

Digital and Data Committee Meeting

Wed 28 August 2024, 09:30 - 12:00

Agenda

09:30 - 09:30 1. PRELIMINARY MATTERS 0 min

1.1. Welcome and Introductions

Ian Wells, Committee Chair

1.2. Apologies for Absence

Ian Wells, Committee Chair

1.3. Declarations of Interest

Ian Wells, Committee Chair

09:30 - 09:30 2. CONSENT AGENDA 0 min

2.1. Items for Approval

2.1.1. Unconfirmed Minutes of the Meeting held on 21 May 2024

Approval Ian Wells, Committee Chair

 2.1.1. Unconfirmed Minutes 21 May 2024 Digital and Data - (v3).pdf (8 pages)

2.1.2. Unconfirmed Minutes of the In-Committee Meeting held on 21 May 2024

Approval Ian Wells, Committee Chair

 2.1.2. Unconfirmed In-Committee Minutes 21 May 2024 - Digital and Data.pdf (3 pages)

2.1.3. Outcome of the Committee Self Effectiveness Survey 2023-2024

Cally Hamblyn, Assistant Director of Governance & Risk

Deferred from last Committee Meeting

 2.1.3. Outcome of Digital and Data Self Effectiveness survey 2023-2024.pdf (4 pages)

2.1.4. Freedom of Information Policy

Approval Stuart Morris, Director of Digital

 2.1.4 Freedom of Information Policy v6 2024.pdf (38 pages)

2.1.5. Information Asset Procedure

Approval Stuart Morris, Director of Digital

 2.1.5 Information Asset Procedure.pdf (16 pages)

2.2. Items for Noting


2.2.1. All Wales Independent Member Digital Network Highlight Report

Noting Cally Hamblyn, Assistant Director of Governance and Risk

 2.2.1. IM Digital Network Highlight Report.pdf (4 pages)

2.2.2. Committee Annual Cycle of Business

Noting Ian Wells, Committee Chair

 2.2.2. Digital and Data Committee Annual Cycle of Business 2024-25.pdf (2 pages)

2.2.3. Committee Forward Work Plan

Noting Ian Wells, Committee Chair

 2.2.3. Forward Work Plan - DDC 28 August 2024.pdf (2 pages)

2.2.4. Action Log

Noting Ian Wells, Committee Chair

 2.2.4. Action Log Digital and Data Committee 28 August 2024.pdf (2 pages)

09:30 - 09:30 3. MAIN AGENDA

0 min

3.1. Matters Arising not otherwise contained on the Action Log

Discussion Ian Wells, Committee Chair

3.2. Spotlight Topic - Progress against Digital and Data Programmes

Discussion Stuart Morris, Director of Digital

Verbal presentation.

09:30 - 09:30 4. GOVERNANCE

0 min

4.1. Organisational Risk register

Discussion Cally Hamblyn, Assistant Director of Governance and Risk

 4.1a Org RR Cover Paper DDC Aug 24.pdf (6 pages)

 4.1b App 1 Org RR Jul 24 - DDC.xlsx (3 pages)

4.2. Information Governance Group Highlight Report

Discussion Claire Northwell-Todd, Head of Information Governance

 4.2. Information Governance Group Highlight Report - D&D 28 August 2024.pdf (6 pages)

4.3. Internal Audit Reports

Discussion Stuart Morris, Director of Digital

4.3.1. Internal Audit Review - Technical Resilience (Updated Management Actions)

Stuart Morris, Director of Digital

This item was also received at the Audit & Risk Committee on the 15th August 2024

 4.3.1. IA Review - Technical Resilience Updated Mmt Actions ARC 15 August 2024.pdf (20 pages)

09:30 - 09:30 5. IMPROVING CARE

0 min

5.1. Digital and Data Assurance Report

Noting Karen Winder, Assistant Director of Digital Systems

 5.1. Digital and Data Assurance Report -28 August 2024.pdf (13 pages)

5.2. Medical Records Assurance Report

Noting Matthew Swarfield, Head of Clinical Admin Transformation

Item To Follow

09:30 - 09:30 6. SUSTAINING OUR FUTURE

0 min

No specific item on this occasion. The Private Session will consider the Cyber Security Continuity Exercise that took place at the end of July 2024.

09:30 - 09:30 7. ITEMS TO BE DISCUSSED AT IN COMMITTEE MEETING

0 min

The following business sensitive items are to be discussed in the closed session:

- Organisational Risk Register - Cyber / Business Sensitive Risks
 - Cyber Improvement Programme
 - Digital Critical Incidents
-

09:30 - 09:30 8. OTHER MATTERS

0 min

8.1. Committee Highlight Report to Board

Discussion Ian Wells, Committee Chair

8.2. Any other urgent business

Information Ian Wells, Committee Chair

8.3. How did we do today?

Information Ian Wells, Committee Chair

09:30 - 09:30 9. Date and Time of the Next Meeting

0 min

The next meeting is scheduled for the 19th November 2024. This will be the last meeting of the Digital & Data Committee.

Agenda Item Number: 2.1.1

Unconfirmed Minutes of the Meeting of Cwm Taf Morgannwg University (CTMUHB) Digital & Data Committee Held on Tuesday 21 May 2024 via Microsoft Teams

Members Present:

Ian Wells	Independent Member (Committee Chair)
Lynda Thomas	Independent Member (Committee Vice Chair) (In Part)
Carolyn Donoghue	Independent Member
Kath Palmer	Vice Chair of Board

In Attendance:

Stuart Morris	Director of Digital / Senior Information Risk Owner
Andrew Nelson	Assistant Director of Data Intelligence & Compliance
Steve Macdonald	Assistant Director for Digital Delivery
Matthew Swarfield	Head of Clinical Administration Transformation
Robert Bleasdale	Associate Medical Director for Digital / Consultant Cardiologist
Paul Chilcott	Lead Infrastructure Architect / Interim Head of Cyber, ICT Department
Cally Hamblyn	Assistant Director of Governance and Risk
Tyler Lewis	Corporate Governance Officer (Committee Secretariat)

1. PRELIMINARY MATTERS

1.1 Welcome and Introductions

In opening the meeting, the Chair **welcomed** all those present. The Chair also noted the format of the proceedings in its virtual form.

1.2 Apologies for Absence

Apologies had been received from:

- Claire Northwell-Todd, Head of Information Governance
- Suzanne Rodgers, Assistant Director of Digital Transformation
- Christian Smith, Chief Nursing Information Officer
- Karen Winder, Assistant Director of Digital Systems

1.3 Declarations of Interest

No declarations of interests were received.

2. CONSENT AGENDA

2.1 **FOR APPROVAL**

2.1.1 **Unconfirmed minutes of the meeting held on 21st February 2024**

The minutes were **APPROVED** as an accurate record.

2.1.2 **Unconfirmed minutes of the In-Committee meeting held on 21 February 2024.**

The minutes were **APPROVED** as an accurate record.

2.1.3 **Committee Annual Report 2023-2024**

The Committee Annual Report was **APPROVED**.

2.2 **FOR NOTING**

2.2.1 **All Wales independent member network highlight report**

The report was **NOTED**.

2.2.2 **Committee Annual Cycle of Business**

The Committee Annual Cycle of Business was **NOTED**.

2.2.3 **Committee Forward Work Plan 2024-25**

There were no items identified for inclusion in the forward work plan.

2.2.4 **Action Log**

The Action Log was **NOTED**.

2.2.5 **Digital Operating Model – Final Internal Audit Report**

The audit report was **NOTED**.

3. **MAIN AGENDA**

3.1 **Matters arising not contained within the action log**

There were no matters arising to report.

3.2 **Spotlight Topic – Update on National Application Programmes**

S. Morris provided Members with a detailed presentational update on the application of National programmes.

Following the detailed presentation, Committee members raised a number of points. K Palmer enquired about the approach of the Digital and Data Plan to grouping and prioritising programmes, and how this approach impacts the risk profile.

L. Thomas proposed a shift in priorities and recommended an alternative approach, prioritising programs with a business case and highlighting those making progress to increase awareness of Digital Health for Wales.

C. Donoghue underlined the significance of aligning with national policy, addressing rejection trends in business cases and systems, as well as the escalated risk associated with an underfunded business case.

At a recent national meeting, I. Wells highlighted the ongoing concern regarding the declining number of approved business cases. He emphasised the potential benefits of engaging in a comprehensive dialogue with colleagues on this pertinent issue.

S. Morris highlighted the significant level of detail regarding the grouping and prioritisation of previously outlined programmes, and recognised that whilst some were without accompanying business cases, they are still being deliberated. He flagged an issue concerning the funding sought for business cases and acknowledged a disparity in funding from the governments of England and Wales.

K. Palmer expressed concerns about potential financial deficits compromising patient care quality and safety, emphasising the need for a comprehensive understanding of the main contributing factors.

S. Morris confirmed the attainment of significant milestones in line with the National plan for 2024-2025 and drew attention to an ongoing Business Case concerning the Llantrisant Health Park and the acquisition of digital resources. He highlighted the crucial nature of digital cellular pathology for the Health Board and advised that its business case will be presented for endorsement at the July Board Meeting.

A. Nelson reported that specific integration layers experienced failures due to an 8-year-old Application Programming Interface that did not comply with modern Clinical Data Repository standards which consequently led to challenges in submitting applications to National Programmes.

R. Bleasdale highlighted the indication of organisational maturity and emphasised the importance of co-ordination within the organisation, strategies for escalating issues, the value of shared listening and learning from clinical colleagues at a National Level, and implementing a modular Electronic Patient Record system with a robust core.

The Chair thanked digital colleagues for the robust update and responses to the queries raised by Members and proposed that a further meeting is arranged to delve deeper into matters in an offline setting.

The Committee **NOTED** the contents of the update.

Resolution

Action

It was agreed upon by Committee Members and the Director of Digital to hold a more in-depth discussion outside of the Committee Meeting.

4. **INTEGRATED GOVERNANCE**

4.1 **Organisational Risk Register**

C Hamblyn presented the Organisational Risk Register drawing attention to the updates in the cover paper and those highlighted in red in the appendix to the report.

I. Wells raised a concern regarding risk 5761 relating to "Cross Health Board Data Sharing" and sought clarity on the absence of National data resource in providing the service. D. Hurford acknowledged the issue which predominantly impacts the Prince Charles Hospital teams in relation to patient crossover. He emphasised the potential clinical risk associated with this and advised that Digital Health and Care Wales are working with the Health Board to seek a solution. He committed to providing updates to Members as required.

Resolution The Committee **REVIEWED** the report and sought assurance on the risk mitigations as appropriate.

4.2 **Information Governance Group Highlight Report**

A. Nelson presented the highlight report and provided an update on details of the key issues considered by the Information Governance Group at its meeting on the 9 May 2024.

A. Nelson proposed a meeting to discuss recommendations for cyber resilience in the Directive on Networked Infrastructure and Services (NIS-D) cyber improvement plan as assurance is required on the next steps to complete the plan's actions.

I. Wells commented on the necessity of incorporating local cyber training as part of compliance training.

K. Palmer sought clarification concerning the awareness of the training compliance rates highlighted in red following the dissolution of the Digital and Data Committee. A. Nelson assured the Committee that there are established processes in place to monitor training compliance.. C. Hamblyn advised that this area of activity will be considered in the Operational Delivery Committee in the new structure. Furthermore, S. Morris highlighted that any

cybersecurity-related issues would be addressed during Board Briefing sessions as well as within the appropriate new Committees

Resolution The Committee **NOTED** the report.

4.3 **Digital and Data Arrangements for the New Joint Commissioning Committee (JCC) – Verbal Update**

G. Watts delivered a verbal update to the Members regarding the progress of the new JCC governance arrangements. He addressed queries raised by members and underlined the significance of collaboration with the Information Governance Team, particularly as the Cwm Taf Morgannwg Health Board (CTMUHB) serves as the host for the JCC. He clarified that those working within the JCC are employees of CTMUHB and therefore must adhere to the policies and procedures of the Health Board.

Resolution The Committee **NOTED** the update.

Action The Director of Corporate Governance has agreed to provide updates to Members once the final governance arrangements have been finalised.

4.4 **Digital Future Ways of Working at Board Committee Level**

S Morris presented the report updating the Committee on the proposed approach for reporting and assurance of the Digital and Data portfolio in light of changes to the Board Committee structure.

Whilst unrelated to the Board Structure, S Morris referenced that the National digital governance arrangements are evolving within Welsh Government, noting that a Technology Leadership Portfolio Board had been established but is in its infancy.

In providing the update S Morris focussed on the incorporation of strategic digital discussions into the upcoming Strategic Development Committee, along with augmenting governance to ensure active cyber engagement in meetings. Additionally, he assured the Committee that digital considerations will be visible at Board level.

C. Hamblyn assured Members that she is undertaking a review of the Terms of Reference to ensure comprehensive coverage of digital and data-related matters. Furthermore, she intends to present Cyber assurance as a prominent agenda item to the Audit and Risk Committee.

K. Palmer sought assurance regarding the strategic presentation of in-committee items to the new committees and the significance of prioritising and planning for business-sensitive items over the long term. She suggested, a joint in-committee meeting may prove advantageous. In response, C. Hamblyn agreed to explore the suggestions as part of the review and

reiterated that the new structure allows flexibility in terms of whether topics are considered at Board Briefings, Board Development, or strategic discussions at Board.

C. Donoghue sought confirmation from the Digital Team that digital activity would be covered under the new Committee framework. S. Morris expressed optimism that Digital activity will have visibility across the board, and discussed how Members of the Digital Committee could act as Digital champions to facilitate conversations.

During discussions A. Nelson reiterated the importance of integrating Information Governance and data protection continuity into meetings. C. Hamblyn indicated that the structure has not been shared as it is currently in progress and suggested that future Board development sessions should include an educational component to ensure Independent Members gain a comprehensive understanding of the various information governance activity and roles such as the DPO, Caldicott Guardian etc.

Resolution The Committee **NOTED** the report.

5. **IMRPOVING CARE**

5.1 **Digital and Data Assurance Report**

S. Macdonald presented the report that updates the Committee on the extensive work plan delivered by Digital & Data Directorate.

During the update, S. Macdonald discussed that there has been progress in the deployment of network improvement, Wi-Fi access points, and the introduction of new technology including cyber vault and data domain implementation.

A. Nelson drew attention to the growing demand for digital and data services essential for supporting 'Business as Usual' activities, whilst outlining the significance of establishing a robust digital foundation. Additionally, he highlighted challenges related to program planning and delivery, attributing them to the substantial amount of money available and its distribution flexibility.

C. Donoghue valued the report for highlighting regular business activities and for its comprehensive coverage.

Resolution The Committee NOTED;

- The projects both system and infrastructure
- The challenges with the current level of capital and revenue funding to sustain a digital programme
- The increase in National Systems without local business cases.

5.2 **Medical Records Assurance Report**

M. Swarfield presented the report that summarised the current position regarding the following;

- The number of missing medical records;
- Casenote availability audit
- Casenote movement and activity
- Medical Records incidents
- Record storage at Princess of Wales
- Digitisation of patient records
- Records Retention and Destruction
- Patient Contact Services activity

I. Wells referenced that consultant names were included in the report. S. Morris noted that he had approved their inclusion, however upon reflecting on discussion at the meeting advised Members that they would be redacted in future reports. C. Hamblyn instructed the Corporate Governance Team to redact the consultant names.

K. Palmer expressed concern about the instances involving the medical records and asked if they had been sufficiently discussed or if they needed to be escalated further within the Health Board. S. Morris recognised the concerns and advised that risks are escalated and reported to the Executive Team. He advised that the current digital records strategy is still under review, pending work on storage pressures, progress on digital records and the financial position to progress digitisation.

Resolution The Committee **NOTED** the report.

6. **SUSTAINING OUR FUTURE**

6.1 **Clinical Coding AI Enabled Transformation Programme**

A. Nelson introduced J. Gapper and K. O'Shea, who presented an update on the demonstrable progress and benefits of the Health Boards execution of the AI enabled strategic transformation, highlighting the following;

- Quality of Coding
- Coding completeness
- Extending the scope of coding beyond inpatient and daycases.
- Workforce development
- Autocoder development
- Future direction

C. Donoghue welcomed the new development on the auto coding system and congratulated the team for taking the lead in this area.

Resolution The Committee **NOTED** the progress made in taking forward the coding improvement plan over the past year and the successful delivery of the Welsh Governments quality and completeness targets.

7. **Items to be discussed at the In-Committee**

The Chair advised that the following business sensitive items were to be discussed in the closed session:

- Cyber Improvement Programme
- External Audit Report - Cyber Resilience - Cyber Assessment Framework
- Organisational Risks relating to Cyber and Infrastructure Resilience
- Digital Critical Incidents

8. **OTHER MATTERS**

8.1 **Committee Highlight Report to Board**

I. Wells advised that the Corporate Governance Team would draft the highlight report for approval by himself and the Executive Lead.

8.2 **Any other urgent business**

No further areas of Business were identified.

8.3 **How did we do in this meeting?**

I. Wells invited feedback from Members either directly or via the Corporate Governance Team, suggesting this is received within the next two weeks.

9. **DATE AND TIME OF NEXT MEETING**

28 August 2024 at 9:30am.

Agenda Item Number: 2.1.2

Unconfirmed Minutes of the Meeting of Cwm Taf Morgannwg University (CTMUHB) Digital & Data In- Committee Held on Tuesday 21 May 2024 via Microsoft Teams

Members Present:

Ian Wells	Independent Member (Chair)
Lynda Thomas	Independent Member (Vice Chair) (In Part)
Carolyn Donoghue	Independent Member
Kath Palmer	Vice Chair

In Attendance:

Stuart Morris	Director of Digital / Senior Information Risk Owner
Andrew Nelson	Assistant Director of Data Intelligence & Compliance
Steve Macdonald	Assistant Director for Digital Delivery
Matthew Swarfield	Head of Clinical Administration Transformation
Robert Bleasdale	Associate Medical Director for Digital / Consultant Cardiologist
Paul Chilcott	Lead Infrastructure Architect / Interim Head of Cyber, ICT Department
Cally Hamblyn	Assistant Director of Governance and Risk
Tyler Lewis	Corporate Governance Officer (Committee Secretariat)

1. PRELIMINARY MATTERS

1.1 Welcome and Introductions

In opening the meeting, the Chair **welcomed** all those present. The Chair also noted the format of the proceedings in its virtual form.

1.2 Apologies for Absence

Apologies had been received from:

- Claire Northwell-Todd, Head of Information Governance
- Suzanne Rodgers, Assistant Director of Digital Transformation
- Christian Smith, Chief Nursing Information Officer
- Karen Winder, Assistant Director of Digital Systems

1.3 Declarations of Interest

No declarations of interests were received.

2. CONSENT AGENDA

2.1 FOR APPROVAL

2.1.2 Unconfirmed minutes of the In-Committee meeting held on 21 February 2024.

The minutes were **APPROVED** as an accurate record.

2.2 FOR NOTING

2.2.1 Cyber Improvement Programme

P. Chillcott, Head of Cyber Security presented the report The continued delivery of effective clinical services is dependent upon reliable and resilient digital and data services, and a mature and responsive cyber security service.

Resolution The Committee **NOTED** the progress made in taking forward the cyber improvement plan this quarter and **CONSIDERED** the three key risks identified and determine whether the plan is sufficient to improve the Health Boards' mitigation of these risks taking into consideration the wider operating environment.

2.2.2 Organisational Risk Register

C. Hamblyn, Assistant Director of Governance & Risk presented the report The report for the Committee to review and discuss the organisational risk register and consider whether the assigned risks had been appropriately assessed.

The Committee;

Resolution **REVIEWED** the risks escalated to the Organisational Risk Register at Appendix 1 and **CONSIDERED** whether the Committee can seek assurance from the report that all that can be done is being done to mitigate the risks

3. MAIN AGENDA

3.1 Matters arising not contained within the action log

There were no matters arising to report.

4. IMPROVING CARE

4.1 External Audit Report – Cyber Resilience – Cyber Assessment

P. Chillcott presented the report that updates the Committee on the findings of the CRU review: CRU Cyber Security Assurance Report – CTMUHB.

The Committee AGREED;

- The findings made by the Cyber Resilience Unit in their assessment of our cyber maturity, noting the degree of subjectivity that exists in this process.
- That the findings and recommendations will be considered in the wider context of the cyber improvement plan and the prioritisation framework and guidelines that the NIST framework sets out.

4.2 Digital Critical Incidents

P. Chillcott presented the report that updated the Committee on the care and manage its business, expectations and requirements for the provision of resilient and reliable services increase.

Resolution The Committee **NOTED** the Digital & Data incidents that occurred over the period, and the dependence of the Health Board on 3rd party and NHS Wales suppliers.

5. Any other urgent business

No further areas of Business were identified.

