data that they create or process is accurate, up to date and fit for purpose. NHS Wales organisations will implement procedures where necessary to support staff in producing high quality data and information.

6. Training and Awareness

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

Staff who need support in understanding the legal, professional and ethical obligations that apply to them should contact their local information governance department.

7. Monitoring and compliance

NHS Wales trusts its workforce, however it reserves the right to monitor work processes to ensure the effectiveness of the service. This will mean that any personal activities that the employee practices in work may come under scrutiny. NHS Wales organisations respect the privacy of its employees and

does not want to interfere in their personal lives but monitoring of work processes is a legitimate business interest.

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

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

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

8. Review

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

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

9. Equality Impact Assessment

This policy has been subject to an equality assessment.

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

Annex: Policy Development - Version Control

Revision History

Date	Version	Author	Revision Summary
26/06/2018	V1	Andrew Fletcher on behalf of the IGMAG Policy Sub Group	
1/12/2020	V d 1.1	Andrew Fletcher on behalf of the IGMAG Policy Sub Group	Draft incorporating comments
14/01/2021	2	Andrew Fletcher (Chair of the IGMAG policy sub group)	Final Policy

Reviewers

This document requires the following reviews:

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1/12/2020	1.1	IGMAG Policy sub group	Sub group of the Information Governance Management and Advisory Group
4/01/2021	1.1	Information Governance Management and Advisory Group	All Wales Information Governance Leads
4/01/2021	1.1	Welsh Partnership Forum	All Wales workforce leads and trade unions
7/01/2021	1.1	Equality Impact Assessment	Equality Impact Assessment Group
14/01/2021	1.1	Information Governance Management and Advisory Group	All Wales Information Governance Leads
14/01/2021	1.1	Wales Information Governance Board	Advisory Board to the Minister for Health and Social Care (Welsh Government)

Approvers

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4/01/2020	2	Information Governance Management and Advisory Group	All Wales Information Governance Leads
14/01/2021	2	Wales Information Governance Board	Advisory Board to the Minister for Health and Social Care (Welsh Government)

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

Equality Duties

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

Key	
✓	Yes
x	No
-	Neutral

Human Rights Based Approach – Issues of Dignity & Respect

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

Measuring the Impact

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

Outcome report

Equality Impact Assessment: Recommendations Please list below any recommendations for action that you plan to take as a result of this impact assessment						
Recommendation		**Action Required**	**Lead Officer**	**Time - scale**	**Resource implications**	**Comments – updates below 7/1/21**
1	Updated statement in policy	Inclusion of reference to protected characteristics rather than homophobic, bi-phobic, racist etc so inclusive of all in the statement	AF	ASAP	Time	Amended – see section 9 prior to previous issue (wording retained in current policy)
2	Communication of the changes	Make sure staff aware of the changes	AF	ASAP	Time	Original policy subject to local processes. Local communication in Velindre and NWIS NWIS communication 2/10/2018 here: https://informatics.wales.nhs.uk/news/Pages/2018/October/Policies-Approved-Sept%202018.aspx Communication on current policy conveyed to Welsh Partnership Forum. Current Policy subject to local consultation prior to implimentation.
3	Updated EQIA statement	Inclusion of reference to protected characteristics	AF	ASAP	Time	Amended – see section 9 prior to previous issue (wording retained in current policy)

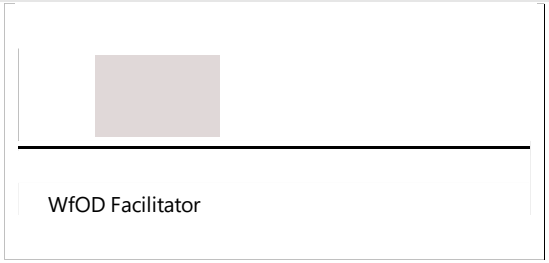
Recommendation	Likelihood	Impact	Risk Grading
1	2	2	4
2	2	2	4
3	2	2	4

Risk Assessment based on above recommendations – if policy is approved in original format refer to grading in appendix 1

Reputation and compromise position	Outcome
This policy provides security and reassurance to stakeholders that the information we hold is used appropriately and any breach may lead to fines and reputational damage.	Secure and appropriate use of information.
Training and dissemination of policy	
Although this is a high level policy, staff need to know about this framework and make staff aware of the policy.	