6. DATE OF NEXT MEETING

The next meeting was scheduled for 28 August 2024



Agenda Item

2.1.3

Digital & Data Committee

**Committee Annual Self Effectiveness Survey Outcome
2023-2024 & Improvement Plan**

Dyddiad y Cyfarfod / Date of Meeting	28/08/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Tyler Lewis, Corporate Governance Officer
Cyflwynydd yr Adroddiad / Report Presenter	Ian Wells, Independent Member/Chair Digital & Data Committee
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Stuart Morris, Director of Digital

Pwrpas yr Adroddiad / Report Purpose	For Noting
---	------------

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome

Acronyms / Glossary of Terms	
Digital Health and Care Wales	DHCW



1. PURPOSE

- 1.1 The Chair of the Digital & Data Committee is required to present an annual report to the Board outlining the Committee's business through the financial year to provide an assurance. As part of this process, The Committee are required to undertake an annual self-assessment questionnaire.
- 1.2 Members of the Committee are asked to discuss and review the feedback set out in this report which relate to its activities and performance during 2023-2024
- 1.3 Members should note that 6 responses were received out of a total of 11 which equated to 55%

2. SUMMARY REPORT

Positive Assurance

1. Committee Effectiveness:

- Approximately 83% of respondents confirmed that there are approved Terms of Reference in place, clearly defining the role of the Committee, and that these are reviewed on an annual basis.
- An Annual Report of the Committee was prepared and presented to the Board, providing assurance that the Committee's activities align with its defined remit.
- A Committee Annual Cycle of Business has been established to be addressed throughout the year.

2. Committee Business

- 83% of respondents expressed the view that meetings were held with sufficient frequency to effectively address planned matters.
- All respondents (100%) concurred that the Committee was endowed with sufficient authority and resources to perform its role effectively.
- Members agreed that the Committee met often enough to cover all planned topics effectively, giving enough time for questions and discussions that lead to open and productive debates.
- The Committee expressed the opinion that each agenda item was conclusively addressed, ensuring clarity regarding outcomes.
- All respondents (100%) agreed that clear boundaries between this Committee and other Committees were well-defined, with appropriate cross-referral.
- Members felt adequately supported by Executive Directors in terms of their attendance, the quality and length of submitted papers, and their responsiveness to challenges and questions.
- Unanimously (100%), Members acknowledged that the Committee provided clear and concise updates on its activities and appropriately escalated any concerns through Highlight Reports to the Board.



	<p>3. Behaviour, Culture and Values</p> <ul style="list-style-type: none"> The Committee expressed that the meetings were effectively chaired, with a clear sense of purpose and well-defined outcomes. Members and Attendees were consistently courteous and professional during meetings. It was noted that the atmosphere at the meetings was conducive to open and productive debate. All Members (100%) reported a positive experience with remote or virtual Committee meetings. Feedback indicated that this was a highly engaged Committee, characterized by supportive and constructive challenge. <p>4. Welsh Language</p> <ul style="list-style-type: none"> Currently, there has been no requirement to conduct Committee meetings in Welsh, as reflected in the responses received. However, if a Member or Attendee expressed a preference for conducting meetings in Welsh, the Committee would accommodate this request as appropriate.
Areas of Note	<p>1. Committee Effectiveness</p> <ul style="list-style-type: none"> The Committee reviewed and approved its Annual Report for 2023-2024 during the meeting held in May 2024. The report was subsequently submitted to the Board in May 2024. The Committee Cycle of Business, to further complement the Forward Work Programme, was approved by the Committee during the meeting in February 2024 and has been implemented accordingly. <p>2. Committee Business</p> <ul style="list-style-type: none"> Feedback was received expressing concerns on the dissolution of the Committee following the August 2024 meeting. Members sought assurance regarding the establishment of a clear Digital and Data Strategy within the new Committee structure. They also requested ongoing clarity about the deliverables of DHCW in their collaboration with the Health Board, as well as a strategic direction for Electronic Patient Records.
Areas Requiring Further Consideration	<p>Committee Effectiveness - Areas for action/improvement</p> <ul style="list-style-type: none"> Maintain ongoing collaboration with DHCW and ensure regular updates on their progress with the Health Board.
Action Plan	<p>In response to the areas of improvement identified the following actions are proposed:</p> <ul style="list-style-type: none"> Ensure that the Digital and Data agenda remains a key focus in the new Committee structure. It is important that issues continue to be prominently addressed and effectively managed, with clear processes



	in place to oversee and support digital and data initiatives within the restructured Committee.
Appendices	N/A

3. RECOMMENDATION

3.1 The Committee is asked to **NOTE** the report.

Freedom of Information Act Policy

Document Type:	Non Clinical Organisational Wide Policy
Ref:	IG 02
Author:	Claire Northwell, Head of Information Governance
Executive Sponsor:	Director of Digital
Approved By:	Digital & Data Committee
Approval / Effective Date:	
Review Date:	August 2027
Version:	6

Target Audience:

People who need to know about this document in detail	All staff are required to comply with this policy. The term staff includes permanent, temporary, contracted and voluntary staff of the Health Board, including Independent Members and those with honorary contracts who have access to and create officially recorded information.
People who need to have a broad understanding of this document	All staff are required to comply with this policy. The term staff includes permanent, temporary, contracted and voluntary staff of the Health Board, including Independent Members and those with honorary contracts who have access to and create officially recorded information.
People who need to know that this document exists	All staff are required to comply with this policy. The term staff includes permanent, temporary, contracted and voluntary staff of the Health Board, including Independent Members and those with honorary contracts who have access to and create officially recorded information.

Integrated Impact Assessment:

Equality Impact Assessment Date & Outcome	Date: June 2024
	Outcome: Neutral
Welsh Language Standard	No
Date of approval by Equality Team:	

Aligns to the following Wellbeing of Future Generation Act Objective

Co-create with staff and partners a learning and growing culture



Disclaimer:

If the review date of this document has passed please ensure that the version you are using is the most up to date version either by contacting the author or CTM_Corporate_Governance@wales.nhs.uk

CONTENTS PAGE

		Page
1	Purpose	4
2	Policy Statement	4
3	Principles	4
4	Scope	4
5	Legislative and NHS Requirements	5
6	Procedure	5
7	Training Implications	6
8	Review, Monitoring and Audit Arrangements	6
9	Managerial Responsibilities	6
10	Retention / Archiving	7
11	Non-Conformance	7
12	Equality Impact Assessment Statement	7
13	References	7
14	<p>Appendices</p> <p>Appendix 1 – Right of Access Detailed Procedures</p> <p>Appendix 2 – Guidelines on the Disclosure of Staff Information</p> <p>Appendix 3 – Guidelines for the Reuse of Public Sector Information</p>	8 - 39

1. PURPOSE

The purpose of this policy is to outline what Cwm Taf Morgannwg University Health Board (referred hereafter as "CTMUHB") intends to do to ensure compliance with the Freedom of Information Act, referred to hereafter as the Act. The Act, deals with access to official recorded information held by public authorities. Parallel regulations deal with access to environmental information which are only referenced within this Policy.

2. POLICY STATEMENT

CTMUHB is committed to complying with the Act and recognises in full the rights and obligations established it, particularly in relation to access to the recorded information it holds. This policy and its supporting procedures and documentation is the framework by which the Health Board aims to meet its obligations.

3. PRINCIPLES

CTMUHB supports a climate of openness and will take measures to help and inform the public in relation to their rights as contained within the Act, based on the following principles:

- A general right of access in relation to recorded information held by public authorities, subject to certain conditions and exemptions
- A duty on public authorities to provide a reason for refusal where access to information is refused in reliance on an exemption from disclosure
- A duty on every public authority to adopt and maintain a publication scheme, approved by the Information Commissioner, and to publish information in accordance with that scheme.

4. SCOPE

This policy applies to all official recorded information held by CTMUHB, irrespective of age, format or location.

All staff are required to comply with this policy. The term staff includes permanent, temporary, contracted and voluntary staff of the Health Board, including Independent Members and those with honorary contracts who have access to and create officially recorded information.

Ref: IG 02

Freedom of Information Act Policy

Page 4 of 38

5. LEGISLATIVE AND NHS REQUIREMENTS

- Freedom of Information Act 2000
- Environmental Information Regulations 2000
- General Data Protection Regulation 2016
- Data Protection Act 2018

6. PROCEDURE

A significant amount of information will be routinely published via the Publication Scheme ([Publication Scheme - Cwm Taf Morgannwg University Health Board \(nhs.wales\)](#)). Requests for other information will be dealt with in a timely manner as required by the Act. However, in cases where the requested information is covered by an exemption, consideration will be given as to whether or not the information should be released. Detailed procedures for dealing with Rights of Access will be followed and can be accessed at Appendix 1. Health Board staff have a duty to provide reasonable advice and assistance to applicants requesting information as outlined within the Act.

Requesters may direct a complaint to the Information Governance Department and are entitled to request an internal review of the handling of their requests. If after an internal review they remain dissatisfied they are entitled to refer the matter directly to the Information Commissioners Office.

CTMUHB acknowledges that patients and staff have a right to privacy and confidentiality and this policy does not overturn the common law duty of confidentiality or statutory provisions that prevent disclosure of personal identifiable information. The release of such information is still covered by the subject access provisions of the Data Protection legislation. Requests for information relating to staff will be considered using the Guidelines on the Disclosure of Staff Information at Appendix 2.

Guidelines for the Reuse of Public Sector Information can be found at Appendix 3.

7. TRAINING IMPLICATIONS

All staff must be aware of the key principles of the Act to enable CTM UHB to meet its legal responsibilities. Staff should be able to:

- identify a publication scheme request for information and give advice where the scheme can be found;
- identify a general request for information;
- direct FOI requests to the Information Governance Team; and
- understand their responsibilities where requests are made concerning their area of responsibility.

Guidance is provided via the Health Board's website and the Information Governance SharePoint pages; however bespoke training can be provided internally as required.

8. REVIEW, MONITORING AND AUDIT ARRANGEMENTS

A full review of this policy will be undertaken every two years or sooner if there are changes to guidance or legislation. On-going monitoring and auditing of this policy will be undertaken by the Head of Information Governance, and the Information Governance Group who receive regular reports on compliance with the Act.

Policy approval will be sought from the relevant Board Committee.

9. MANAGERIAL RESPONSIBILITIES

The Chief Executive will act as the qualified person within CTMUHB and as such will consider the application of exemptions under Section 36 of the Act: Prejudice to the Effective Conduct of Public Affairs.

CTMUHB will nominate an Independent Member of the Board to undertake the role of the FOI Act Champion, when required in respect of any investigations undertaken by the ICO in the event of any appeals.

The Director of Digital will be responsible for ensuring that there are effective arrangements in place to enable compliance with the provisions of the Act as well

as providing periodic reports to the Executive Leadership Group and the Board as required.

The Head of Information Governance will undertake the administration of this policy including the implementation of procedures to ensure compliance with the requirements of the Act. The Department will co-ordinate effective discharge of the duty to provide advice and assistance to applicants and would be applicants imposed under Section 16 of the Act.

All directors and managers are responsible for ensuring that this policy and the associated procedures are implemented in a timely manner within their area of responsibility and communicated to their staff. Further information or guidance may be sought from the Freedom of Information Officer (CTM.FreedomOfInformation@wales.nhs.uk).

10. RETENTION / ARCHIVING

Requests for information under the Act will be retained and archived in line with National Records Management Guidance. This Policy will be subject to version control and archived as required by local policy.

11. NON-CONFORMANCE

All staff are required to comply with this policy and where requested demonstrate such compliance. Failure to comply will be dealt with under the appropriate employment Policy.

It is important to note that it is an offence to alter, deface, block, erase, destroy or conceal any record held by the public authority, with the intention of preventing the disclosure and offenders may be subject to legal proceedings.

12. EQUALITY IMPACT ASSESSMENT STATEMENT

Following an Equality and Welsh Language Assessment this policy is not felt to be discriminatory or detrimental in any way with regard to the equality standards.

13. REFERENCES

- Freedom of Information Act 2000
- Environmental Information Regulations 2000
- General Data Protection Regulation (GDPR)

Ref: IG 02

Freedom of Information Act Policy

Page 7 of 38

- Data Protection Act 2018
- Human Rights Act 1998
- Lord Chancellor's Code of Practice on the Discharge of Public Authorities' Functions under Part I of the Freedom of Information Act 2000, issued under section 45 of the Act (Nov 2002)
- Lord Chancellor's Code of Practice on the Management of Records under section 46 of the Act (Nov 2002)
- Cwm Taf Morgannwg University Health Board Records Management Policy
- All Wales NHS Information Governance Policy

14. APPENDICES

Appendix 1 – Right of Access Detailed Procedures

Appendix 2 – Guidelines on the Disclosure of Staff Information

Appendix 3 – Guidelines for the Reuse of Public Sector Information



Freedom of Information Act Right of Access

Detailed Procedures

INITIATED BY: Director of Digital

APPROVED BY: TBC

DATE APPROVED: TBC

VERSION: 6

OPERATIONAL DATE: September 2018

DATE FOR REVIEW: September 2026

DISTRIBUTION: All Staff via Intranet & Core Brief Message

FREEDOM OF INFORMATION STATUS: OPEN

CONTENTS

	Right of Access – Detailed Procedures	Page
1.	Procedure 1: Where sufficient details are provided to locate the requested information	11
2.	Procedure 2: Where insufficient details are provided to locate the requested information	12
3.	Procedure 3: Information requested is not held	13
4.	Procedure 4: Requests that exceed the appropriate limit	14
5.	Procedure 5: Refusal of a request utilizing the exemptions	17
6.	Procedure 6: Refusal of requests that are deemed vexatious or repeated (section 14)	20
7.	Procedure 7: Transfer of requests for information	21
8.	Procedure 8: Consultation with third parties	22
9.	Procedure 9: Freedom of Information Complaints and Feedback	24

PROCEDURE 1: Where sufficient details are provided to locate the requested information

The Freedom of Information Officer (FoIO) will send an acknowledgement letter within two working days of receipt of the request. The acknowledgement letter will state that the request has been received and is being processed. This contact will be recorded on the Freedom of Information request database.

Where the FoIO has sufficient information to locate and process the request, they will identify the appropriate 'link' person and forward the request to them by email within 2 working days. The email will request that a response is returned by day 10, this timescale will be closely monitored. At this stage, the link person will also be asked if they have any objection to the identified information being disclosed. This contact will be recorded on the Freedom of Information request database.

The information provided by the 'link' will need to be scrutinised and reviewed by their nominated approver within their areas to ensure the information is appropriate, that it fully answers the request prior to sending to the Team. Consideration will then given whether exemptions apply and whether fees or charges are payable. . Please note that spreadsheets are no longer accepted from 'links' due to breaches of the Act, and ICO recommendations.

If any exemptions are applicable, the Procedure: Refusal of Requests – Use of Exemptions will be activated. If the cost of retrieving the requested information exceeds the appropriate limit the Procedure: Refusal on the Grounds of Cost will be activated.

PROCEDURE 2: Where insufficient details are provided to locate the requested information

The Freedom of Information Officer (FoIO) will send an acknowledgement letter within two working days of receipt of the request. The acknowledgement letter will state that the request has been received and is being processed. This contact will be recorded on the Freedom of Information requests database.

Where an applicant has not described the information sought in a way that would enable CTMUHB to identify or locate it, assistance will be provided to enable him or her to describe more clearly the information requested.

The purpose of this contact will be to clarify the nature of the information sought, not to determine the aims or motivation of the applicant. This contact will be recorded on the Freedom of Information request database.

The 20 working day time limit is not activated until the applicant has provided sufficient information for CTMUHB to proceed. If no response is received within three months, the request will be closed. If a response is received the appropriate procedure will be followed.

PROCEDURE 3: Information requested is not held

If, after following the appropriate procedure, it is established that CTMUHB does not hold the requested information, the applicant will be informed as soon as possible within the 20 working day limit. The contact will be recorded within the Freedom of Information request database.

PROCEDURE 4: Requests that Exceed the Appropriate Limit

Section 12 of the Freedom of Information Act 2000 (FOIA) provides an exemption from the obligation to comply with a request for information where the cost of compliance is estimated to exceed the appropriate limit. The appropriate limit is the key concept concerning fees.

Where CTMUHB is concerned, the appropriate limit is set at £450. If the cost of complying with a request exceeds the appropriate limit, the University Health Board can:

- refuse to supply the information on the grounds of cost, or
- can offer to provide the information if the applicant is prepared to pay a fee.

Where it has been estimated that cost of compliance exceeds £450, the Health Board can charge the total amount for:

- determining whether it holds the information;
- locating the information, or documents which may contain the information;
- retrieving the information, or documents which may contain the information, and
- extracting the information from a document(s) in which the information is contained.

The four activities are sequential.

NB: We can take into account the costs attributable to the time that staff (and if applicable, external contractors) are expected to spend on these activities. Such costs are calculated at £25 per hour per person regardless of the actual cost or rate of pay, which means that the limit will be exceeded if these activities exceed 18 hrs.

CTMUHB is not permitted to take into account any time likely to be spent:

- considering exemptions that may apply to the information requested; and
- redacting exempt material.

NB: If a request is refused because the appropriate limit has been exceeded, the organisation must bear in mind the duty under Section 16 of the FOIA to advise and assist an applicant; such advice could include how to 'refine or limit' the request to bring it within the cost limit.

Ref: IG 02

Freedom of Information Act Policy

Page 14 of 38

Refusal on the Grounds of Cost

Where a decision is made to refuse a request because the cost of compliance exceeds the appropriate limit, the requester will be informed via a Refusal Notice issued at the earliest opportunity and within the twenty working day time limit.

The Refusal Notice must:

- Confirm or deny whether the information is held (unless cost of this alone would exceed the appropriate limit);
- Specify the reason for refusal;
- Quote the (Appropriate Limit and Fees) Regulations 2004;
- Provide an estimate of the cost of complying with the request; and
- Specify the exemption, (Section 12 (1)).

As set out in Section 17(7) the applicant will also be informed of the Health Board's complaints procedure and of their right to complain to the Information Commissioner.

NB: The Fees Regulations state that two or more requests to the Health Board can be aggregated for the purposes of calculating costs if they are:

- by one person, or by different persons who appear to the Health Board to be acting in concert or in pursuance of a campaign;
- for the same or similar information; and
- the subsequent request is received by the Health Board within 60 working days of the previous request.

The intention of this provision is to prevent individuals or organisations evading the appropriate limit by dividing a request into smaller parts.

Example Refusal Notice

"Retrieval of the information requested would require a trawl of patient case notes. Whilst these case notes are held by CTMUHB, the Freedom of Information and Data Protection Acts set a limit on the cost of compliance with a request. This limit is set at £450 and we are allowed to aggregate requests, such as those referred to above, for the purposes of calculating the cost of compliance. In relation to your request Q.1 ii), taken as an example, we estimate that the cost of compliance with this element of your request alone would be in excess of £1000 because the Health Board would need to check 253 sets of casenotes, taking an estimated 15 minutes for each case note".

Ref: IG 02

Freedom of Information Act Policy

Page 15 of 38

Accordingly, I find that the cost of compliance with your requests would be excessive such that the exemption at Section 12 (1) of the Freedom of Information Act is engaged.”

If you are dissatisfied, either because the information has not been provided to you, or with the way your request has been handled by the Health Board, you have the right to complain and request a review. If you are still dissatisfied at the end of any review, you may ask the Information Commissioner to adjudicate.

Provision of the information where the applicant is prepared to pay a fee

CTMUHB may take a decision to provide the requested information if the requester is prepared to pay the fee. Where this is the case, the requester will be issued with a Fees Notice. The Fees Notice will specify the fee, (payable in advance), provide the calculations and specify the time limit for a response.

NB: The period from the day the Fees Notice is issued to the day the fee is received does not count towards the 20 working day limit for response. Where the requester wishes to pay the fee, the 20 working days would resume once the cheque is cleared. CTMUHB must ensure that cheques are banked promptly.

If, following the issue of a Fees Notice, the specified fee is not paid within three months beginning on the day on which the fees notice was given to the requester, the request will be closed.

PROCEDURE 5: Refusal of a Request Utilising the Exemptions

The Freedom of Information Act 2000 (the Act) recognises that there are valid reasons for withholding information by setting out a number of exemptions from the right to know. There are 23 exemptions in all, some of which are absolute exemptions, and others which 'qualified' and subject to a 'public interest test'. These exemptions mark out the limits of the right of access to information. If information is properly exempt then there is no right of access to it under the Act.

The exemptions operate in different ways and, when considering applying individual exemptions, CTMUHB will need to consider the following factors:

- The content of the information
- The effect disclosure would have
- The source of the information
- The purpose for which the information was recorded

The Act provides two distinct, but related rights of access to information, which impose corresponding duties on the Health Board, these are:

- the duty to inform the requester whether or not information is held by the Health Board (the duty to confirm or deny), and if so,
- the duty to provide that information to the requester.

Both of these elements are subject to exemptions contained within FOIA.

The Duty to Confirm or Deny in Relation to Exempt Information

This element will be managed by the FoIO, referring to Information Commissioner's Office (ICO) [Awareness Guidance 21](#).

Refusal of a Request where the Information Requested is Exempt from Disclosure under Part II of FOIA (the Exemptions)

The exemptions, listed below, are contained within Sections 21 – 44 of the Act. The ICO has issued guidance on the application of each of the exemptions. This element will be managed by the FoIO referring to the guidance. Exemptions may be absolute or qualified.

- 21. Information accessible to applicant by other means (absolute)
- 22. Information intended for future publication (qualified)

Ref: IG 02

Freedom of Information Act Policy

Page 17 of 38

- 23. Information supplied by, or relating to, bodies dealing with security matters (absolute)
- 24. National security (qualified)
- 25. Certificates under ss. 23 and 24: supplementary provisions.
- 26. Defence (qualified)
- 27. International relations (qualified)
- 28. Relations within the United Kingdom (qualified)
- 29. The economy (qualified)
- 30. Investigations and proceedings conducted by public authorities (qualified)
- 31. Law enforcement (qualified)
- 32. Court records, etc. (absolute)
- 33. Audit functions (qualified)
- 34. Parliamentary privilege (absolute)
- 35. Formulation of government policy, etc. (qualified)
- 36. Prejudice to effective conduct of public affairs (qualified)
- 37. Communications with Her Majesty, etc. and honours. (qualified)
- 38. Health and safety (qualified)
- 39. Environmental information (qualified)
- 40. Personal information (qualified)
- 41. Information provided in confidence (absolute)
- 42. Legal professional privilege (qualified)
- 43. Commercial interests (qualified)
- 44. Prohibitions on disclosure (absolute)

Where a decision has been taken to withhold requested information utilising one (or more) of the exemptions, a notice will be issued within twenty working days (Section 17 of the Act). The notice will:

- a. state that fact;
- b. specify the exemption in question; and
- c. state (if that would not otherwise be apparent) why the exemption applies.

When it is anticipated that the 20 working day limit will be exceeded when considering exemptions, the applicant will:

- a. be informed that an exemption is being considered and that a decision has not yet been reached; and
- b. be provided with an estimated date by which they may expect a decision (the estimate should be realistic and reasonable and must be complied with unless there are extenuating circumstances).

If an estimate is exceeded, the applicant will be given a reason(s) for the delay and offered an apology by the FoIO.

If the FoIO/ Information Governance Manager finds that the estimate is proving unrealistic, the applicant will be kept informed. A record will be kept of instances where estimates are exceeded, and where this happens more than occasionally, steps will be taken to identify the problem and rectify it.

Public Interest Test

In applying a qualified exemption CTMUHB must consider whether the public interest in maintaining the exemption is greater than that in confirming or denying the existence of the information requested and providing the information to the applicant.

If a qualified exemption is being applied, the FoIO will, either in the notice issued, (see above) or in a separate notice, state the reasons for claiming:

- a. that, in all the circumstances of the case, the public interest in maintaining the exclusion of the duty to confirm or deny outweighs the public interest in disclosing whether the Health Board holds the information, or
- b. that, in all circumstances of the case, the public interest in maintaining the exemption outweighs the public interest in disclosing the information.

The statement will not involve the disclosure of information which would itself be exempt information.

The FoIO will record all information request refusal notices. These will be subject to periodic review to maintain consistency in decision making. When considering exemptions, the FoIO will consult with the appropriate Executive Director or Senior Managers and the final decision on the application of the public interest test will rest with the Board level champion for information governance issues.

PROCEDURE 6: Refusal of Requests that are Deemed Vexatious or Repeated (Section 14)

The Information Commissioner's general approach is that a request (which may be the latest in a series of requests) can be treated as vexatious where it would impose a significant burden on the Health Board in terms of expense or distraction and meets at least one of the following criteria:

- it clearly does not have any serious purpose or value;
- it is designed to cause disruption or annoyance;
- it has the effect of harassing the public authority; and
- it can otherwise fairly be characterised as obsessive or manifestly unreasonable.

This is not, however, intended to be a formulaic approach for every request, and each specific request should be looked at and assessed individually.

A request for information which should be available through CTMUHB's Publication Scheme cannot be refused on the grounds that it is vexatious. Requests which may be deemed vexatious or repeated will be dealt with using [Freedom of Information Act Awareness Guidance: Number 22](#) as the reference document.

If a decision is made to refuse a request on the grounds that it is vexatious or repeated, a Section 17 Refusal Notice will be issued. If the Health Board is relying on a claim that the request is vexatious or repeated under Section 14 of the Act, and a notice under Section 17 has already been issued to the applicant stating this fact, a further notice is not required.

PROCEDURE 7: Transfer of requests for information

Where CTMUHB receives a request for information which it does not hold, but which it believes may be held by another public authority, the FoIO will consult with that authority to ascertain whether it holds the information requested. If held by the other public authority, consideration will be given to whether the request should be transferred. If appropriate, the FoIO will oversee the transfer of that request.

If CTMUHB holds some of the information requested, a transfer will be made in respect of the information that it does not hold (but is held by another public authority).

When it becomes apparent that CTMUHB does not hold all or part of the information requested, they will advise the applicant of this fact. A request (or part of a request) will not be transferred without confirmation by the second authority that it holds the information. If this course of action is pursued, the applicant will be informed of this and updated on progress.

Before transferring a request for information to another authority, the FoIO will consider whether a transfer is appropriate. If this is the case, they will consult with the applicant to determine whether they have any objections to the transfer.

If appropriate, they will transfer the request to the other authority if the applicant consents. If the applicant refuses to give consent, the FoIO will advise that he or she can submit a new request to the other authority.

All transfers of requests should take place as soon as practicable, and the applicant should be informed as soon as possible following the transfer. All transfers must be processed within the twenty working day timescale. A record will be kept of all activity associated with the transfer of requests for information to other public authorities.

NB: Where a request, or part of a request, is transferred from one public authority to another, the receiving authority has an obligation under Part I of the Act to treat the transferred application as it would a request received directly from an applicant.

PROCEDURE 8: Consultation with Third Parties

There will be occasions when requested information will contain information that relates to third parties. Disclosure of such information may affect the interests of the third parties and in some instances may also affect their legal rights.

CTMUHB will take appropriate steps to ensure that such third parties, and those who supply public authorities with information, are aware of the Health Board's duty to comply with the Freedom of Information Act, and that information will have to be disclosed upon request unless an exemption applies.

In some cases it will be necessary to consult with third parties in order to establish their views on disclosure of requested information or in order to help determine whether or not an exemption applies to the information requested. The views of the third party may also assist the Health Board to determine where the public interest lies under Section 2 of the Act.

Where information is subject to the common law duty of confidence or where it constitutes "personal data" within the meaning of the Data Protection Act 2018 (DPA), unless a FOIA exemption applies, the Health Board is obliged to disclose that information. Where it is determined that the requested information constitutes "personal data" within the meaning of the DPA, the FoIO will have regard to Section 40 of the Act.

In some cases disclosure of information cannot be made without the consent of a third party. For example, where information has been obtained from a third party and the disclosure of the information without their consent would constitute an actionable breach of confidence (such that the exemption at Section 41 of the Act would apply). In such cases the FoIO will consult the third party seeking their consent to the disclosure, unless this is not practicable, for example because the third party cannot be located or because the costs of consulting them would be disproportionate.

A record will be kept of all contacts with third parties regarding consultations and decision making on the disclosure of information that may affect their legal rights.

Consultation with a number of third parties

Where the interests of a number of third parties may be affected by a disclosure and those parties have a representative organisation which can express views on their behalf, the FoIO could, if consultation is considered appropriate, decide that it would be sufficient to consult that representative organisation.

Ref: IG 02

Freedom of Information Act Policy

Page 22 of 38

If there is no representative organisation, the FoIO may consider that it would be sufficient to consult a representative sample of the third parties concerned. A record will be kept of all contacts with representative organisations or representative samples of third parties in respect of consultations and decision making on the disclosure of information.

Where there is no response or there is a refusal to consent by the third party

If a third party has not responded to consultation, CTMUHB is not relieved of its duty to disclose information under the Act, or its duty to reply within the time specified in the Act.

Similarly, a refusal to consent to disclosure by a third party does not, in itself, mean information should be withheld.

In all cases, it is for CTMUHB, through the FoIO, not the third party (or representative of a third party) to determine whether or not information should be disclosed under the Act. A record will be kept of all responses to consultations and the decision making processes that arise from them.

Procedure 9: Freedom of Information Complaints and Feedback

Requesters may direct an appeal to the Freedom of Information Team and are entitled to request an internal review of the handling of their requests.

All appeals, verbal or written (including those transmitted by electronic means), must be referred immediately to the FoIO / Head of Information Governance and received within 40 working days of the initial response.

Comments and feedback about the discharge of duties of CTMUHB in regard to the Act and Regulations will all be forwarded to the Lead Officer.

All appeals will be dealt with in accordance with the Freedom of Information Act. The FoI Officer will issue a letter of acknowledgement stating that the complaint will be reviewed and responded to within 20 working days. The FoI Officer will then forward details of the complaint to the Information Governance manager to initiate the local resolution stage.

The local resolution stage will involve a review of the request handling process. This will be carried out by a manager usually the Head of Information Governance who has not been involved with the collating and drafting of the initial request), but who has a well-developed understanding of the legislation, including the exemptions and public interest test.

The Head of Information Governance will consider the submissions of the requester and may consult with other persons, departments or third parties, or take legal advice as they consider appropriate.

The Head of Information Governance will discuss the outcome of the review with the Executive Director of Digital and will produce a report outlining findings, conclusion and any recommendations to be made to the internal process.

The Head of Information Governance will notify the requester in writing within 20 working days of the outcome of the appeal process, giving reasons for the decision.

All requesters will also be informed of their right to complain directly to the Information Commissioner if they are dissatisfied with the outcome of the internal review, and will be given the Information Commissioner's contact details.

When the Head of Information Governance is of the opinion that the procedures or processes for handling requests can be improved, they will make a recommendation to the Director of Digital accordingly.

Ref: IG 02

Freedom of Information Act Policy

Page 24 of 38



Guidelines on the Disclosure of Staff Information under the Freedom of Information Act 2000

INITIATED BY:	Head of Information Governance
APPROVED BY:	TBC
DATE APPROVED:	TBC 2024
VERSION:	6
OPERATIONAL DATE:	September 2018
DATE FOR REVIEW:	September 2026
DISTRIBUTION:	All Staff via Intranet & Core Brief Message
FREEDOM OF INFORMATION STATUS:	OPEN

CONTENTS

		Page
1	Background	
2	Purpose	
3	Principles	
4	Review	
5	Summary	
6	Annex A – Employee Information for Disclosure	

1. Background

The Freedom of Information Act 2000 gives the public the right to access official information held by Public Authorities. The Health Board is committed to public openness and routinely publishes information under the Publication Scheme as well as dealing with individual requests for information.

2. Purpose

The purpose of these guidelines is to:

- Advise staff that information may be disclosed about them under the Freedom of Information Act 2000;
- Explain the types of information covered;
- Explain the factors that will be taken into consideration when deciding whether or not to disclose any requested information.

These guidelines do not cover aggregated or anonymised data where individuals cannot be identified.

3. Principles

CTMUHB holds a great deal of information about its staff some of which may be sensitive, personal or information provided in confidence. In most cases it would not be appropriate to release this type of information. Personal information is exempt from disclosure under the Freedom of Information Act 2000, if disclosure would lead to a breach of the data protection principles, for example, if disclosure would be unfair to the employee. This exemption is intended to ensure public openness does not compromise personal privacy.

In addition, there may be other exemptions to be considered that could protect personal information from disclosure. For example, if disclosure constitutes a breach of confidence or would endanger an employee. CTMUHB is also bound by human rights principles to respect employees' rights to respect for their private and family life when deciding whether to disclose information about them.

CTMUHB will inform any staff concerned prior to deciding whether to disclose any information about them. Should an staff member object to the disclosure, this will be taken into account, however it may not prevent the disclosure if it is in the public interest to do so and there is no breach of the data protection or human right principles.

Ref: IG 02

Freedom of Information Act Policy

Page 27 of 38

In line with guidance from the Information Commissioner, the Health Board would consider the following principles to assist in deciding whether or not information should be disclosed:

- Whether the information requested is about an employees' professional or personal life.
- Whether the information requested can be edited to remove personal information.
- Whether employees would expect information to be disclosed. In general more senior staff and those carrying out public functions should expect information to be disclosed.
- Whether the information requested relates to a disciplinary matters. Generally arguments for disclosure are stronger for more serious matters such as serious allegations of impropriety or criminality.
- Whether the employee has objected to disclosure or where disclosure could be damaging to the employee.
- The sensitivity of the information requested.

CTMUHB will generally disclose work-related information about senior staff or those in a public facing role. Genuinely personal, sensitive and non work-related information will not normally be disclosed. It is less likely that information about more junior staff or those not dealing directly with the public will be disclosed.

Annex A describes some of the staff information held by the Health Board and lists which information would normally and not normally be disclosed categorised by senior or public facing staff and junior staff.

4. Review

A review of content will take place within 2 years of the approval date or sooner if required by legislation or policy.

5. Summary

These guidelines will be distributed to all staff using the team brief mechanism, intranet and induction processes. Staff are asked to familiarise themselves with the content and direct any queries to the Head of Information Governance, Ynysmeurig House, Navigation Park, Abercynon, Tel. 01443 744800 or via: CTM.FreedomOfInformation@wales.nhs.uk .

6. Annex A - Employee Information for Disclosure

This is a generic list of information held by the Health Board about its staff, although the list is not exhaustive. It provides advice for staff on the types of information that may or may not be disclosed.

	Information that will normally be disclosed	Information that will NOT normally be disclosed
Senior or Public Facing Staff	<ul style="list-style-type: none"> • Information already published by the Health Board in Annual Reports, such as Executive Director salaries. • Photographs and biographical information relating to staff whose role may be the subject of publicity. • Names, job titles, work e-mail addresses and work telephone numbers. • Years in post, previous positions held in the NHS. • Position within organisational structures, role, duties, work-related responsibilities. • Salary levels or pay bands (not net salary). • Summaries of expense claims, amounts claimed by named employees. • Vocational training or secondments undertaken whilst employed within the Health Board. • Qualifications relevant to carrying out duties. • Business-related entries in office diaries or schedules. 	<ul style="list-style-type: none"> • Personal details obtained as part of the recruitment process, e.g. CVs, application forms, references, etc. • Photographs and biographical information relating to staff whose role is not likely to be the subject of publicity, unless they have consented. • Non-work related information, e.g. personal financial details, sickness records, medical information, family information. • Details of PDRs or other staff interviews, e.g. disciplinary proceedings. • Net salaries or specific information about salaries, pensions or financial benefits. • Home addresses/contact details, next of kin, non-work related information. • Non-work related exams, qualification or training. • Annual leave records, flexi or special leave. • Security clearance information. • Private entries in office diaries or schedules. • Photographs and other details maintained as part of the staff directory.

	Information that will normally be disclosed	Information that will NOT normally be disclosed
Junior Staff	<ul style="list-style-type: none"> Names, job titles, work e-mail address and work telephone numbers of staff in a public-facing role. Salary levels or pay bands (not net salary) Summaries of expense claims, amounts claimed by named employees. 	<ul style="list-style-type: none"> Names, job titles, work e-mail addresses and work telephone numbers of staff NOT in a public-facing role. Personal details obtained as part of the recruitment process, e.g. CVs, application forms, references, etc. Photographs and biographical information, unless they have consented. Non-work related information, e.g. personal financial details, sickness records, medical information, family information. Details of PDRs or other staff interviews, e.g. disciplinary proceedings. Net salaries or specific information about salaries, pensions or financial benefits. Home addresses/contact details, next of kin, non-work related information. Non-work related exams, qualifications or training. Annual leave records, flexi or special leave. Security clearance information. Private entries in office diaries or schedules. Years in post, previous positions held within the NHS. Position within organisational structures, role, duties, work-related responsibilities of staff NOT in public facing role. Vocational training or secondments undertaken whilst employed within the University University Health Board. Qualifications even if relevant to carrying out NHS duties. Photographs and other details maintained as part of the staff directory.



Guidelines for the Reuse of Public Sector Information

INITIATED BY:	Head of Information Governance
APPROVED BY:	TBC
DATE APPROVED:	tbc 2024
VERSION:	5
OPERATIONAL DATE:	September 2018
DATE FOR REVIEW:	September 2026
DISTRIBUTION:	All Staff via Intranet & Core Brief Message
FREEDOM OF INFORMATION STATUS:	OPEN

CONTENTS

		Page
1	Purpose	3
2	Objectives	3
3	Principles	3
4	Scope	4
5	Rights of Access	4
6	Risks	5
7	Charging	5
8	Legislative and NHS Requirement	6
9	Training	6
10	Review, Monitoring and Audit Arrangements	6
11	Managerial Responsibilities	7
12	Retention or Archiving	7
13	Non Conformance	7

1. Purpose

This guidance states our commitment to meet the requirements of the Re-use of Public Sector Information Regulations and any associated guidance from the Lord Chancellor's and the Information Commissioner's Office and outlines mechanisms for ensuring this takes place.

2. Objectives

To outline the requirements for Cwm Taf Morgannwg University Health Board (hereafter "CTMUHB") to provide or permit re-use of information held (in any particular media format) and to ensure that all requests for information received are processed in accordance with the provisions of the Re-use of Public Sector Information Regulations 2005 ('RPSI').

3. Principles

CTMUHB will comply with the requirements of the RPSI, and in particular will:

- Identify public sector information documents that are available for re-use
- Assess whether to charge for re-use of its documents
- Provide a licence, listing the conditions of re-use
- Provide information categories of published and unpublished material available for re-use, for example, databases, statistics and research. The Health Board's Freedom of Information Publication Scheme lists the broad categories of published materials
- Respond to written requests for information as quickly as possible, and in any event within the statutory timescales
- Follow the appeals procedures detailed within the Freedom of Information Act Policy
- In exceptional circumstances, where CTMUHB cannot respond fully within the statutory timescale (for example, where the public interest test must be considered), the Health Board will:
 - Advise the requester, and give an estimated date by which the information will be provided; and
 - Provide as much of the information as possible within the earlier timescale
 - Apply exclusions appropriately and consistently
 - Provide training to users

4. Scope

Ref: IG 02

Freedom of Information Act Policy

Page 33 of 38

This guidance applies to the following:

- Staff, including permanent, temporary, contractual and agency
- Independent Board members
- People, partner agencies, 3rd party suppliers and organisations contracted to work or process any information on behalf of the University Health Board
- Volunteers, students or any other authorized people working with or for the University Health Board.
- Hosting arrangements

The group will also consider issues in respect of the roles and responsibilities of any Committees or bodies hosted by the Health Board on behalf of NHS Wales as appropriate. This being the NHS Wales Joint Commissioning Committee and the National Imaging Academy.

5. Rights of Access

Rights of access will apply to all types of information held by the Health Board regardless of the date of the information:

- Any person or organisation may apply. Access is not confined to UK citizens and permanent residents; foreign nationals may also apply;
- The request must be in writing;
- The requester must state their full name (pseudonyms are not valid) in writing;
- The requester must specify the document requested;
- The requester must state the purpose for which the document is to be re-used;
- The Health Board must acknowledge receipt of the request within two working days;
- A request for information must be answered within 20 working days of receipt of the request. This period may be extended where the request is extensive or complex; and the requester must be informed of this in writing; and
- Information will be reusable subject to changes on a case-by-case basis, except where it is produced for statutory reasons. Each response will detail any conditions for re-use.

Re-use can be refused if the information requested falls within one or more of the exclusions permitted by the Re-use of Public Sector Information (RPSI) :

Ref: IG 02

Freedom of Information Act Policy

Page 34 of 38

Where requests are refused, the applicant will be advised of the decision and has a right to ask for that decision to be reviewed under the Board's FOIA and Environmental Information Regulations (EIR) appeals procedures. If the information is still not released, the applicant will be advised of their right to ask the Office for Public Sector Information (OPSI) to review the decision.

6. Risks

CTMUHB recognises that there are risks associated with non-compliance with the law. This guidance aims to mitigate risks such as:

- Significant risk to CTMUHB, its customers, partner agencies and stakeholders;
- Inappropriate use or disclosure of information, leading to major incidents;
- Breach of the University Health Board's or other's copyright;
- Legislative or financial penalties; and
- Loss of reputation and damage to the Health Board's corporate image.

7. Charging

Although there is no obligation on CTMUHB to make a charge it retains the right to charge, and where a charge is made it will be noted in the Publication Scheme. This will also apply where existing statutory charging arrangements apply

Where the requests are made through other regimes of access, such as EIR and FOI, charging mechanisms will apply, for obtaining this information as well as for disbursements (e.g. postage, printing and photocopying).

CTMUHB will strive to work together and share information with other public sector bodies.

CTMUHB will reserve the right to impose conditions on the re-use of information and levy a charge where this has involved a considerable amount of officer time in either the preparation or release of the information.

Where a number of other public sector organisations are interested in the work of CTMUHB, officers would be encouraged to present seminars, chargeable at prices that are benchmarked in line with other Health Boards.

Where charges are made, the total income should not exceed the cost of collection, production, reproduction and dissemination of documents and a reasonable return on investment.

Users must ensure that any future contracts with external organisations clearly states which party owns copyright to information.

8. Legislative and NHS Requirement

All policies and procedures must provide clarity to meet external legislative and NHS requirements such as Health and Safety, European legislation and Health Care Inspectorate Wales.

The following legislation and national guidance must be considered in the development and maintenance of this guidance and its supporting documents:-

- Data Protection Act 2018
- General Data Protection Regulation
- The Human Rights Act 1998
- The Common Law Duty of Confidentiality
- The Freedom of Information Act 2000
- NHS Wales Caldicott and its requirements
- Welsh Language Act 1993
- Equality Act 2010
- Environmental Information Regulations.