Is the policy etc lawful?	**Yes** ☒	**No** ☐	**Review date**
Does the EQIA group support the policy be adopted?	**Yes** ☒	**No** ☐	**3 years**

Signed on behalf of NWIS Equal Impact Assessment Group



Appendix 1

	Impact, Consequence score (severity levels) and examples				
	1	**2**	**3**	**4**	**5**
	Negligible	**Minor**	**Moderate**	**Major**	**Catastrophic**
Statutory duty	No or minimal impact or breach of guidance/statutory duty Potential for public concern Informal complaint Risk of claim remote	Breech of statutory legislation Formal complaint Local media coverage – short term reduction in public confidence Failure to meet internal standards Claims less than £10,000 Elements of public expectations not being met	Single breech in statutory duty Challenging external recommendations Local media interest Claims between £10,000 and £100,000 Formal complaint expected Impacts on small number of the population	Multiple breeches in statutory duty Legal action certain between £100,000 and £1million Multiple complaints expected National media interest	Multiple breeches in statutory duty Legal action certain amounting to over £1million National media interest Zero compliance with legislation Impacts on large percentage of the population Gross failure to meet national standards

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

NHS Wales
Information Security Policy

Author: Information Governance Management Advisory Group Policy Sub Group
Approved by: Information Governance Management Advisory Group
Approved by: Wales Information Governance Board
Version: 2
Date: 14th January 2021
Review date: 13th January 2023

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Contents

1. Introduction

This document is issued under the All Wales Information Governance Policy Framework and maintained by the NHS Wales Informatics Service (NWIS) on behalf of all NHS Wales organisations.

2. Purpose

The purpose of the Policy is to set out the responsibilities of NHS Wales organisations in relation to the security of the information they process. Processing broadly means collecting, using, disclosing, sharing, retaining or disposing of personal data or information.

These responsibilities include, but are not restricted to, ensuring that:

- All systems are properly assessed for security;
- The confidentiality, integrity, availability and suitability of information is maintained;
- All individuals as referenced within the scope of this policy are aware of their obligations.

This policy must be read in conjunction with relevant organisational procedures.

Information must only be shared where there is a defined purpose to do so. Nothing in this policy will restrict any organisation from sharing or disclosing any information provided they have an appropriate legal basis for doing so. Any information sharing which involves Personal Data or business sensitive information must be transferred securely.

3. Scope

This policy applies to the workforce of all NHS Wales organisations including staff, students, trainees, secondees, volunteers, contracted third parties and any persons undertaking duties on behalf of NHS Wales.

For the purpose of this policy ‘NHS Wales Organisations’ will include all NHS Wales organisations including all Health Boards and NHS Trusts.

It applies to all forms of information processed by NHS Wales organisations; and covers all business functions and the information, information systems, networks, physical environment and relevant people who support those business functions.

For the purpose of this policy “confidential information” refers to all personal data as defined by the data protection legislation, and information subject to the Duty of Confidence such as confidential business information and information relating to living or deceased individuals.

4. Roles and responsibilities

The Chief Executive is responsible for ensuring the highest level of organisational commitment to the policy and the availability of resources to support its implementation and any associated legal requirements. Specific responsibilities will be delegated to the Data Protection Officer, Senior Information Risk Owner and the Caldicott Guardian or an Executive Director as appropriate.

Managers are responsible for the implementation of this policy within their department/directorate. In addition, they must ensure that their staff are aware of this policy, understand their responsibilities in complying with the policy requirements, and are up to date with mandatory information governance training. Breaches of the policy must be reported via local incident reporting processes and dealt with in line with the All Wales Disciplinary Policy where appropriate.