9. Training

To enable users to comply with this guidance and with the RPSI, the Health Board will:

- Establish and maintain an RPSI framework and promote compliance with the legislation;
- Provide adequate and appropriate training and guidance to all users;
- Maintain a register of requests;
- Ensure that audit trails of all written correspondence in relation to a request for information are maintained;
- Monitor application of guidance; and
- Revise guidance and training as appropriate.

10. Review, Monitoring and Audit Arrangements

Ref: IG 02

Freedom of Information Act Policy

Page 36 of 38

This guidance will be continually monitored and will be subject to review at two yearly intervals.

An earlier review may be warranted if one or more of the following occurs:-

- As a result of regulatory / statutory changes or developments;
- Due to the results / effects of critical incidents; and
- For any other relevant or compelling reason.

11. Managerial Responsibilities

The Chief Executive has overall responsibility for RPSI within the Health Board. The Executive Director of Digital has delegated responsibility for the corporate implementation, co-ordination and monitoring of compliance with the legislation.

All users will:

- Understand and adhere to their responsibilities for handling RPSI requests in line with policy and procedures; and
- Respond to both written and verbal requests in line with CTMUHB procedures and guidelines.

The Executive Director of Digital is responsible for the strategic elements, taking into account all related legal and NHS requirements.

The Head of Information Governance is the senior professional lead for the development and coordination of effective governance within the Health Board and with its partners.

Managers at all levels within the Health Board are responsible for continuing compliance within their areas, and ensuring that this guidance is built into local processes.

12. Retention or Archiving

In cases of incidents, / complaints / claims and other legal processes it is often necessary to demonstrate the guidance in place at the time of the investigation. Therefore this guidance will be archived and stored in line with the Records Management Policy.

13. Non Conformance

Ref: IG 02

Freedom of Information Act Policy

Page 37 of 38

The Health Board views RPSI compliance seriously. Compliance is monitored by, but not limited to, regular quality checking and ad hoc audits of Directorates as required. The nature of non-compliance will dictate the course of action to be taken, for example:

- Employees may be subject to the disciplinary process;
- Issues involving Independent Board members will be referred to the Chairman; and
- Third Party issues will be handled via contractual arrangements.

INFORMATION ASSET REGISTER MANAGEMENT PROCEDURE

Document Type:	Non Clinical Procedure
Ref:	IG 08
Author:	Claire Northwell, Head of Information Governance
Executive Sponsor:	Director of Digital
Approved By:	Management Board (Non Clinical Procedures Only)
Approval / Effective Date:	
Review Date:	August 2027
Version:	3

Target Audience:

People who need to know about this document in detail	All staff
People who need to have a broad understanding of this document	All staff
People who need to know that this document exists	All staff

Integrated Impact Assessment:

Equality Impact Assessment Date & Outcome	Date: August 2024 Outcome: Neutral
Welsh Language Standard	No
Date of approval by Equality Team:	August 2024
Aligns to the following Wellbeing of Future Generation Act Objective	Provide high quality, evidence based, and accessible care



Disclaimer:

If the review date of this document has passed please ensure that the version you are using is the most up to date version either by contacting the author or CTM_Corporate_Governance@wales.nhs.uk

CONTENTS PAGE

1. PROCEDURE STATEMENT	3
2. SCOPE	3
3. AIMS AND OBJECTIVES	4
4. DEFINITIONS	4
5. RESPONSIBILITIES	4
6. IMPLEMENTATION/POLICY COMPLIANCE	7
7. EQUALITY IMPACT ASSESSMENT STATEMENT	8
8. REFERENCES	8
9. RELATED POLICIES	8
10. INFORMATION, INSTRUCTION AND TRAINING	8
11. APPENDICES	8

1. PROCEDURE STATEMENT

Information, in any form or format, is considered one of the biggest assets of any organisation. This procedure will establish a structured approach to the identification, management and risk assessment of information assets.

This procedure applies to Cwm Taf Morgannwg University Health Board and its hosted bodies, collectively referred to in this document as “the organisation”.

The implementation of this procedure will ensure that information assets are managed in a robust and consistent way across the organisation by identifying information assets and assigning the “ownership” and management of assets to senior accountable staff in their role as Information Asset Owners (IAO). It is important that managing information assets is not seen as the responsibility of information governance / technology staff, but a support role is required from these staff.

2. SCOPE

This procedure applies to all staff employed by or working on behalf of Cwm Taf Morgannwg University Health Board and its hosted organisations, collectively referred to in this document as “the workforce”. This will include trainees, students, secondees, agency staff and any individual or third party undertaking duties on behalf of the organisation.

The scope applies to all information assets held within, or on behalf of, the organisation. Information assets are defined as:

“A body of information, defined and managed as a single unit so it can be understood, shared, protected and exploited efficiently. Information assets have recognisable and manageable value, risk, content and lifecycles.”
(*National Archives*)

Information assets come in many shapes and sizes which may include systems, databases, spreadsheets, medical devices, software, applications, development tools, paper-based systems or systems where information is held in another format. Information assets are of important value and are used to provide services or undertake core business functions of the organisation.

Ref: IG 08

Policy Title: Information Asset Register Management Procedure

Page Number: 3

3. AIMS AND OBJECTIVES

The approach outlined in this procedure will assist the organisation in complying with relevant data protection legislation and Caldicott requirements.

All information assets must be identified and recorded on the organisational Information Asset Register (IAR). This will assist the organisation in understanding the information it holds and also to identify which of these assets are critical to the effective functioning of the organisation.

Information asset risks will be assessed and managed by the identified IAO. This will assist the organisation in ensuring adequate, appropriate technical and organisational measures are in place to maintain the security and confidentiality of each information asset.

4. DEFINITIONS

IAR – Information Asset Register

IAO – Information Asset Owner

IAA - Information Asset Administrator

SIRO – Senior Information Risk Owner

IG – Information Governance

5. RESPONSIBILITIES

An overview of roles and responsibilities are provided at **Appendix A**.

5.1 Chief Executive

The Chief Executive has overall responsibility for information within the organisation and for ensuring that the security and confidentiality of information assets is managed.

This responsibility is discharged through the Senior Information Risk Owner (SIRO) as the designed member of staff with responsibility for monitoring information risk within the organisation. Advice and briefings will be received from the SIRO as appropriate.

5.2. Senior Information Risk Officer (SIRO)

Ref: IG 08

Policy Title: Information Asset Register Management Procedure

Page Number: 4

The Director of Digital is the designated SIRO. The SIRO has overall responsibility for managing information risk across the organisation and is accountable to the Board for ensuring information risks are recorded and mitigated where applicable. Key responsibilities include:

- Ownership of the risk assessment process for information risk, including review of the annual risk assessment of information assets;
- Reviewing and agreeing the escalation and action plan in respect of identified risks;
- Providing a focal point for the resolution and / or discussion of information risk issues;
- Ensuring the organisational approach to information risk is effective in terms of resource, commitment and execution of roles;
- Ensuring the Chief Executive and the Board are adequately briefed on information risk issues.

The SIRO is supported by the IAO and Information Governance (IG) Team in undertaking this role.

5.3 Information Asset Owner (IAO)

An IAO is a senior member of staff who is the nominated owner for one or more identified information assets. Where there are a number of IAOs for one information asset a lead IAO should be identified for the purposes of implementing this procedure, this is particularly important for assets that span across multiple areas of the organisation.

The identified IAO must be a member of staff who is senior enough to make decisions concerning the information asset at the highest level. IAOs are directly accountable to the SIRO for information risk and must provide assurance that any risks are being managed effectively in respect of the information assets that they own. IAOs are expected to have a strategic understanding of the business objectives and how the information assets they own contribute to and affect these objectives. The IAO will therefore document, understand and monitor:

- What information assets are held and for what purposes;
- How information is created, amended or added to over time;
- The confidentiality, integrity and availability of their assets;
- Who has access to the information and why;

Ref: IG 08

Policy Title: Information Asset Register Management Procedure

Page Number: 5

- Risks associated with their information assets ensuring they are reviewed at least annually and added to the IG risk register where required.

An IAO may assign day to day responsibility for each information asset to an administrator to support them in their role. IAAs will usually be a staff member with operational responsibility for managing risks relating to their information assets.

5.4 Information Asset Administrator (IAA)

The IAA will support the IAO in ensuring this procedure and any relating to the specific management of the information asset are followed and complied with. IAAs will usually manage the information asset on a daily basis and assist in implementing appropriate controls to ensure confidentiality and security. IAAs will recognise actual or potential security incidents and consult the IAO on incident management. There may be more than one IAA for an information asset however a lead IAA may be nominated for the purposes of completing the information asset registration.

5.5 Caldicott Guardian

The Medical Director undertakes the role of Caldicott Guardian acting as the “conscience” of the organisation in relation to the uses of patient information. As well as providing a focal point for patient confidentiality, information sharing and providing strategic input at Board level.

5.6 Information Governance (IG) Team

The IG team will support the implementation of this procedure by developing, administering, monitoring and maintaining the IAR and risk management data collection tools. Specialist information governance advice and guidance will be provided, where required, to IAOs and IAAs on implementing this procedure and on effectively managing their information assets. The team will also support the SIRO in undertaking his duties and in ensuring the Information Governance Group are informed of any identified risks via the IG Risk Register.

5.7 Line Managers

Line Managers must ensure that the workforce comply with this procedure and that IAOs and IAAs effectively undertake their required roles.

Ref: IG 08

Policy Title: Information Asset Register Management Procedure

Page Number: 6

5.8 Workforce

The workforce must be familiar with this procedure and, where required, undertake the above roles in relation to information assets.

6. IMPLEMENTATION/POLICY COMPLIANCE

6.1 Information Asset Register

All information assets must be identified and recorded on the organisational IAR.

A minimum data set will be collected on the register to include the asset name and department, the IAO, purpose of the asset, the format, location, critical status and data volume. The risk management section will include information such as business continuity, information, legal basis, security and access controls.

There is an expectation that all information assets will be added to the register when created, or for existing assets, within a timely manner to ensure the register is accurate and up to date. Reviews of the register entries must take place annually or sooner where changes are made. Where information assets are replaced or made obsolete, this must be identified on the register. It is essential when registering an information asset that the IAO is accurately identified for each unique asset.

Please see Appendix B for more information on the registration of assets.

The Information Asset Register can be found on the Information Governance SharePoint page [Information Asset Register - Home](#).

6.2 Information Security Incident Management

Where an information security incident or data breach relating to an information asset is identified, immediate action should be taken to contain the breach and the SIRO must be informed.

A DATIX incident form should be submitted within 24 hours to allow the Information Governance Team to assess whether the incident is of a severity to require external reporting to the Information Commissioner's Office.

7. EQUALITY IMPACT ASSESSMENT STATEMENT

This policy has been screened for relevance to Equality. No potential negative impact has been identified.

8. REFERENCES

- Data Protection Act 2018
- General Data Protection Regulation (2016)
- National Archives Guidance
- NHS Wales Information Governance Toolkit

9. RELATED POLICIES

[**ALL WALES INFORMATION GOVERNANCE POLICY**](#)

[**ALL WALES INFORMATION SECURITY POLICY**](#)

10. INFORMATION, INSTRUCTION AND TRAINING

The Core Skills Framework requires that the workforce undertake mandatory Information Governance Training bi-annually. Specific training needs for the roles and responsibilities outlined within this procedure should be discussed and explored during individual personal development reviews.

This procedure will be reviewed bi-annually or sooner if required by:

- legislative, regulatory or statutory changes or developments;
- lessons learned from incidents or changes in practice;
- other relevant or compelling reasons.

Monitoring and auditing of the procedure will be undertaken by the Information Governance Team as part of the Information Governance Work Programme.

11. APPENDICES

Appendix A – Roles & Responsibilities Overview

Appendix B - Information Asset Register (IAR) Registration Guidelines

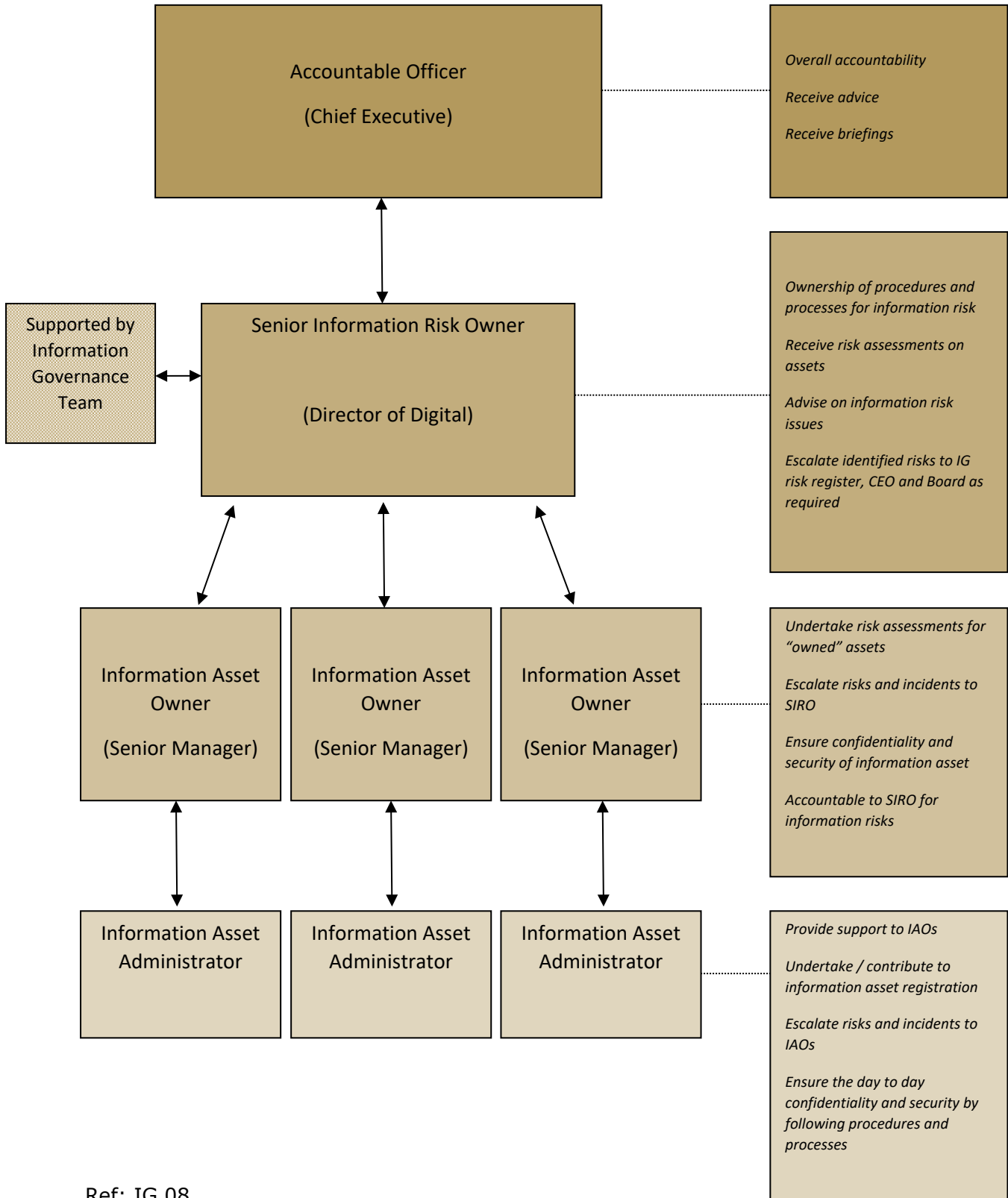
Ref: IG 08

Policy Title: Information Asset Register Management Procedure

Page Number: 8

Appendix A

Information Asset Management – Roles & Responsibilities Overview



Information Asset Register (IAR) Registration Guidelines

What is the IAR?

The IAR is a central register of the information assets owned by Cwm Taf Morgannwg UHB. Having a central register helps the organisation to understand the information it holds and to identify assets that are critical to the effective functioning of the organisation. It also assists the organisation in complying with data protection laws and regulations.

What is an information asset?

Information asset is the term used for information of value to the organisation. Information assets come in many shapes and sizes and are used to provide services or undertake the business functions of the organisation.

Some examples of information assets are listed below:

- Systems
- Spreadsheets
- Applications
- Paper Based Information Systems
- Data Files
- Databases
- Software Packages
- Development Tools
- Information Systems in Other Formats
- Data Warehouses

How do I add an information asset to the register?

It is important to avoid duplicate entries on the register. Before registering any new assets, you must check the summary registration list to ensure that your information asset has not already been entered.

You can find the summary registration list and the link to the information asset registration form for new entries under the Information Asset Register button on the [Information Governance intranet pages](#). Please click on the 'IAR Summary' button to check if your asset is there.

If your asset is not included there then please click on the 'New Asset' button to open the form.

You will be asked 40 mandatory questions to register your information asset. Most of the questions require a simple 'Yes' or 'No' answer. The registration form must be completed in one session and should take around 5-10 minutes.

Field	Description
-------	-------------

Ref: IG 08
Policy Title: Information Asset Register Management Procedure
Page Number: 10

Information Asset Name	The name of the system / database / asset should be entered in this field. Where the information asset name consists of an acronym this may be used, however the full name should also be entered in brackets alongside.
Department	There are multiple departments to choose from in relation to the where the asset is used. Where an information asset is used across all Health Board departments there is an option to select "organisation wide" from the options.
Information Asset Owner (IAO)	The IAO is the senior manager responsible for the data contained within the information asset. The IAO will have a strategic understanding of the business objectives and how their information asset contributes to these. They will have a full understanding of the purpose of their asset and any risks to the data held. Where there are multiple IAOs a lead must be identified for the purposes of the register.
IAO E-mail Address	The e-mail address will be used as a contact point for cascading risk assessments and reviews to the IAO.
Information Asset Administrator (IAA)	The IAA is responsible for the day to day management of the information asset. They may be in the role of system manager or similar and will support the IAO in ensuring appropriate controls are in place to protect the confidentiality and security of the information asset. Where there are multiple IAAs a lead must be identified for the purposes of the register.
IAA E-mail Address	The e-mail address will be used as a contact point for cascading registrations and reviews to the IAA.
Information Asset Purpose	The purpose of the information asset should be entered in this field. The description should include any services or business functions supported by or reliant on the information asset.
Data Types	<p>For data protection purposes, the organisation must understand the types of data held within an information asset. Where data can be used to identify a person, this is classed as personal identifiable data.</p> <p>Any medical or clinical information is classed as sensitive data, however there may be some categories with additional sensitivities such as sexual or mental health data.</p>
Critical Asset	When considering if an information asset is "critical" think about how the organisation could provide services / business functions if the asset were to suddenly become unavailable. The following key questions may help you to decide: Is the information asset critical to the functioning of the organisation? Are there other information assets that contain similar or duplicate information? Would there be clinical risks or

Ref: IG 08

Policy Title: Information Asset Register Management Procedure

Page Number: 11

	potential incidents if the information asset was unavailable?
Storage	Most of the Health Board's information assets are stored on local or national servers, but consideration should be given to those that may be externally hosted, by a third party supplier for example. Paper information assets or those in other formats may be stored in a physical storage environment rather than a virtual one.
Format	Most information assets will be electronic or paper. However the option of "other" format is available. Where other is selected the format should be specified.
Data Volume	When considering the volume of data within an information asset, think about the number of records or individuals. For example, if the organisation had to report an incident about a cyber-attack we would need to understand the number of individuals affected.
Live	Information assets will inevitably change over time, some may be replaced with newer systems or become obsolete. The organisation needs to understand if information assets are "live" and currently in use.
Risk Management	
Confidentiality	
Security Controls	There are a range of options to choose from for electronic and paper based security controls. Please select all that apply and specify any additional controls not already listed by selecting "other".
Generic Log-In	Please specify where generic details (rather than a named NADEX ID) are used to log in to an electronic asset. For paper assets or those in other formats choose "Not Applicable".
Registration Process for New Users	Please specify where there is a registration process for new users of an information asset. This may include completion of a registration form, allowing access to an electronic asset via NADEX ID or providing a swipe card or key code for paper-based assets.
Training for New Users	Please specify where new users are provided with training prior to allowing access to or using an information asset.
Removing User Access	Access to information assets should be promptly removed for users leaving the organisation or moving to roles where access is no longer required. Please state if there is a process in place to manage this.
Time-Out Functionality	Please specify where automated "time-out" functionality is used within an electronic asset. "Time-Out" reverts to the log-in screen (requiring a password) where the user is inactive for a defined

Ref: IG 08

Policy Title: Information Asset Register Management Procedure

Page Number: 12

	<p>period of time. For paper assets or those in other formats choose "Not Applicable".</p>
Data Sharing within NHS Wales	<p>Is data from within the information asset shared internally within NHS Wales? NHS Wales includes other Health Boards, Trusts and Primary Care Contractors. If "yes", please include further detail when prompted.</p>
Data Sharing outside of NHS Wales	<p>Is data from within the information asset shared externally to NHS Wales? For example, to NHS England, partner organisations or other third parties. If "yes", please include further detail when prompted.</p>
Data Sharing Agreements	<p>Where data is shared for purposes other than the direct care of a patient, a data sharing agreement, information sharing protocol or similar must be in place. Please upload any documentation that supports data sharing arrangements in this section.</p>
Data Protection Legislation	<p>Under data protection law the Health Board must have a legal basis for processing personal information. If required, further information is available on the ICO website. Choose one or more from the available options to justify the processing of personal data within your information asset. Where this personal data is not used, please select "Not Applicable".</p>
Data Protection Legislation for Sensitive / Special Category Data	<p>Under data protection law the Health Board must have a legal basis for processing personal information which is classed as sensitive / special category data. This includes data such as medical, sexual, racial or ethnic origins, political and religious views. If required, a full list of special category data can be found on the ICO website. Choose one or more from the available options to justify the processing of special category data within your information asset. Where this special category data is not used, please select "Not Applicable".</p>
Interdependencies	<p>Some information assets rely on others to function correctly. For example, a clinical system may include a patient demographic feed from a patient administration system to ensure data is kept as accurate as possible. Where your information asset has similar interdependencies please choose "yes" and include further detail when prompted. For paper assets or those in other formats choose "Not Applicable".</p>
Integrity	

Ref: IG 08

Policy Title: Information Asset Register Management Procedure

Page Number: 13

Accurate Data	Amendments or updates are often required to maintain data accuracy. Please specify if there is a process in place for your information asset.
User Audits	User audits logs contain information such as actions taken by a user, locations of records and access made to records. These can be available in varying detail for both electronic and paper information assets. Please specify if user audits logs are available within your asset.
Routine Audits	Routine audits should be undertaken on information assets. Audits can help to identify problem areas such as data inaccuracy or inappropriate accesses made by a user. Where routine audits are undertaken please choose "yes" and include further detail when prompted.
Deletion	Data should be managed in line with records management policies and procedures. These will include retention and disposal schedules for all types of data. Please specify whether data can be deleted from your information asset as required.
Version Control	Multiple versions of an information asset may be available, particularly where testing or data migration occurs for electronic assets. Please specify whether version control is used to protect the integrity of the data within your asset.
Availability	
Third Party Hosted Assets	Information assets may sometimes be hosted by a third party. Examples include, where a supplier hosts an electronic system or where paper records are maintained outside of the Health Board. Where "yes" is selected as the response to this question you will be prompted to answer a number of other questions relating to the arrangements in place. Additional questions will include whether data is stored outside of the UK, whether a contract / SLA is in place and whether a data processing agreement is in place.
Business Continuity Plans	Business continuity plans should be in place to ensure the smooth running of services or business functions should the information asset become unavailable. Please specify if there are plans in place for your information asset.

Data Back-Up	Electronic information assets should be backed up regularly to allow the data to be recovered should it ever become unavailable. Please specify if there are back-ups in place for your information asset.
Risk of Viruses (& Similar)	For electronic information assets stored on the NHS network, IT will routinely put measures in place to protect against viruses, worms, trojans and similar risks. For assets hosted by a third party, these risks should be addressed as part of the contract or service level agreement. Please specify if there are processes in place to protect your information asset.
Cyber Attacks	For electronic information assets stored on the NHS network, IT will routinely put measures in place to protect against Cyber Attacks. For assets hosted by a third party, these risks should be addressed as part of the contract or service level agreement. Please specify if there are processes in place to protect your information asset.
Updates / Upgrades	For electronic information assets, regular updates and upgrades help protect against security risks, fix bugs within the system and provide improved functionality. Please specify if there are processes in place for your information asset.
Mobile Devices	Many modern electronic information assets use mobile technology to access and record data using mobile devices. Mobile devices may include tablets, laptops or similar. Appropriate security measures should be in place to protect devices against inappropriate access, loss of data and theft. Please specify if your information asset uses mobile devices and if so that there are adequate security measures in place.
Retention Period	<p>We need to document how long the records are required to be kept:</p> <ul style="list-style-type: none"> This information is contained within Appendix A of the records policy. <p>You can also find further guidance on retention periods at NHS Digital.</p> <p>If your records are required to be kept longer than the retention guidance due to the Infected Blood Inquiry, then please state this or add it in the additional information box.</p>

Ref: IG 08

Policy Title: Information Asset Register Management Procedure

Page Number: 15

Can I view / amend my entry on the register?

Yes, you will have the option to view your registration form upon completion. You can also view your asset by clicking on the 'Check Previous Asset Submission' icon. You should be able to see all the assets you have submitted and you can select to edit them. They will then be sent to the IG team for approval.

How often must I review my entry on the register?

Entries in the register must be reviewed annually. Notifications to review your registration will be sent from the Information Governance Team on an annual basis. You can make a change/amendment to your entry at any time by contacting the Information Governance Team.

What if I have other questions or queries?

Please contact the Information Governance Team via CTM.IGTeam@wales.nhs.uk for any other questions or queries relating to the Information Asset Register.



DIGITAL HEALTH AND CARE WALES NETWORK CHAIR'S REPORT FOR BOARD

Agenda Item	
--------------------	--

Date of Board Meeting	26 September 2024
------------------------------	-------------------

Public or Private	Public
IF PRIVATE: please indicate reason	N/A

Name of Committee	Independent Member Digital Network
Chair of Committee	Maynard Davies, Independent Member, Hywel Dda UHB
Lead Executive Director	Chris Darling, Director of Corporate Affairs Board Secretary, DHCW
Date of Last Meeting	17 July 2024
Prepared By	Julie Robinson, Corporate Governance Coordinator
Presented By	David Selway, Vice Chair of the Network

Purpose of the Report	For Assurance
Recommendation	
The Board is being asked to: NOTE the content of the report for ASSURANCE .	

STRATEGIC MISSION	Be the trusted strategic partner and a high quality, inclusive and ambitious organisation
--------------------------	---

CORPORATE RISK (ref if appropriate)	
--	--

WELL-BEING OF FUTURE GENERATIONS ACT	A healthier Wales
If more than one standard applies, please list below:	

DHCW QUALITY STANDARDS	N/A
If more than one standard applies, please list below:	

<u>DUTY OF QUALITY ENABLER</u>	Information
<u>DOMAIN OF QUALITY</u>	Effective
If more than one enabler / domain applies, please list below:	

EQUALITY IMPACT ASSESSMENT STATEMENT	Date of submission: N/A
No, (detail included below as to reasoning)	Outcome: N/A
Statement: There is no requirement for an EQIA.	

APPROVAL/SCRUTINY ROUTE: Person/Committee/Group who have received or considered this paper prior to this meeting		
COMMITTEE OR GROUP	DATE	OUTCOME
Laura Tolley, Head of Corporate Governance	August 2024	Reviewed
Committee Chair	August 2024	Approved

IMPACT ASSESSMENT	
QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes, please see detail below Should the appropriate assurance not take place, there could be unforeseen quality and safety implications to the DHCW services provided
LEGAL IMPLICATIONS/IMPACT	No, there are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATION/IMPACT	No, there are no specific financial implication related to the activity outlined in this report
WORKFORCE IMPLICATION/IMPACT	No, there is no direct impact on resources as a result of the activity outlined in this report.
SOCIO ECONOMIC IMPLICATION/IMPACT	No. there are no specific socio-economic implications related to the activity outlined in this report

Acronyms			
DHCW	Digital Health and Care Wales	SHA	Special Health Authority

Definitions	
ALERT	Alert the Board/Committee to areas of non-compliance or matters that need addressing urgently
ASSURE	Detail here any areas of assurance that the Committee has received
ADVISE	Detail here any areas of ongoing monitoring where an update has been provided to the Committee

PRIVATE SESSION

ALERT	<ul style="list-style-type: none"> There were no items for the Board to be alerted to.
ASSURE	<ul style="list-style-type: none"> DHCW Primary Care Strategy. The Network were joined by the DHCW Director of Primary, Community and Mental Health Digital Services who presented slides on the DHCW Primary Care Strategy and discussed the work being undertaken in this area which focused on supporting users needs and putting users at the forefront of design and delivery. The Network were informed on the development of the Dental Access Portal that was being trialled in Powys, the roll out plans for a public facing portal and the benefits this would bring. The Network also discussed the primary care functionality in the NHS App and the roadmap of delivery to improve this. Welsh Government Perspective – One year on update The Network received an update on the perspective of Welsh Government one year on and discussed the ways in which the Network could support the work being done in the digital space by Welsh Government.
ADVISE	<ul style="list-style-type: none"> Funding, Prioritisation The Network had an open discussion with the Chief Digital Officer, Welsh Government on the need to address the value of digital and prioritise funding and investment in this area.

Delegated action taken by the network.
N/A

Date of next network meeting:
30 October 2024

Digital & Data Committee

Cycle of Business

(1st February 2024 – 31 March 2025)

The Digital & Data Committee should, on annual basis, receive a cycle of business which identifies the reports which will be regularly presented for consideration. The annual cycle is one of the key components in ensuring that the Committee is effectively carrying out its role.

The Cycle of Business covers the period 1st February 2024 to 31st March 2025. In recognition of the new Board and Committee arrangements approved in March 2024 any activity beyond the implementation of the new arrangements will be captured in a legacy document and captured in the new Committee structure as appropriate.

The Cycle of Business has been developed to help plan the management of Committee matters and facilitate the management of agendas and committee business.

The principal role of the Committee is set out in the Standing Orders 1.0.1.

The Committee is an independent member committee of the Board and has no executive powers, other than those specifically delegated in the Terms of Reference.

The purpose of the Committee is to provide scrutiny on behalf of the Board on all matters relating to digital & data. The Committee provides a level of assurance to the Board that all appropriate actions are being taken to reduce risks in these areas.

Digital & Data Committee Cycle of Business (1st February 2024 – 31st March 2025)

Item of Business	Executive Lead	Reporting period	FEB 2024	April 2024	May 2024	June 2024	July 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025
Preliminary Matters															
Minutes of the previous Board Meeting	Director of Corporate Governance	Every Meeting	R		R			R			R			R	
Action Log	Director of Corporate Governance	Every Meeting	R		R			R			R			R	
Internal Control & Risk Management															
Digital & Data Committee Annual Report	Director of Corporate Governance	Annually			R										
Digital & Data Committee Annual Self-Assessment	Director of Corporate Governance	Annually			R										
Digital & Data Committee Terms of Reference	Director of Corporate Governance	Annually			R										
Digital & Data Committee Annual Cycle of Business Review February – Routine meetings for Review and Noting Only	Director of Corporate Governance	Annually	R												
ICT															
DHSSG – Highlight Report to Committee	Director of Digital	Quarterly	R		R			R			R			R	
ICT Business Continuity	Director of Digital	Annually						R							
Information Governance															
IGG – Highlight Report to Committee	Director of Corporate Governance	Quarterly	R		R			R			R			R	
Governance & Assurance															
Organisational Risk Register	Director of Corporate Governance	Quarterly	R		R			R			R			R	
Internal & External Audit Reports	Director of Digital/ Director of Corporate Governance	Following finalisation of the report findings (as appropriate)	R		R			R			R			R	
All Wales Independent Member Network Highlight Report	Director of Corporate Governance	Quarterly	R		R			R			R			R	
Improving Care															
Digital programme Assurance Report	Director of Digital	Every Meeting	R		R			R			R			R	
Critical Incidents Report	Director of digital	Every Meeting	R		R			R			R			R	

DIGITAL & DATA COMMITTEE – FORWARD WORK PLAN 2024				
Origin of Request	Category of Report / Presentation (Deferred Item/ Additional Item/ Ad-Hoc Item)	Item Title	Lead Officer	Intended Meeting Date
Requested at agenda planning meeting 15 July 2024	Additional Item	Information Governance Toolkit	Chief Information Officer	Deferred for readiness consideration at the November 2024 meeting.
Annual Cycle of Business	Annual Item	Outcome of the Committee Self Effectiveness Survey 2023-24	Director of Corporate Governance/Board Secretary	Item deferred from May 2024 to August 2024
Requested at agenda planning meeting 15 July 2024	Additional Item	Spotlight Topic: Digital from the Primary Care perspective	Director of Digital	To be confirmed
Requested at agenda planning meeting 15 July 2024	Additional Item	Spotlight Topic: Patient Centred Contact	Director of Digital	Deferred for readiness consideration at the November 2024 meeting.

Completed Activity from the Forward Work Plan:				
Annual Cycle of Business	Annual Item	Annual Cycle of Business 2024-25	Director of Corporate Governance/Board Secretary	Completed - 12 th March 2024
Annual Cycle of Business	Annual Item	Committee Annual Report 2023-24	Director of Corporate Governance/Board Secretary	Completed - 21 st May 2024
Requested via email.	Additional Item	Spotlight: e-prescribing	Assistant Director of Digital Transformation	Completed - 14 th November 2023
Requested at agenda planning meeting September 23	Additional Item	Internal Audit Report - Infrastructure Management	Director of Digital	Completed - 14 th November 2023
Requested at agenda planning meeting September 23	Additional Item	Spotlight: Cyber Assessment Framework	Assistant Director for Data and Compliance	Completed - 14 th November 2023

Requested at Agenda Planning Meeting for September 2023	Additional Item	Breach Analysis for Subject Access Requests	Chief Information Officer	Completed - 12 September 2023
Requested at Agenda Planning Meeting for September 2023	Additional Item	Internal Audit Report – Performance Management	Director of Digital	Completed - 12 September 2023
Requested at Agenda Planning Meeting for June 2023	Ad-Hoc Item	Spotlight: NHS Wales APP		Completed - 12 June 2023
Requested at Agenda Planning Meeting for June 2023	Additional item	Internal Audit Report: Follow Up Transfer of Bridgend Informatics Service	Assistant Director of Informatics	Completed - 12 June 2023
Requested at Agenda Planning Meeting for June 2023	Additional Item	ICO Audit Action Plan Progress Report	Chief Information Officer	Completed - 12 June 2023
Annual Cycle of Business	Annual Report received by Committee	Draft Committee Annual Report	Assistant Director of Governance & Risk	Completed - 12 June 2023

Digital and Data Committee – Action Log

Date of Meeting Action Originated	Issue	Lead Officer	Timescale for Action to be completed	Status of Action
At Agenda planning session held on 16 July 2024	<p>IG Toolkit</p> <p>Provide an update to Members on the current progress and implementation of the IG toolkit.</p>	Chief Information Officer	<p>September 2024</p> <p>Deferred for consideration at the November 2024 meeting.</p>	<p>In progress</p> <p>Deferred for readiness consideration at the November 2024 meeting.</p>
21 February 2024	<p>Spotlight: Patient Centered Contact Presentation</p> <p>Update Members with an update on the opportunity to bid for funds held by WG to support Patient centred contact programme</p>	Director of Digital	<p>September 2024</p> <p>Deferred for consideration at the November 2024 meeting.</p>	<p>In Progress</p> <p>In response to additional preparedness time needed this item will be deferred from May and added to the August Committee agenda. Deferred for readiness consideration at the November 2024 meeting.</p>

COMPLETED ACTIONS

Date of Meeting action originated	Issue	Lead Officer	Timescale	Status
21 February 2024	<p>Digital Risk Register</p> <p>The Digital team have a thorough review of all current Digital Risks.</p>	Director of Digital	May 2024	<p>COMPLETED</p> <p>Initial review has been undertaken. Now an ongoing process aligned to BAF.</p>

Agenda Item 2.2.4

14 November 2023	<p>Digital and Data Assurance Report Board Development Session planned for February 2024 on the digital transformation agenda with opportunities and challenges.</p>	Director of Digital	March 2024	<p>COMPLETED The Board Development session held on 13 March 2024.</p>
14 November 2023	<p>Information Governance Group Highlight Report. To review workforce element around CTM mandatory training being 85% below target. Members wished to raise the concern of mandatory training to November Board Meeting via the highlight report.</p>	Chief Information Officer		<p>COMPLETED The issues around mandatory training are regularly raised at Board Meetings.</p>
March 2023	<p>Information Governance Group Highlight Report To bring a deep dive on breach analysis for subject access requests on mental health back to the Committee in 3 months' time.</p>	Chief Information Officer		<p>Completed Received at September 2023 meeting</p>



Agenda Item

4.1

Digital & Data Committee

Organisational Risk Register

Dyddiad y Cyfarfod / Date of Meeting	28/08/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Cally Hamblyn, Assistant Director of Governance & Risk
Cyflwynydd yr Adroddiad / Report Presenter	Cally Hamblyn, Assistant Director of Governance & Risk
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

Pwrpas yr Adroddiad / Report Purpose	FOR REVIEW
---	------------

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Service, Function and Executive Formal Review	June/July	RISKS REVIEWED
Operational Management Board	12 th June 2024	ENDORSED RISKS WHERE APPLICABLE FOR ELG
Executive Leadership Group	15 th July 2024	MANAGEMENT SIGN OFF RECEIVED
Quality & Safety Committee	23 rd July 2024	REVIEW OF ASSIGNED RISKS
People & Culture Committee	7 th August 2024	REVIEW OF ASSIGNED RISKS
Audit & Risk Committee	15 th August 2024	FOR REVIEW

Acronyms / Glossary of Terms	



1. Situation / Background

- 1.1 The purpose of this report is for the Committee to review and discuss the organisational risk register and consider whether the assigned risks have been appropriately assessed.

2. Specific Matters for Consideration

Risk Review

- 2.1 Care Groups and Central leads are continuing to review and update their assigned risks taking into account feedback received from Members in relation to scoring, actions with associated timeframes and ensuring timely reviews. This will be a continuous improvement area that Members will hopefully note will evolve and improve over the next 12 months.
- 2.2 The Operational Management Board / Chief Operating Officer approves escalation of Care Group risks to the Organisational Risk Register.
- 2.3 The Executive Lead approves escalation of central/core function risks to the Organisational Risk Register.
- 2.4 Risks on the organisational risk register have been updated as indicated in red in Appendix 1.
- 2.5 Please note that the risk updates are captured at the time the Organisational Risk Register being finalised for submission, which on this occasion was the 5th July 2024. Where review dates have passed and updates were not available these have been followed up and a request to update sent. Reviews received after this date will be reflected in the next iteration.

Training

- 2.6 Risk training, although not a core training requirement under the statutory and mandatory framework, has been added to the Electronic Staff Record (ESR) to support staff in registering for training and to support ease of reporting. This is managed by the Quality Assurance and Compliance Team. Interest in the course continues with positive uptake.
- 2.7 The sessions are run by the Assistant Director of Governance & Risk and Heads of Quality and Safety. The session is held virtually via Teams on a monthly basis for a duration of 1 hour and covers the following areas:
Risk Management Approach



Practical Approach to Managing Risk
Risk Assessment and Scoring
Datix Risk Management Module

- 2.8 To date **637** members of staff trained to date since training commenced in 2021.
- 2.9 Focused sessions to discuss risk have also been undertaken with Care Group Leads and other departments/directorates as required.
- 2.10 Feedback on the training continues to be positive, please see below:
- 2.11 47 attendees have provided formal feedback (using the URL Code for the Evaluation Form, which was introduced in November 2023).
- 70% (33/47) provided a score of 5/5 in terms of content of the session
 - 26% (12/47) provided a score of 4/5 in terms of content of the session
 - 4% (2/47) provided a score of 3/5 in terms of content of the session
- 2.12 100% of the 47 attendees providing formal feedback found that:
- The session provided the right amount of information.
 - They gained more confidence and knowledge in risk management having attended.
 - They would recommend this training to a colleague.
- 2.13 96% of the 47 attendees providing formal feedback said they felt more confident to escalate a risk through the organisation.
- 2.14 Some of the recent comments from the session in June, received through evaluation, have been included below:
- *"Useful to understand escalation processing more detail";*
 - *"Very well delivered with a lot of information included";*
 - *"I realised in the session that I don't have a good understanding of how risk is assessed in the organisation and potentially our team should be utilising this more so it initially started as confusing for me but is still very helpful";*
 - *"Right amount of information given in the presentations and well explained by the presenter"; and*
 - *"Good comprehensive information and resources to refer to".*

3. Key Risks / Matters for Escalation

3.1 NEW RISKS

No new risks escalated to the Organisational Risk Register as assigned to this Committee.

3.2 CHANGES TO RISKS

Risk Score Increased

No risks that had been escalated to the organisational risk register were increased in score in the July iteration.

Risk Score Decreased

No risks escalated to the Organisational Risk Register as assigned to this Committee were decreased in risk score.

3.3 CLOSED RISKS REMOVED FROM THE ORGANISATIONAL RISK REGISTER

No risks that had been escalated to the organisational risk register were closed in the July iteration.

3.4 ORGANISATIONAL RISK REGISTER – VISUAL HEAT MAP BY DATIX RISK ID (RISK RATED 15 AND ABOVE)



Consequence	5				4664 5276	
	4				4337 4671	5669 5761
	3					4672 5040
	2					
	1					
CxL	1	2	3	4	5	
	Likelihood					

3.5 EMERGING RISKS

No emerging risks notified for inclusion in the July iteration Organisational Risk Register.