The workforce must familiarise themselves with the policy content and ensure the policy requirements are implemented and followed within their own work area. Mandatory information governance training must be undertaken at least every two years. Breaches of this policy must be reported via local incident reporting processes.

5. Policy

5.1 User Access Controls

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

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

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

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

5.1.1 Physical Access Controls

All organisations are responsible for determining the security measures required based on local risk assessment. All staff are responsible for following these security measures and to ensure they maintain confidentiality and security at all times regardless of the setting (e.g. when working from home or working in the community).

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

Where physical security measures exist it must be ensured that they are employed at all times (e.g. filing cabinets must be locked, security doors and windows must be closed securely, blinds to secure areas closed). Access cards, PIN codes, keycodes, etc. must be kept secure and regularly changed as required.

The workforce must ensure a clear desk and clear screen when away from their work area ensuring that confidential information, in any format, is secure and not visible to anyone who is not authorised to access it.

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

5.1.2 Passwords

The workforce are responsible for the security of their own passwords which must be developed in line with NHS guidance ensuring they are regularly changed. Passwords must not be disclosed to anyone, and users must not allow anyone to access any work using their log-in details.

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

5.1.3 Remote Working

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

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

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

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

5.1.4 Staff Leavers and Movers

Managers will be responsible for ensuring that local leaving procedures are followed when any member of the workforce leaves or changes roles to ensure that user accounts are revoked / amended as required and any equipment and/or files are returned. Confidential information, including access to confidential information, must not be transferred to a new role unless authorised by the relevant heads of service or their delegate. The relevant checklist for leavers and movers must be completed in all cases.

5.1.5 Third Party Access to Systems

Any third party access to systems must have prior authorisation from the IT Department, and where personal data is involved, authorisation must also be sought from the Information Governance Department.

5.2 Storage of Information

All information stored on behalf of, or within NHS Wales organisations is the property of that organisation. All software, information and programmes developed for NHS Wales organisations by the workforce during the course of their employment will remain the property of the organisation.

Users are not permitted to use their personal devices or store confidential information on a personal device for the purpose of carrying out NHS Wales business unless they have been explicitly authorised to do so in line with a documented organisational process (e.g. a Data Protection Impact Assessment).

All systems supported by NHS Wales organisations will be backed up as part of their backup regime. Unless specifically told otherwise this will not include information held on local hard drives, portable devices or removable media. Users must not store information on local drives (usually referred to as the C Drive). Exceptions to this may be for legitimate work purpose to a device that is encrypted.

5.3 Portable Devices and Removable Media

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

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

All portable devices must utilise appropriate technical measures to ensure the security of all data.

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

Removable media includes, but is not limited to, USB ‘sticks’ (memory sticks), memory cards, external hard drives, CDs / DVDs and tapes, including those used in medical devices. Appropriate controls must be in place to ensure any information copied to removable media is secure.

5.4 Secure Disposal

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

5.4.1 Paper

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

5.4.2 Electronic

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

5.4.3 Other Items

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

5.5 Transporting and relocation of information

5.5.1 Transporting Information

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

5.5.2 Relocating information

When information, regardless of format, is to be physically relocated, local procedures must be formulated and followed by staff to ensure no information is left at the original location.

6. Training and Awareness

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

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

7. Monitoring and compliance

NHS Wales trusts its workforce, however it reserves the right to monitor work processes to ensure the effectiveness of the service. This will mean that any personal activities that the employee practices in work may come under scrutiny. NHS Wales organisations respect the privacy of its employees and does not want to interfere in their personal lives but monitoring of work processes is a legitimate business interest.

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

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

Concerns about possible fraud and/or corruption should be reported to the Counter Fraud team.