3.6 Board Assurance Framework – Principal/Strategic risks assigned to this Committee

Risk no	Strategic / Principal Risk	Strategic Goal	Lead(s) for this risk	Assurance committee	Current score	Scoring Trajectory (since the last report received by the Board)
5.	Delivery of a digital and information infrastructure to support organisational transformation	Improving Care 	Director of Digital	Digital & Data	16 (C4xL4)	

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals 150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	A Resilient Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (Ilyw.cymru)) / Link to Enablers of Quality (Duty of Quality Statutory Guidance (gov.wales))	Learning, Improvement & Research
	If more than one applies please list below:
Dolen i Feysydd Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (Ilyw.cymru)) / Link to Domains of Quality (Duty of Quality Statutory Guidance (gov.wales))	Safe
	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) /	No - Not Applicable
	If more than one applies please list below:



Environmental /Sustainability Impact (5Rs)

Impact Assessment		
Ansawdd <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /</i> Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: <input type="checkbox"/>	No: <input checked="" type="checkbox"/>
	Outcome:	If no, please include rationale below: Not required for the Organisational Risk Register. Individual risks may have been subject to QIA.
Cydraddoldeb a'r Gymraeg <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /</i> Equality and Welsh Language <i>Have you undertaken an Equality and Welsh Language Impact Assessment Screening?</i>	Yes: <input type="checkbox"/>	No: <input checked="" type="checkbox"/>
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below: Not required for the organisational Risk Register. Individual risks may have been subject to an Impact Assessment.
Cyfreithiol / Legal	Yes (Include further detail below) See detail captured for each risk	
Enw da / Reputational	Yes (Include further detail below) See detail captured for each risk	
Effaith Adnoddau <i>(Pobl /Ariannol) /</i> Resource Impact <i>(People / Financial)</i>	Yes (Include further detail below) See detail captured for each risk	

5. Recommendation

5.1 The Committee are asked to:

- **Review** the risks escalated to the Organisational Risk Register at Appendix 1.
- **Consider** whether the Committee can seek assurance from the report that all that can be done is being done to mitigate the risks

6. Next Steps

6.1 The Organisational Risk Register will be submitted to the relevant Board and Committees.

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
Index ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (Current)	Heat Map Link (Consequence & Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
1	5276	Director of Digital	Central Support Function - Digital and Data	Assistant director of therapies and health science	Sustaining Our Future	Business Objectives - Operational Patient safety Digital Healthcare Wales interdependencies	Failure to deliver replacement Laboratory Information Management System, LINC Programme, by summer 2025. THEN: operational delivery of pathology services may be severely impacted. RESULTING IN potential delays in treatments, affecting the quality and safety of a broad spectrum of clinical services and the potential for financial and workforce impact.	Currently LINC Programme reports progress against timeline to LINC Programme Board and Chief Executive Group. Business continuity options are being explored including extending the contract for the current LIMS to cover any short term gap in provisions. An expert stock take review of the LINC programme has been completed with findings presented to Collaborative Executive Group (CEG) to inform next steps.	Update May 2024 - CTMUHB have appointed internally into the 2 x fixed term band 7 clinical systems support roles for Pathology - once these posts have been backfilled these posts will be able to fully support LIMS implementation. The 1 x 8a fixed term clinical systems manager for Pathology has just gone out to advert, hoping to recruit externally - this post will provide project oversight and co-ordination. These posts will bring CTM in line with other Health Board's in terms of dedicated pathology IT support, however, Health Boards across Wales are looking for extra support in addition to this. Pathology continues to hold monthly LIMS deployment meetings with Digital Health Care Wales (DHCW) to facilitate progress. Update July 2024 - The 8a post is now filled and pathology/IT team is working on delivering the LIMS Project. No change to risk scoring due to resource limitations across Wales.	Digital & Data Committee Quality & Safety Committee	20	C5xL4	5 (C5xL1)	↔	26.10.2022	04.07.2024	31.08.2024
7	4664	Director of Digital	Central Support Function - Digital & Data	Assistant Director for Data Intelligence, Compliance & Design	Creating Health	Legal / Regulatory Statutory duty, regulatory compliance, accreditation, mandatory requirements	Ransomware Attack resulting in loss of critical services and possible extortion IF: The Health Board suffers a major ransomware attack. Then: there could be potential data loss and subsequent loss of critical services. Resulting in: Catastrophic service loss to all clinical and business services adversely impacting on population health management, patient care, business continuity, health and wellbeing of staff, organisational relationships, substantial financial risk and the UHB's other routine and improvement work - culminating in a culture of mistrust of the Health Board and all things digital leading to the likelihood of the opportunities that present from digital transformation being less likely to be achieved.	Business sensitive risk and therefore detail captured in closed session of the Committee.									
12	5761	Executive Medical Director	Medical Directorate Function	Medical Directorate Manager	Improving Care	Patient / Staff Public Safety Impact on the safety - Physical and/or Psychological harm	Cross Health Board Data Sharing IF: Digital services across Wales are unable to resolve an ongoing issue with the ability to share patient data in both directions across health boards/trusts Then: Clinical staff across CTM will be unable to provide the safe and effective care to patients using transparent, available data Resulting in: Potential harm to the patients of CTM due to the lack of clinical information available to clinicians when making clinical assessments	For CTM, this is a particular issue in Prince Charles Hospital as there is a lot of patient cross over at the boundary of Aneurin Bevan Health Board. As a health board we continue to raise this as a serious patient safety issue and will continue to press for a solution with Digital Health Care Wales. CTMUHB have asked for alternate options for a quicker solution and timescales to be aligned with these. This has been added as an agenda item for discussion at the next All Wales Medical Director meeting.	Digital Health Care Wales have been working on the ability to share data in both directions so data flows in the Health Board systems - this has been an issue for some time. ABLHB have allocated some project resource to scope, map and plan the work needed, however, resources will need to be allocated by C&V and AB to get the work done. There was a strong commitment from Pan-South East Wales Regional Digital to work closer together and link into a wider regional programme board, this was repeated at the regional planning meeting. As of March 2024, the update from DHCW is that they are working on delivering the open architecture to support sharing documents and diagnostic results. Update July 2024 - There has been no update on progressions since the last update reported, therefore, the risk remains the same. CTMUHB continue to liaise with DHCW on seeking a solution. Next review 1.8.2024.	Quality & Safety Committee Digital & Data Committee	16	C4xL4	8 (C4xL2)	↔	26.04.2024	01.07.2024	01.08.2024
15	5669	Director of Digital	Central Support Function - Digital and Data	Assistant Director for Digital Delivery	Improving Care	Service / Business Interruption Increased cost of Citrix Subscription	IF: the proposed increase in costs for providing thin client (Citrix) desktops to staff is not affordable or fully funded THEN: Some or all of the staff that use Citrix will no longer be able to do so RESULTING IN Staff being unable to access local and national systems Citrix is used by staff to access Virtual Desktops from IGEL thin client devices - 4000 across. These devices only work with Citrix. Staff who access systems using Windows Laptops and PC's will be affected less severely, although many do use Citrix for certain functions. Aside from the CTM Local use and costs for Citrix - National applications that are delivered via Citrix are also in scope of the cost increase, and DHCW have indicated that any costs associated with this are likely to be passed on directly to the organisation.	Renewal costs will increase. Work underway with NHS Wales and Citrix to arrive at the best value licensing on an all Wales basis. CTM Renewal is March 2024, although an interim offer has been made which will take the renewal to December 2024 - allowing all NHS Wales organisations to align their renewals and for negotiations around licensing levels and quantities to be fully understood.	Update July 2024 - Progress continues to mitigate the risk. National conversations with Citrix are progressing which are led by DHCW. We have got a firmer understanding of the cost increases, and while the cost increase are not as much as initially anticipated they still present a cost challenge. DHCW are to write out to Directors of Digital and Directors of Finance with setting out the proposed position.	Digital & Data Committee	16	C4xL4	2 (C1xL2)	↔	12.01.2024	04.07.2024	02.08.2024
20	4337	Director of Digital	Central Support Function - Digital & Data	Assistant Director for Digital Systems	Creating Health	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	Integrating Patient Records across the Health Board IF: The Health Board does not have a unified electronic health and care record and systems which are integrated across the organisation and with our primary and social care providers Then: The Health board will be unable to deliver safe, high quality, clinically and cost effective care to patients Resulting In: Compromised safety of patients needing treatment that are reliant on clinical test results and information being available to clinicians to plan and deliver the treatment plan and the requirement for sub-optimal manual processes	Key Controls 1. SBUHB Service Level Agreement 2. Bridgend disaggregation and the one-CTM aggregation plan 3. NHS Wales Control Agreement and data sharing agreements 4. Numerous national service management boards and Technical oversight groups providing strategic, tactical and operation governance. 5. National ePR programme and systems Gaps in Control The full business case for the Bridgend / old-CT integration remains unfunded. There are currently a number of CTM systems that are not compatible with Bridgend systems. There is insufficient discretionary capital funding available to support delivery of the aggregation plan. There is no data item integration with GP systems, the A&B Clinical Workstation or Local Authority system. Numerous delays in NHS Wales progressing open architectural approach which results in CTM UHB being unable to access our own data as data items (required for linking systems and data analysis) Strategic approach to becoming an anchor organisation to encourage SMEs not developed, resulting in challenges in proceeding with small agile developments Discipline of organisation in keeping to the supported application platforms is being challenged - in particular staff are keen to exploit the opportunities presented by the MS365 platform however there are no resources available to support, train or integrate this platform within the EPR architecture	Update April 2024 - Progress is being made with consolidation/merger of the clinical systems to provide single departmental solutions across CTM to allow for better patient experience and help service redesign. The Welsh Patient Administration System (WPAS) merger is still on track for May 2025 this will deliver a single Patient Administration System (PAS) solution across CTM which is then the platform to look at how CTM delivers services. There is on going work with Digital Health Care Wales (DHCW) to ascertain the impact of the WPAS merger on the National suite of systems and how the changes will impact data and data flows. Update July 2024: Good progress is still being made and May 16th 2025 has been identified as the agreed merger weekend. DHCW are progressing national systems and local clinical systems for the merger.	Digital & Data Committee	16	C4 x L4	8 (C4xL2)	↔	14.10.2020	04.07.2024	30.08.2024
29	4671	Director of Digital	Central Support Function - Digital & Data	Assistant Director for Data Intelligence, Compliance & Design	Creating Health	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	Lack of a resilient and performant Digital Network Infrastructure and Assets IF: The Health Board suffers regular local and/or national network issues and/or outages to critical clinical and business systems or performance issues in accessing and using systems. Then: there could be a detriment to patient care, inefficiencies in care provision and loss in confidence by Health Board staff in the technology provided to them leading to them using alternative software and bespoke systems (including paper based systems) to carry out their duties which are not integrated. Resulting in: delays in clinical decisions and consequently treatment which may affect clinical outcomes, reduced levels of productivity and thus poorer access to services, staff appetite to work digitally and in accordance with the digital standards required to realise the full strategic benefits of an integrated record and repository not being realised. Other consequences include: Loss of information integrity and accessibility as multiple copies of clinical records. Threat of malware being introduced on to the network from unmanaged data, systems and software. Possible breaches to the GDPR, safeguarding and information governance risks. Mistrust by staff of the ICT systems and services they are using	Key Controls 1. A structure of National local and service management and change boards are in place and operational 2. Recommendations and advice from National All Wales Infrastructure Programme and 2 Local Infrastructure reviews developed into architectural programme 3. Service Management and Asset Management Improvement Programme established 4. Risk Audit Governance & Cyber Security Board which meets monthly to discuss and take action on service delivery incidents Gaps in Control Insufficient Capital to meet many of the recommendations in the infrastructure plan Cloud policy is undeliverable, given the scarcity of revenue, skills and knowledge Wi-Fi coverage not perfect Discretionary capital programme limited to £300k for rolling replacement in 2022/23 resulting in HB continuing to operate with large number of computers aged more than 10 years. Insufficient people within the infrastructure team to ensure that all interdependencies are prepared prior to changes (often pushed nationally) are made. Deficiencies in our disaster recovery and business continuity architecture	Update July 2024 - Interview for vacant wireless post taking place first week of July. This will provide capacity to undertake the wireless review. Wireless Access Points are being built and rollout has commenced. The project to replace ISE has now completed, and users are being migrated to the new solution. Continuous review of network components, to ensure currency and maintenance of security standards. Capital Programme is progressing and this includes a number of remedial improvements in PoW. Staffing - An OCP is currently being undertaken within the Digital Delivery team which will improve leadership capacity and capability.	Digital & Data Committee	16	C4 x L4	9 (C3xL3)	↔	03.05.2021	04.07.2024	30.08.2024
32	4672	Director of Digital	Central Support Function - Digital & Data	Assistant Director for Data Intelligence, Compliance & Design	Creating Health	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	Access to a complete, integrated, and coded medical record. IF: The Health Board is not able to record information accurately and reliably, with complete and up to date information Then: the data informing the clinical, regional and organisational decisions we and our partners (including WG) make, will be inaccurate, out of date or incomplete Resulting In: Degradation in our delivery of the quadruple aim and strategic objectives and damage to our reputational standing with our population and partners. Further we will be prevented from driving forward our ambitions to become a digital organisation, an exemplar for R&D and Value etc.	Business sensitive risk and therefore detail captured in closed session of the Committee.									
37																	

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence & Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
5040	Director of Digital	Central Support Function - Digital & Data	Assistant Director for Data Intelligence, Compliance & Design	Creating Health	Operational: Core Business Objectives Projects Including systems and processes, Service /business interruption	Digital Healthcare Wales (DHCW interdependencies)	<p>IF: The Health Board can not integrate new applications into its digital architecture in a timely fashion</p> <p>Then: there could be a detriment to patient care, inefficiencies in care provision and loss in confidence by Health Board staff in the technology provided to them leading to them using alternative software and bespoke systems (including paper based systems) to carry out their duties which are not integrated and major strategic priorities for the organisation (e.g. Bridgend aggregation and the deployment of the new Emergency Department system) not being delivered</p> <p>Resulting in: delays in clinical decisions and consequently treatment which may affect clinical outcomes, reduced levels of productivity and thus poorer access to services, staff appetite to work digitally and in accordance with the digital standards required to realise the full strategic benefits of an integrated record and repository not being realised. Other consequences include:</p> <ol style="list-style-type: none"> 1. Loss of information integrity and accessibility as multiple copies of clinical records. 2. Failure and delay of digital system deployments (e.g. WEDS) 3. Possible breaches to the GDPR, safeguarding and information governance risks. 4. Mistrust by staff of the ICT systems and services they are using 5. Money being wasted 	<p>A Myrdin strategic programme group has been established, chaired by the CEO of DHCW to map out how the constraints can be overcome</p> <p>SLAs are in place between DHCW and NHS Wales organisations, however their futility has been exposed by demand pushing the waiting times for developments to start (not complete) to over 12 months</p> <p>Gaps in controls:</p> <p>WG have agreed some funding for the PAS element, however the DHCW JMTP continues to be a top down decision process rather than one being based on HB (user / customer) needs - driven in part by demand overwhelming their capacity (much of which is either Covid born or results from the significant overrun in establishing a minimum viable product to replace CanISC) and numerous critical constraints not continuing to be observed in the system whilst the architecture remains closed. HB carrying vacancies in critical areas with no capacity to cover the work from within. As a consequence programme to digitise the Emergency Department processes and records has been suspended. Data acquisition from DHCW products is a curates egg, some new APIs are being made available to standards, however latest PAS offering is via csv download, presenting challenges to adoption of standards within certain areas. UHB still awaiting availability of access to key HB data such as radiology and tests results.</p>	<p>Update July 2024 - The Digital SLG engaged with Ethical Healthcare, who are conducting a review of a national EPR requirements, we are expecting a report towards the end of June 2024. The Digital SMT also undertook a development session with the Director of Digital at BCUHB to gain a better understanding of the work they have carried out in this space. A strategic outline proposal is still planned for the July 2024 Board meeting.</p>	Digital & Data Committee	15	C3xL5	9 C3xL3	++	07.02.2022	04.07.2024	30.08.2024

38



Agenda Item

4.2

Digital & Data Committee

Highlight Report: Information Governance Group

Dyddiad y Cyfarfod / Date of Meeting	28/08/2024
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Claire Northwell, Head of Information Governance
Cyflwynydd yr Adroddiad / Report Presenter	Claire Northwell, Head of Information Governance
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Stuart Morris, Director of Digital

Pwrpas yr Adroddiad / Report Purpose	For Noting
---	------------

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Information Governance Group	08/08/2024	Endorsed

Acronyms / Glossary of Terms	
FOIA	Freedom of Information Act
SAR	Subject Access Request
IG	Information Governance
ICO	Information Commissioner's Office
DPIA	Data Protection Impact Assessment



1. Introduction

- 1.1 This report had been prepared to provide the Digital and Data Committee with details of the key issues considered by the Information Governance Group at its meeting on the 8th August 2024.
- 1.2 Key highlights from the meeting are reported in section 3.

2. Purpose of this Meeting

- 2.1 The purpose of the Information Governance Group is to develop and implement a framework for Information Governance across the organisation and to reinforce a strong ethos of Information Governance. The Information Governance Group will drive the broader information governance agenda and provide the Committee with assurance that effective information governance best practice mechanisms are in place within the organisation.

3. Highlight Report

Alert / Escalate	<p>Risk Escalation - The Medical Records Team presented a report to the IG Group indicating pressures and risk with areas such as; record retention and destruction, overseas visitor tracking, record storage, missing records and high numbers of misfiled records. The Group advised that this needs to be escalated to Operational Management Board. The Clinical Records Modernisation Manager, will amend the report to remove any PII and submit to the Board for scrutiny.</p> <p>Positive Escalation – The IG team has achieved 82.94% compliance with the ESR e-learning. This is the highest figure achieved to date. It was noted that some senior staff are non-compliant with their training and a report will be submitted to Stuart Morris for him to review and where necessary contact people.</p>
Advise	<p>The IG Group discussed the number of misreported incidents on Datix and a recommendation was made by the Chair, Stuart Morris that an IG representative should attend the 'Executive Director led Patient Safety Weekly Meeting', chaired by Greg Dix, Executive Director of Nursing which meets on Mondays. Stuart Morris will facilitate this action.</p>



Assure

The IG Team continue to work towards their KPI targets and the Group acknowledged their work provided in the KPI report and appendices. Below are sections from the report for the Committee to view on compliance with FOIAs and SARs.

The table below represents a summary of the activity relating to FOIAs for the health board in 2023/24. Between the periods March 2024 – June 2024, 204 requests were received with a compliance rate of 94% for this reporting period.

FOI requests for 2023/24				
Freedom of Information CTMUHB	Mar-24	Apr-24	May-24	Jun-24
Number of Requests	44	57	65	38
Number of Requests withdrawn	0	0	0	0
No responded within timescales	40	55	61	36
% responded within timescales	90%	96%	93%	94%
Number of exemptions applied	15	20	29	16
Actual number of questions	228	371	406	302
ICO appeals	0	0	0	0
Number of requests still outstanding (Unanswered)	3	0	1	0
Freedom of Information for Joint Commissioning Committee from April 2024 (previously EASC/WHSSC)	Mar-24	Apr-24	May-24	Jun-24
Number of Requests	1	1	0	0
No responded within timescales	1	1%		
% responded within timescales	100%	100%		
Number of exemptions applied	0	0		
Actual number of questions	2	7		
ICO appeals	0	0		
Number of requests still outstanding (Unanswered)	0	0		

The table below shows the number of personal data requests for Cwm Taf Morgannwg University Health Board (CTMUHB) for the period March 2024 to June 2024. They have been split into Service Groups as they manage their own request process.



Data Protection - Subject Access requests for 2023/2024				
Medical Records (These inc. all 3rd party requests, i.e. police, etc.)	Mar-24	Apr-24	May-24	Jun-24
Number of requests	289	369	309	347
Number of exemptions applied	0	0	0	0
Number of late responses	0	0	0	0
Mental Health	Mar-24	Apr-24	May-24	Jun-24
Number of requests	43	40	44	40
Number of exemptions applied	1	4	7	TBC
Number of late responses	13	34	11	30
Mental Health - SARs for POW Acute and Mental Health (completed under SLA with SBUHB)	Mar-24	Apr-24	May-24	Jun-24
Number of requests				
Number of exemptions applied	Requested but not provided by SBU			
Number of late responses				
CAMHS	Mar-24	Apr-24	May-24	Jun-24
Number of requests	22	31	34	12
Number of exemptions applied	3	0	2	0
Number of late responses	1	0	2	0
Corporate (inc workforce)	Mar-24	Apr-24	May-24	Jun-24
Number of requests	4	2	2	5
Number of exemptions applied	2	1	1	0
Number of late responses	1	0	0	0
Occupational Health	Mar-24	Apr-24	May-24	Jun-24
Number of requests	2	3	2	2
Number of exemptions applied	0	0	0	0
Number of late responses	2	0	1	1



	WHSSC - SARs	Mar-24	Apr-24	May-24	Jun-24
	Number of requests	0	0	0	0
	Number of exemptions applied	0	0	0	0
	Number of late responses	0	0	0	0
	Managed GP practice	Mar-24	Apr-24	May-24	Jun-24
	Number of requests	11	46	59	43
	Number of exemptions applied	0	2	3	1
Number of late responses	0	2	0	2	
Inform	The FOIA Policy and Information Asset Register Management Procedure were endorsed for approval. These will appear as separate agenda items on the Digital and Data Committee consent agenda for approval.				
Appendices	N/A				

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals 150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	Not Applicable
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Enablers of Quality</i> <i>(Duty of Quality Statutory Guidance (gov.wales))</i>	Data to Knowledge
	If more than one applies please list below:
Dolen i Feysydd Ansawdd <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Domains of Quality</i> <i>(Duty of Quality Statutory Guidance (gov.wales))</i>	Effective
	If more than one applies please list below:



Objectives / Strategy	
Effaith Amgylcheddol / Cynaliadwyedd (5R) / Environmental / Sustainability Impact (5Rs)	Choose an item. If more than one applies please list below:

Impact Assessment		
Ansawdd <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /</i> Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: <input type="checkbox"/>	No: <input checked="" type="checkbox"/>
	Outcome:	If no, please include rationale below:
Cydraddoldeb a'r Gymraeg <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /</i> Equality and Welsh Language <i>Have you undertaken an Equality and Welsh Language Impact Assessment Screening?</i>	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	If no, please include rationale below:
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau <i>(Pobl / Ariannol) /</i> Resource Impact <i>(People / Financial)</i>	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

- 5.1 The Digital and Data Committee is asked to **NOTE** the highlights outlined in section 3 of this report.