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

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Annex: Policy Development - Version Control

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

Equality Duties

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

Key	
✓	Yes
x	No
-	Neutral

Human Rights Based Approach – Issues of Dignity & Respect

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

Measuring the Impact

What operational impact does this **policy, service, scheme or project**, have with regard to the Protected Characteristics. Please cross reference with equality duties	
	Impact – operational & financial
Race	The revised policy is high level and focused on the security of information and the operational service management boards need to consider the detail around cyber security and procedures. It is about protecting information around the protected characteristics so it is used appropriately.
Sex/gender	
Disability	
Sexual orientation	
Religion belief and non belief	
Age	
Gender reassignment	
Pregnancy and maternity	
Marriage and civil partnership	
Other areas	
Welsh language	
Carers	

Outcome report

Equality Impact Assessment: Recommendations
Please list below any recommendations for action that you plan to take as a result of this impact assessment

	Recommendation	Action Required	Lead Officer	Time-scale	Resource implications	Comments
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3	Updated EQIA statement	Inclusion of reference to protected characteristics	AF	ASAP	Time	Amended – see section 9 prior to previous issue (wording retained in current policy)

Recommendation	Likelihood	Impact	Risk Grading

1	2	2	4
2	2	2	4
3	2	2	4

Risk Assessment based on above recommendations – if policy is approved in original format refer to grading in appendix 1

Is the policy etc lawful?	**Yes** ☒	**No** ☐	**Review date**
Does the EQIA group support the policy be adopted?	**Yes** ☒	**No** ☐	**3 years**

Signed on behalf of NWIS Equal Impact Assessment Group

WfOD Facilitator

	1	2	3	4	5
	Negligible	**Minor**	**Moderate**	**Major**	**Catastrophic**
Statutory duty	No or minimal impact or breach of guidance/statutory duty Potential for public concern Informal complaint Risk of claim remote	Breech of statutory legislation Formal complaint Local media coverage – short term reduction in public confidence Failure to meet internal standards Claims less than £10,000 Elements of public expectations not being met	Single breech in statutory duty Challenging external recommendations Local media interest Claims between £10,000 and £100,000 Formal complaint expected Impacts on small number of the population	Multiple breeches in statutory duty Legal action certain between £100,000 and £1million Multiple complaints expected National media interest	Multiple breeches in statutory duty Legal action certain amounting to over £1million National media interest Zero compliance with legislation Impacts on large percentage of the population Gross failure to meet national standards

Appendix 1

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

Cyfarfod a dyddiad: Meeting and date:	Digital and Information Governance Committee 18/6/2021
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Summary of business considered in private session to be reported in public
Cyfarwyddwr Cyfrifol: Responsible Director:	Dr Chris Stockport, Executive Director Primary & Community Care
Awdur yr Adroddiad Report Author:	Jody Evans, Corporate Governance Officer
Craffu blaenorol: Prior Scrutiny:	None
Atodiadau Appendices:	None

Argymhelliad / Recommendation:

The Committee is asked to note the report.

Ticiwch fel bo'n briodol / Please tick as appropriate

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		**Ar gyfer Trafodaeth For Discussion**		**Ar gyfer sicrwydd For Assurance**		**Er gwybodaeth For Information**	**x**

Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable	**N**

Sefyllfa / Situation:

To report in public session on matters previously considered in private session.

Cefndir / Background:

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.

The Digital and Information Governance Committee considered the following matters in private session on 26.3.2021:

DIG21/21 Ombudsman Thematic Report - Justice Mislaid
DIG21/22 Cyber Security update
DIG21/23 Business continuity planning
DIG21/24 National systems and timelines of events - Annual Plan
DIG21/25 Data Quality of Freedom of Information Responses relating to Covid 19
DIG21/26 Welsh Community Care Information System

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications
This report is purely administrative. There are no associated strategic implications other than those that may be included in the individual reports.

Opsiynau a ystyriwyd / Options considered
This report is purely administrative. There are no associated implications other than those that may be included in the individual reports.

Goblygiadau Ariannol / Financial Implications

This report is purely administrative. There are no associated financial implications other than those that may be included in the individual reports.

Dadansoddiad Risk / Risk Analysis
This report is purely administrative. There are no associated risk implications other than those that may be included in the individual reports.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance
Compliance with Standing Order 6.5.3.

Asesiad Effaith / Impact Assessment
This report is purely administrative. There are no associated impacts or specific assessments required.