Technical Resilience Final Internal Audit Report

June 2024

Cwm Taf Morgannwg University Health Board

Contents

Executive Summary 3

1. Introduction..... 4

2. Detailed Audit Findings..... 4

Appendix A: Management Action Plan 11

Appendix B: Assurance opinion and action plan risk rating 19

Review reference:	CTM-2324-20
Report status:	Final
Fieldwork commencement:	3 April 2024
Fieldwork completion:	24 April 2024
Draft report issued:	1 May 2024
Management response received:	3 June 2024
Final report issued:	7 June 2024
Auditors:	Martyn Lewis IT Audit Manager
Executive sign-off:	Stuart Morris, Director of Digital
Distribution:	Paul Chilcott, Lead Infrastructure Architect
Committee:	Audit and Risk Assurance Committee



Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Acknowledgement

NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Disclaimer notice - please note

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit & Risk Assurance Committee.

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

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with the Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Executive Summary

Purpose

The purpose of the review was to provide assurance that there is enactment of technical resilience and awareness of fault domains to ensure the Health Board is maximising the potential for resilience within the architecture.

Overview

We have issued Reasonable assurance on this area.

Digital services are provided using a resilient architecture, and there have been recent improvements with a new room within Prince Charles Hospital and a move towards a hyper converged environment. However, we note that DR site provision does not enable full capacity. There is some testing of aspects of resilience and there are recovery plans and instructions in place, although these have not been updated to reflect the new environment.

There is a good process for backing up Health Board data, and we note recent improvements to this. Where incidents occur there is a process for investigation and learning lessons to reduce future recurrence.

The key issues requiring management action are:

- fully testing the resilience position;
- ensuring appropriate DR plans and instructions are in place for all aspects; and
- defining a priority for emergency service provision and restore order.

Report Opinion



Reasonable assurance

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Trend

None

Assurance summary¹

Objectives	Assurance
1 Resilience Design.	Reasonable
2 Resilience Testing	Reasonable
3 Recovery Plan	Limited
4 Back Ups	Substantial
5 Continual Improvement	Substantial

Key Matters Arising

	Objective	Control Design or Operation	Recommendation Priority
3	Resilience Testing	Operational	Medium
4	Disaster Recovery Plan	Operational	Medium
5	Application DR Plans	Operational	Medium
6	Restore / Resilience Priority	Operational	High

1. Introduction

- 1.1 In line with the 2023/24 Internal Audit Plan for Cwm Taf Morgannwg University Health Board (the 'Health Board' or 'organisation') a review of technical resilience has been undertaken in order provide assurance of the Health Board's ability to maintain acceptable service levels through, and beyond, severe disruptions to its critical processes and the IT systems which support them.
- 1.2 In an environment where technology outages impact an organisation's ability to operate, and customers require services to be 'always on', near-instantaneous recovery is often required with minimal data loss. The environment is made up of inter-related layers, each with its own risks and resilience requirements:
- **Infrastructure** – the foundation layer consists of components such as power, network connectivity, physical security and environment controls, and data centres providing the hosting environment.
 - **Environment** – the infrastructure supports the environment and is the storage and compute functions of the systems (cloud, physical or virtual servers).
 - **Platform** – the environment supports the platform which is the operating systems, databases, and the management of storage and compute resources that host the applications.
 - **Applications** – the software tools which allow the organisation to perform its business and operational processes.
- 1.3 The potential risks considered in the review were as follows:
- i. Severe disruptions to critical processes and IT systems, resulting in unacceptable service levels and patient harm.
 - ii. Loss of key processing or networking services.
 - iii. Legal and regulatory breaches.
 - iv. Reputational damage and/or financial loss.
- 1.4 The scope of the review was limited to Health Board hosted applications and the critical enabling infrastructure on which they are dependent. Infrastructure and applications hosted and provided by other organisations such as the PSBA (Public Sector Broadband Aggregation) and WCP (Welsh Clinical Portal) were not included.

2. Detailed Audit Findings

Objective 1: Resilience is designed into the delivery of the technical infrastructure, the design has been enacted appropriately and applications ensure the designed resilience is used.

- 2.1 The Health Board's digital services are provided from two main sites, a primary site in Prince Charles Hospital (PCH), and the second being Royal Glamorgan Hospital (RGH). We note that each hospital has dedicated rooms for IT infrastructure items relating to the site. Improvements have recently been made to the PCH site with the establishment of a new, dedicated datacentre room.

-
- 2.2 A third site, Princess of Wales Hospital (PoW) is being changed from hosting Swansea Bay University Health Board services, with these having now disaggregated and services for PoW users being provided from the Health Board's sites. The PoW site is being developed as a disaster recovery (DR) site for CTM. As such, the provision of services enables geographical resilience.
 - 2.3 Provision at the main site (PCH) is from two rooms separated across site in different fire zones, and at the secondary (RGH) from two rooms. However, we note that these are next to each other.
 - 2.4 We reviewed the resilience in place for the key sites within the Health Board and note the following:
 - 2.5 Both the primary and secondary sites have dual power feeds with generator support and the racks are fed by two power distribution units (PDU).
 - 2.6 There is uninterruptible power supply (UPS) in place for all key areas. This is a mixture of room and rack based at PCH, and room based at RGH. There is redundancy in the power and UPS supply as a single aspect can be lost without impact on service, thus indicating an N+1 redundancy (where a single item can fail without impact on service). We note that both the UPS and generators are regularly tested, and we understand that the runtime for the UPS at PCH was 2 hours.
 - 2.7 Cooling is provided, with the new room at PCH having three computer room air conditioning (CRAC) units which operate as two active and one on standby, thus providing N+1 redundancy, and the older room having eight wall mounted units. We understand that the room can be sufficiently cooled using six, so providing N+2, with a similar position at RGH.
 - 2.8 The contents of the rooms are documented, and rack content audits are undertaken which enables the team to track both equipment location, and power and cooling needs.
 - 2.9 There is dual networking in place, with resilient routing of cables which has recently been improved.
 - 2.10 There is monitoring in place for the datacentre rooms. The Health Board uses a mixture of the building management system, Solar Winds and NetBotz rack-based software to monitor its infrastructure. These provide alerts and there is a dashboard for site monitoring. We also note the new room within PCH uses smart PDUs which monitor the power supplies.
 - 2.11 There is extensive use of virtualisation software in order to provide resilience within each site. The Health Board is moving away from the previous Hyper-V environment and onto VMware on a hyperconverged environment using Dell VxRail. This is a combination of servers and storage within a distributed infrastructure platform with intelligent software that manages the whole environment and provides a greater degree of resilience.
 - 2.12 The VxRail environment is complex and enables self-monitoring to track the 'health' of the environment to detect and resolve issues before they impact on

service delivery. Fault domains have been defined within the environment with a fault tolerance of 1, which provides resilience by ensuring that virtual machines (VMs) are provided across the domains so the loss of one will not stop services.

- 2.13 The VMware version in use is version 7, and key resilience enabling functionality is active such as Vmotion and VSphere High Availability, which enable virtual machines to be kept running in the event of disruptions. VSphere Fault Tolerance is also active, with primary and secondary fault domains defined.
- 2.14 We do note that the position within RGH is not as advanced as the implementation of VMware, and VxRail is still ongoing. In addition, PoW is not an active site, but management's intent is to use this as a disaster recovery site which can rapidly activate a VxRail cluster to provide services.
- 2.15 Currently Vcenter Site Recovery Manager (SRM) is not in use which automates disaster recovery, although we note that Dell RecoverPoint is in use which replicates virtual machines (VMs) over the network to PoW. The use of SRM could speed up the time taken to recover services. **Matter Arising 1**
- 2.16 Clustering is in use with the PCH production environment provided using five nodes in each room, (SQL using four nodes in each room), these are linked to paired switches in each room, providing on site resilience. We confirmed the capacity to ensure that all services can be run from either room within the PCH cluster, although we note that there is little additional capacity currently available, which may restrict the implementation of new services unless more is provided.
- 2.17 In the event of a loss of PCH, services can be provided from RGH (or PoW once established). The failover process is not automatic and so a manual process would need to be invoked, we discuss the procedures for which under Objective 3. However, we note that RGH does not have the capacity to run all digital services, and neither will PoW. As such, the loss of the primary site will adversely impact on the delivery of digital services. **Matter Arising 2**
- 2.18 Digital services are provided in general by two teams in the directorate: the Clinical Systems team; and the Infrastructure team. The teams work closely together, and when new applications are being developed and installed the Clinical Systems team inform infrastructure of the criticality, user base and technical requirements, and the infrastructure team then design and provide the appropriate server infrastructure.
- 2.19 Our testing of the design of applications in terms of resilience identified that resilience is designed with the following items included to varying extents:
- Geographic resilience;
 - Use of load balancing and multiple servers;
 - Virtualisation; and
 - Clustering.

2.20 We note that there is greater resilience built in for those services defined as critical (both clinical and administrative), which confirms that the Health Board is focusing resources on the most valuable services.

Conclusion:

2.21 The core infrastructure is provided using a resilient architecture across two main geographically distant datacenters, with extensive use of virtualisation. Improvements continue to be made with a move onto a modern hyperconverged architecture which better enables resilience, although we note that the current position does not provide full capacity at secondary sites. The physical equipment is protected with dual power and redundant cooling. Resilience is designed into applications, in particular for those deemed critical to the organisation. Accordingly, we have provided **Reasonable Assurance** for this objective.

Objective 2: Resilience is subject to testing at both infrastructure and application level to ensure that processes are operating as anticipated.

2.22 There is no structured process for testing the resilience of the infrastructure in order to ensure it functions as anticipated.

2.23 There is testing of some of the components as part of normal operations, with restores of virtual machines being an example. We also note that there is monthly testing of generators which interrupt the power supply from mains to UPS.

2.24 There is some testing of application failover as normal operation and as part of maintenance of applications and of UPS, where services are failed over to one room to enable patching, then failed back. We also note that the document management system (CITO) resilience has been tested, as has the provision of Citrix services.

2.25 We note that the move onto the VxRail environment is ongoing, and there has been an element of testing of the resilience elements as part of that process. As we note above, the intent is to use PoW as a DR site, although this has not been fully provisioned as yet with the hardware capacity in place and the prioritised replication of VMs being scheduled into the digital workplan.

2.26 However, there is no structured process for testing the resilience of the infrastructure or applications in order to ensure it functions as anticipated in the event of a rack, room or site failure, and there has been no full testing of the resilience of the digital provision as a whole which would ensure that all services could be brought back, or re-provisioned from an alternative site within the timeframes defined in the service catalogue. **Matter Arising 3**

Conclusion:

2.27 There is testing of the resilience of component parts of the infrastructure such as the UPS. There is testing of aspects of resilience such as individual failover, and there has been some testing as part of the implementation of VxRail. However, there is no full testing of resilience and no formal plan for resilience testing. Without a full test, the Health Board cannot be fully assured that its disaster recovery plans

will operate as anticipated. Accordingly we have provided **Reasonable Assurance** over this objective.

Objective 3: An effective and tested recovery plan which meets the business requirements should be in place.

- 2.28 There is a Server and Storage Services Continuity and Recovery document which contains key information over the architecture in place, the resilience arrangements for core infrastructure and servers, discusses failure scenarios and includes restore instructions in place that set out how to restore virtual servers and how to restore data from the backups. This document defines a set of resilience tiers for applications and includes information on the recovery time (RTO) for each tier.
- 2.29 However the documentation is out of date as it still references the previous Hyper-V environment and has not been updated to reflect the new VxRail environment. We note that this is a new architecture and there was a stated intent to update the DR documentation. **Matter Arising 4**
- 2.30 There are specific application DR documents for some services, with newer, critical services having more detailed information. Eg CITO and Citrix, although as we note above, these are out of date. However, not all individual applications, (non critical) have DR plans, with reliance placed on the server team to restore provision as per the core server DR document. While this may be appropriate, there is inconsistency in approach, and service leads were not always aware of their resilience tier and RTO / recovery point objective (RPO) **Matter Arising 5**
- 2.31 The architecture has changed, and this better enables DR planning with the ability to use PoW as a recovery site. However, the capacity at both PoW and RGH is not sufficient to run all services and so the Health Board will only be able to run prioritised, critical services in the event of the loss of the primary site. In addition, the failover and restore process requires manual intervention and given the number of services this may take a considerable amount of time.
- 2.32 There is a service catalogue in place which defines all services provided, and this includes an indication of criticality. However, there is no full categorisation of services and no prioritisation over what should be restored to alternative sites, and in which order. **Matter Arising 6**
- 2.33 This is also true for Citrix, as although there is a DR plan in place which sets out the arrangements for failing over and restoring services, there is no restore order and no identification of RTO / RPO. **Matters Arising 6**

Conclusion:

- 2.34 Although there are restore instructions in place and there are disaster recovery documents in place, these are out of date due to the implementation of a new architecture, and there is no full set of instructions for recovery from varying levels of incident. There is no up to date prioritised list of services that sets out a restore order, and not all applications have DR plans. We note that the DR site provision is being improved and there is an intent to review the DR plan. Accordingly, we have provided **Limited Assurance** over this objective.

Objective 4: Back-ups are taken appropriately, are tested and protected from unauthorised access and change to enable resilience.

- 2.35 We note that the processes in place for backup up and recovery of data have recently been covered within our 2022/23 Cyber Security internal audit report, and we have reported a positive outcome within that review.
- 2.36 There is a process for ensuring backups of Health Board data are taken, which uses the Commvault facility, with backups taken to disk and then to tape. Backups are stored securely and are encrypted, and there is a process of monitoring the backup process and testing backups by restore to confirm their validity.
- 2.37 We further note that there has been recent investment to improve the security and resilience of the backups. The investment was for the implementation of Cyber Vault, which provides greater storage security and an air gap in order to reduce the risk associated with ransomware.

Conclusion:

- 2.38 There is an appropriate process for backup of data, and securely storing to ensure that this is available at the point of need. The validity of backed up data is also tested to ensure that it is usable and we note improvements to security of backups are underway. Accordingly we have provided **Substantial Assurance** over this objective.

Objective 5: There is a continual process of review and assessment, including post-incident reviews to identify the root causes of disruptions.

- 2.39 As part of our 2023/24 review of IT infrastructure we note that there was monitoring of the core infrastructure (network, servers, firewalls) which provides alerts in the event of an issue with any component, with the main monitoring tool in use being SolarWinds. Our work confirmed that there are resilience related alerts set up within the dashboard available and that there has been some adjustment of alert thresholds in order to obtain more meaningful alert information.
- 2.40 In addition to the SolarWinds monitoring there is rack based monitoring, for example, NetBotz in the old PCH room with sensors that monitor temperature, humidity, and provide relevant alerts.
- 2.41 For the new PCH room there is better integration with the building management system, so there are alerts provided and a daily check on the room status. The room also features smart PDUs which enable active monitoring of power supplies.
- 2.42 Any failures within the infrastructure are dealt with using a service management approach, with incidents recorded and subject to investigation and resolution. The Infrastructure team have developed a major incident tracker which enables them to monitor incidents and ensure that actions to investigate and resolve are maintained.
- 2.43 Our work confirmed that when incidents occur, they are subject to appropriate investigation to establish the root cause of the failure. As part of the investigation, potential lessons are considered and these feedback into the management

processes to improve resilience in the future, and we note configuration changes that have been enacted following incidents.

Conclusion:

2.44 There is a monitoring process in place which provides alerts where issues are impacting on resilience and rectifying any issues. There is a service management process in place which appropriately deals with incidents to enable improvements to be made. Accordingly, we have provided **Substantial Assurance** over this objective.

Appendix A: Management Action Plan

Matter Arising 1: Use of SRM (Operation)		Impact	
<p>Currently, Vcenter Site Recovery Manager is not in use which automates disaster recovery, although we note that Dell RecoverPoint is in use which replicates VMs over the network to PoW. The use of SRM could speed up the time taken to recover services.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> Delays in restoring services 	
Recommendations		Priority	
1.	<p>Consideration should be given to enabling SRM in order to better facilitate DR to alternate sites.</p>	<p>Low</p>	
Agreed Management Action		Target Date	Responsible Officer
1.1	<p>A review into the use of SRM will be carried out. Although an automated DR would be optimal, there are a number of scenarios where it would be preferred to have manual intervention into this type of response. This is in part due to some of the other work that would be required to ensure systems were accessible at the DR site such as network addressing.</p> <p>The UHB is working with CISCO to design and architect a modern network that supports DR more seamlessly.</p>	30/09/2024	Lead Infrastructure and Security Architect

Matter Arising 2: Full Resilience (Operational)		Impact	
RGH does not have the capacity to run all digital services, and neither will PoW. As such, the loss of the primary site will adversely impact on the delivery of digital services.		Potential risk of: <ul style="list-style-type: none"> Delays in restoring services 	
Recommendations		Priority	
2.1	The Health Board should consider increasing alternate site capacity to enable full service delivery.	Medium	
Agreed Management Action		Target Date	Responsible Officer
2.1	An assessment has identified that POW has the capacity to enable full service delivery, as such replication of Virtual machines and services is being targeted to the PoW Datacentre.	Completed	Lead Infrastructure and Security Architect / IT Clinical Systems Manager

Matter Arising 3: Resilience Testing (Operation)		Impact
<p>There is no structured process for testing the resilience of the infrastructure or applications in order to ensure it functions as anticipated and the instructions work. In addition, there has been no full testing of the resilience of the digital provision as a whole which would ensure that all services could be brought back, or re-provisioned from an alternative site within the timeframes defined in the service catalogue.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> Delays in restoring services
Recommendations		Priority
3.1	<p>Once the DR site has been provisioned the resilience position should be tested to ensure it operates as anticipated.</p> <p>Going forward resilience should be subject to regular testing, failing over between rooms and across sites to ensure it still operates.</p>	Medium
Agreed Management Action		Target Date
3.1	<p>A schedule for end-to-end failover testing will be produced and implemented. This should include a full prioritised recovery of systems and validation by system managers/end users. An ongoing log will be maintained.</p>	31/12/2024
		Responsible Officer
		Lead Infrastructure and Security Architect / Head of Server Management

Matter Arising 4: Disaster Recovery Plan (Operational)		Impact	
<p>The DR documentation in place is out of date as it still references the previous Hyper-V environment and has not been updated to reflect the new VxRail environment.</p> <p>We note that this is a new architecture and there was a stated intent to update the DR documentation.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> Delays in restoring services 	
Recommendations		Priority	
4.1	<p>The DR plan should be updated to reflect the new environment. The plan should consider the main types of failure such as IT, power, communications and cover the network infrastructure.</p> <ul style="list-style-type: none"> The DR plan should include processes to follow in order to restore services in the event of varying degrees of failure such as: Failure of site > provision of failover instructions, restore priorities; Failure of rack > provision of failover and restore instructions; Failover of VM > restore and restore from backup; and Failure of system – VM restore / backup restore. 	<p>Medium</p>	
Agreed Management Action		Target Date	Responsible Officer
4.1	<p>The UHB will establish a prioritised plan, incorporating step by step procedures for the restoration of services following a major incident, under 4 separate scenarios, incorporating the fault domain failures as relevant (site, rack, VM, system):</p> <ul style="list-style-type: none"> - Cyber impacting affecting CTM network and services - Environment impact affecting CTM network and services (e.g. utility loss, flood or fire) 	30/12/2024	Head of Server Management

	<ul style="list-style-type: none">- Loss of DHCW services- Loss of WAN &/or Cloud services (external to NHS Wales hosted services which we access via DHCW, PSBA & internet)		
--	---	--	--

Matter Arising 5: Application DR Plans (Operational)		Impact	
<p>Not all individual applications have DR plans, with reliance being placed on the server team to restore provision as per the core server DR document. While this may be appropriate, there is inconsistency in approach, and service leads were not always aware of their resilience tier and RTO / RPO.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> Delays in restoring services 	
Recommendations		Priority	
5.1	<p>An assessment of the need for individual service DR plans should be undertaken. Following that detailed DR documentation should be in place, either within the Server DR document, or within individual DR documents for each service which sets out the architecture, and processes to follow in order to restore the service.</p> <p>The DR documentation should explicitly include information on the resilience tier and RTO/RPO and this should be communicated to service leads.</p>	<p>Medium</p>	
Agreed Management Action		Target Date	Responsible Officer
5.1	<p>The criticality of systems will be prioritised based on criticality. The exercise to document DR plans for all critical systems as defined by NIS regulations will continue with progress overseen by the Cyber Security Assurance Board.</p> <p>The DR documentation will include information on the resilience tier and RTO/RPO and will be communicated to system managers.</p>	30/12/2024	IT Clinical Systems Manager

Matter Arising 6: Restore / Resilience Priority (Operational)		Impact	
<p>The DR site provision cannot host all services and moving to alternate site provision involves manual intervention that may take time given the number of services involved.</p> <p>There is a service catalogue in place which defines all services provided, and this includes an indication of criticality. However, there is no full categorisation of services and no prioritisation over what should be restored to alternative sites, and in which order.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> Delays in restoring services 	
Recommendations		Priority	
6.1	The services to be restored to alternate sites should be formally defined and a prioritised order for recovery set out. This should be based on a formal assessment of service criticality and risk.	High	
Agreed Management Action		Target Date	Responsible Officer
6.1	<p>1) The UHB will establish a prioritised plan, incorporating step by step procedures for the restoration of services following a major incident, under 4 separate scenarios:</p> <ul style="list-style-type: none"> - Cyber impacting affecting CTM network and services - Environment impact affecting CTM network and services (e.g. Utility, flood or fire) - Loss of DHCW services - Loss of WAN &/or Cloud services (external to NHS Wales hosted services which we access via DHCW, PSBA & internet) 	30/12/2024	Lead Infrastructure and Security Architect / IT Clinical Systems Manager

<p>The plan will be in line with the organisation’s overall major incident response plan but will consider informatics resources e.g. the capacity of data centres, dependency and availability of underlying infrastructure and services (e.g. NADEX)</p> <p>This will be a substantial plan and to actually implement the plan is anticipated to have a significant resource requirement. The prioritisation will be in line with the classifications provided by the Civil Contingencies Act around service criticality and risk.</p> <p>2) The mapping of elemental infrastructure and systems (i.e. the critical rebuild materials) to the most critical services will be carried out to determine what will need to be restored is the initial element of this work (e.g. Network, IP addressing, NADEX)</p> <p>3) Contract re-negotiations to make these critical rebuild materials and the critical applications themselves available for on prem rescue and recovery will then be required, prior to the business case process being followed for this functionality to be procured. (i.e. it will cost to launch and run LIMs from the a local on prem viable copy of the application & to ensure that this copy is supported and up to date.)</p>		
--	--	--

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	Substantial assurance	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
	Reasonable assurance	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.
	Limited assurance	More significant matters require management attention. Moderate impact on residual risk exposure until resolved.
	No assurance	Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved.
	Assurance not applicable	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

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



NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership](#)



Agenda Item

5.1

Digital & Data Committee

Digital & Data Assurance Highlight Report

Dyddiad y Cyfarfod / Date of Meeting	28/08/2024
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Karen Winder Assistant Director of Digital Systems
Cyflwynydd yr Adroddiad / Report Presenter	Karen Winder Assistant Director of Digital Systems
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Stuart Morris, Director of Digital

Pwrpas yr Adroddiad / Report Purpose	For Noting
---	------------

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
N/A		



ACRONYMS	
CTMUHB	Cwm Taf Morgannwg University Health Board
DR	Disaster Recovery
GFDC	Ground Floor Data Centre
HEPMA	Hospital Electronic Prescribing & Medicine Administration
MECM	Microsoft End Point Configuration Manager
MFD	Multi-Functional (Print) Device
PCH	Prince Charles Hospital
POW	Princess of Wales
RGH	Royal Glamorgan Hospital
UEM	Blackberry Unified End Point Management
WG	Welsh Government
WPAS	Welsh Patient Administration System
YCR	Ysbyty Cwm Rhondda



1. Situation /Background

- 1.1 The Care groups service redevelopment and improvement plans are underpinned by digital and data services. This is at a time when like all other services digital and data need to balance staff and spending and meet its requirement to make substantial cash releasing efficiency savings (CRES) progress. If potential solutions are digital and data in nature there will need to be appropriate funding from directorates from cost savings or top sliced.
- 1.2 The Bridgend disaggregation is only funded for the WPAS merger with no capital or revenue allocated to support the other tranches of work required, this has been prioritised within the team using existing resources. That said, any opportunities for slippage from the capital programme are being sought to meet this funding gap. The current financial climate is now putting a strain on the resources and potentially slowing progress.
- 1.3 Due to the current financial pressures, there is scrutiny for each position requested. This will delay the delivery of the anticipated benefits, reducing the likelihood of recruiting talent, preventing teams from adopting agile approaches and impacting morale of the existing workforce. This is also leading to continual reprioritisation of routine work.
- 1.4 The revised breakdown of the Digital & Data £1.6m discretionary capital allocation for 2024/25, (25% of the Discretionary Capital programme), noted at the March 2024 Executive Capital Management Group (ECMG), including rolling replacement and new staff equipment, is provided below. A request is pending, to reconfigure these allocations in order to implement a major upgrade of the end of life Jayex solution to the Vitalhub system, that currently that supports Outpatients across PCH/RGH/YCR/YCC. This essential upgrade will provide our patients and staff with the latest functionality and adds significant value to the patient flow within our outpatient departments.
- 1.5 Digital was allocated £1 million of revenue investment through the IMTP for non-pay pressures, of which £700k was allocated to the DHCW SLA cost pressure, with the balance assigned to local pressures such as Citrix licensing, Allocate Rostering, and Oracle FMS.

Allocations	Original /£k	Revised 05/04/24	Change
ICT Allocation	1,888	1,638	
Capitalised IT Staff	320	320	
B/F 23/24 schemes (to cover prior year spends)			
Rolling Replacement Programme	500	500	
IT Equipment new staff	150	150	
Strategic schemes:-			
WNCR	50	50	
Bridgend - Cardiology	50	50	
Enablement of therapies systems	100	80	-20



Allocations	Original /£k	Revised 05/04/24	Change
Enablement of community systems and mental health systems	100	80	-20
ICU solution for Bridgend	100	100	
Infrastructure Review delivery (includes active and passive networking, telecoms, and devices)	200	108	-92
Bridgend specific schemes (disaggregation)	200	200	
Balance/contingency to be committed to further ICT strategic schemes (subject to business cases)	118	0	-118
ICT Allocation Total	1,888	1,638	-250
Balance of ICT Allocation	-	-	

2. Specific Matters for Consideration

2.1 Highlights of the projects and work plan being delivered by Digital & Data Directorate

SERVICE	UPDATE
Network	<ul style="list-style-type: none"> Switch replacement programme: <ul style="list-style-type: none"> The Network edge switch upgrade at YCR has been completed, however the two Cisco 6509 core switches still need to be replaced. There are significant financial and service implications to do this. The Switch replacement programme at RGH is progressing well, all edge cabinets have now been completed as well as 5 of the 8 plantroom cabinets. Switch software updates – UHB wide <ul style="list-style-type: none"> New firmware has been released for the '9300' and '3850' switches, with 80% and 65% of switches having been upgraded, respectively. Firewall replacement programme across the UHB <ul style="list-style-type: none"> New Cisco 4112 10Gb firewalls are now live in POW. These each have a connection to a 10Gb PSBA circuit forming a HA connection. Alongside a tertiary SBU link back to NPT. All small site SoHo type firewalls (circa 55xx) are to be replaced in the coming months with newer more capable models (Cisco 1010 and 1120) meaning that all sites will have Firepower capable devices at the front door. Until this upgrade has been completed all 5506 and 5508 firewalls have been upgraded to the latest version of firmware to overcome a recently announced Cisco vulnerability. The new cabinets have been installed and staff have moved into the recently refurbished areas of PCH ground and first floor. These include Physio/OPD/Endoscopy and Theatres.



SERVICE	UPDATE
	<ul style="list-style-type: none"> • Pathology and Radiology have now also had new cabinets installed as part of the next phase of works. These cabs have already been fully populated with network equipment ready for the moves. • Implementation and rollout of the new Cisco ISE solution, making the protection of the wireless network more robust and resilient. • Multitone paging commissioning at all 3 sites <ul style="list-style-type: none"> • Completed • Next stage integration of alarm panels in RGH and PCH to allow alarms to be monitored from anywhere on the network. (Switchboard Centralisation project) • Switchboard consolidation/centralisation – a plan to centralise all switchboards and estates systems/panels at a single site by October has been requested, which will require significant investment of pay and non-pay resources, and which was not on the workplan for this year. Whilst this will deliver significant savings in Facilities, it may introduce significant risks to the switchboard and Estates operations. • Planning and design phase for Phase III of the PCH Ground and First Floor which will see the removal of the ICT Portacabin and the building of a replacement facility ongoing.
Infrastructure (servers)	<ul style="list-style-type: none"> • VXRail Infrastructure hardware upgrades have commenced to add additional Memory (RAM) capacity into production clusters in RGH & PCH. RGH Completed w/c 29th July with PCH planned for w/c 5th August. • VXRail upgrades, including firmware and code of all clusters across PCH, RGH & POW scheduled to take place over the coming two months. • Into BAU with regards to server support in POW with all elements of server infrastructure disaggregated. • SQL Upgrades planned on test and live environments of CITO to allow systems team to schedule application upgrades. • Digital Cellular pathology going live on new storage platforms in PCH. Server Team carried out upgrades on each storage platform to bring them up to the latest stable release code. • VM migrations on going from Hyper V to new VMWare Estate in PCH approx. 25 Virtual Machines remaining. Project to pick up pace again when the Memory upgrades have been installed. • VM migrations on-going in RGH with this activity scheduled to pick up pace following the Memory upgrades. • On-going discussions with major projects with regards to moving out of the IT1 Data Centre into a new Data Centre (SDC) as part of ground and first floor phase 3 works in PCH. • The Data Domain / Cyber Vault project is progressing, there were slight delays due to hosting arrangements in POW. We are now in the process of arranging installation dates.



SERVICE	UPDATE
	<ul style="list-style-type: none"> • Commvault backup environment upgrades taken place as part of pre-requisites to install the new Cyber Vault into our environment. • Project on-going to reduce the number servers running out of support operating systems.
End User Computing	<ul style="list-style-type: none"> • Maturing of Desktop Support and Service Desk functions ongoing to continue the improved customer satisfaction and reduced wait times for staff seeking support. • New escalation function thoroughly tested. Unfortunately, due to funding, we have had to pause on this exercise but will look for future opportunities to achieve this improvement. Interim measure in place to mitigate impact of removal of this function using staff from other teams. • Microsoft licensing – year three renewal figures have been submitted and accepted. Licenses now in place and conversations beginning regarding the next renewal. User profiling and continuous review leading to an ongoing cost avoidance of c£1m. • Delivery of hardware ordered out of year end opportunities have been completed. Testing and planning underway to begin initial rollout August 2024. • Using the Aternity End User Experience monitoring solution, ongoing carbon reduction being implemented across end user device estate. Laptops completed and planning underway for desktops. Expected significant savings to the organisation from this exercise. • Legacy Operating system eradication ongoing. • Adoption of Microsoft 365 EndPoint Manager solution and removal of Blackberry UEM including replacement/reconfiguring of over 1500 devices have been completed. Blackberry Environment has now been completely decommissioned. • Welsh Government award for addressing Cyber concerns on legacy hardware running legacy operating systems has now been provided and orders placed. Delivery completed and kit rollout is ongoing. • New mobile telephony contract was awarded and migration to new contract has been completed.
Digital Transformation Team – Programmes & Projects	<ul style="list-style-type: none"> • Leading the HePMA project. Recruitment is underway across all disciplines. Several workshops held with stakeholders and Nervecentre colleagues to finalise the documentation required for the contract. The contract is now signed between CTMUHB & Nervecentre and the project will be formally launched in September 2024. The team have continued to work with collaboratively with colleagues from C&V to be as efficient as possible and avoid duplication of effort. The team have also been liaising closely with Trusts in NHS England to understand lessons learned from their HePMA implementations. • Programme managing the overarching Bridgend Disaggregation Programme, this includes the management of all the ICT Bridgend Transition activity and ensuring all infrastructure work and clinical systems alignment is on track



SERVICE	UPDATE
	<ul style="list-style-type: none"> • Project managing all aspects of the highly complex WPAS merger engaging with all stakeholders across CTM, SBUHB and DHCW to ensure all activity is planned and monitored • Managing Project Portfolio Board and user expectations • The Health Board has withdrawn from WICIS. Exploratory work has been undertaken by the project to assess cost, time resource and benefits of expanding the use of the current Phillips CareVue in RGH and PCH and also considering deployment into POW, awaiting decision from Health Board on the way forward. • The Digitisation of Patient Contact Services Business Case has been completed. Discussions have commenced with WG government on next steps. • Managing the OpenEyes project • Programme management of the ICT Bridgend Transition activity and ensuring all infrastructure work and clinical systems alignment is on track • WNCR paediatric national project board has recommended pause of digital development due to 20% cut in funding from Welsh Government. Project Board have proposed standardisation work continues.
Digital Transformation - Business Change	<ul style="list-style-type: none"> • eWhiteboards <ul style="list-style-type: none"> ○ Planning 'Go Live' with Tirion Birthing Centre, ○ Liaising with CAMHS and Palliative Care (POW) ○ Working with Maternity regarding ADTs in WPAS ○ Discussion in relation to functionality development for Maternity ○ Collating contacts for new areas planned (Mental Health and Pharmacy) • Review of outstanding areas to be undertaken and providing ongoing support for T Drive and the D2RA pathway (List View / ETOC) and ADT/MTED • Provided the business change expertise for the transition of the POW to CTMUHB infrastructure • Process mapping cardiology in POW in preparation to moving users to the CTM instances of the MUSE and McKesson system as part of the clinical system disaggregation
Digital Systems	<ul style="list-style-type: none"> • CELLMA – POW – CT system business analysis started in preparation for single instance • ICCA system and infrastructure upgrade preparation • OPAS – SSRS dedicated server live for legacy data view. • WPRS continuation of service uplift to WPRS Full • H2H preparation • MITS go live scheduled August 2024 • Scoping of Centrale foetal monitoring software deployment started and hardware replacements in readiness for BC approval • WCP Major Upgrade • POW ED Radiology Electronic Requesting planning



SERVICE	UPDATE
	<ul style="list-style-type: none"> • POW Path ETR uptake\deployment scheduling • Muse single instance pan CTM – August 2024 • POW ED ECG hardware and data quality improvements • Sentinel Upgrade commence May • Modality refresh of all ECHO carts • Local readiness undertaken for National Solutions • Endoscopy – HESA single instance pan CTM • CSSD\HSDU - HESSDA single instance pan CTM • LIMS2 go live 2025 • RISP/PACS go live 2026 • HEPMA go live 2026 • HEPMA: • WG funding has been agreed by WG now progressing to Implementation planning
Software Development	<p>Ward e-Whiteboard system – developing a validation portal that facilitates the updating of certain fields reportable to WG</p> <p>ED e-Whiteboard solution – foundations of the solution are being put in place whilst 6goals team finalise detailed specification</p> <p>Synchronisation of the demographic data and updating the available codesets to enable the maternity and theatre systems (MITS & TOMs) to go live in POW, noting they are already in use in old-CT.</p> <p>Text and Remind system now live for configured services (inc. CAMHS, CYP, Endoscopy and POW clinics). Still awaiting Radiology Go Live date.</p> <p>School vaccination consent capture system upgraded following security concerns. (not live yet)</p> <p>FHIR forms being developed for clinical data capture in Dermatology</p> <p>Continuing discovery audit on End of Life Architecture and Technical Debt.</p> <p>Good progress made in designing the infrastructure required to deploy CTM software reliably, securely and resiliently.</p>
Clinical Coding	Autocoder re-developed to incorporate an additional 400 coding rule changes.
Business Intelligence	<p>Continuing re-platforming of Business Intelligence to PowerBI – with associated training, branding changes and developing professional Design Pattern standards.</p> <p>Incorporated Predictive Measures into Cancer (SCP) and Unscheduled Care apps for service testing.</p> <p>New/iterated BI dashboard releases for:</p> <ul style="list-style-type: none"> • Discharge Flow Monitoring • A&E Validation Assistance <p>A&E Performance Measures</p> <p>Outpatient Activity</p> <p>SCP (Single Cancer Pathway) performance and activity</p> <p>Clinical Coding performance</p> <p>Finance Apps (costed performance for CTM & Out of Area)</p> <p>Waiting Times App</p>



SERVICE	UPDATE
	<p>Theatre Performance Nursing Care Records data) Flu Dashboard Ad Hoc support to service colleagues in BI matters.</p>
Analytics	<ul style="list-style-type: none"> • Development of SDEC activity view completed for all activity modalities (A&E, IP, OP activity) in preparation for completion of SDEC service model. • Development of an ED Safety Huddle support tool to assist with planning in EDs. • Delivered ABUHB / CTM cross border A&E activity analysis. • VBHC project continues receipt of support for analysis of pathways and data submissions for Heart Failure, Alcohol, Diabetic Podiatry and Type 1 Diabetes Activity projects. • Work on pathology modernisation won a Bevan Award • Stochastic modelling of capacity requirements in the new Llantrisant Health Park (Concorde) development completed
Corporate Reporting	<ul style="list-style-type: none"> • Regular support to Organisation on Ad Hoc reports, FoI Requests, Data Submissions, DSCN implementations. • Support to Enhanced Community Care group in developing submission process. • Development of Data Quality reports to support service areas examining improvement of their data completeness and accuracy. • Additional support on Data Quality for WPAS migration. • Analysis of data requests begun to assist with targeting/prioritising self-service developments. • Continuing data and analytical support to the Vax and Immunisation project group on Covid-19, Flu, Child Vax and MMR programmes (MMR support unfunded but judged critical given reported outbreaks).
Data Warehousing and Engineering	<ul style="list-style-type: none"> • AMaT (Clinical Audit) data pipeline to the Data Warehouse iterated to include new data items and a wider data range for analysis. - Completed · • New Data feeds to the CTM data warehouse established for Endoscopy Activity · • Child Health data sets and Vaccinations · Heavy Support to validation of the WPAS Data Migration Project. · • New data flow to Promptly for PROMS, PREMS, CROMS, Value Based Health Care. · • Support Finance teams for Costing returns. · Support SDEC operational data flow. · • DATIX data pipeline national discussions. · Development of a formal D2RA/POCD delays data set to support analysis and BI developments in Discharge flow management. · Numerous new



SERVICE	UPDATE
	DataSets/Models established to foundationally support analytical/BI projects.
National Data Repository	<ul style="list-style-type: none"> • Data Sharing and Processing Agreements: Currently being discussed with GP Data Protection Officers (DPO). • Primary Care API Testing: Ongoing testing with BlackPear for the Primary Care API work. • CTMUHB eForms Service: Now in UAT, featuring a new Patient Portal that allows Practitioners to log in and complete various clinical eForms. • DSPP Project Collaboration: A workplan has been agreed with the DSPP project to enable patient-facing forms for self-referral through the NHS Wales App. Digital Health and Care Wales (DHCW) are interested in using and contributing to the CTMUHB eForms Project. • Frailty Score Index: Developed a frailty score index that is currently undergoing clinical validation by Orthopaedics for use in the new fracture liaison service. • Welsh Referrals Service Integration: Collaborating with DHCW to use the Welsh Referrals Service to facilitate Service Requests within the health board from CDR-developed applications. • FHIR Modelling of WPAS A&E System: FHIR modelling of the WPAS A and E module is well underway, with an expected delivery date of August 2024. This will be shared with the rest of Wales for free and fair reuse. • PROMS integration: An Integration Engine has been developed to provide patient & appointment data to Promptly as FHIR over an S3 bucket. Work soon commencing to move to FHIR for communication and further develop the script to support the national PSOM model
Performance Reporting	<ul style="list-style-type: none"> • The performance report continues to be iteratively updated in line with WG and Board direction. Ownership and accountability of the content and accuracy of the performance data remain a significant concern to the Informatics teams. • Commenced Performance Management Engagement Sessions with Care Groups and Analytical/BI team to develop Performance Framework and the applications to support its regular reporting. • Co-ordinated Minimum DataSet (MDS) submission and modelling to support WG submission for the 2024/35 IMTP. • Co-ordinated Minimum DataSet (MDS) submission for Q4 2023/34 return to WG · Collation and submission of biannual Policy Assurance Documentation for WG submission.
Architecture	<ul style="list-style-type: none"> • Leading the Bridgend Infrastructure programme with weekly focussed sessions and coordination – 1 key workstream remains – Telephony. This is progressing in line with plans. • All servers hosted on legacy SBU hardware in POW have been migrated to CTM and SBU Legacy hardware decommissioned.



SERVICE	UPDATE
	<ul style="list-style-type: none"> Completing an infrastructure baseline mapping exercise to supporting the identification of risks pertaining to key Infrastructure components and review and remediation of these. Reviewing the Nationally and Local programmes (RIS, ePMA) solutions and ensuring that CTM has appropriate Infrastructure architecture to support the use of these cloud service through secure and resilient links through to effective access to Local Business continuity services. Reviewing the impact of the G&FF refurbishment in line with the ICT hosting within PCH and the Infrastructure strategy

3. Key Risks / Matters for Escalation

- 3.1 The current financial climate will impact the digital and data programme as the availability of both the capital and revenue does not meet the overall Health Board requirements.
- 3.2 A number of National projects are proposed without local business cases and agreed funding.
- 3.3 Drive to digital ways of working without adequate funding to be able to plan a constructive rolling replacement programme present reputational risk to the UHB in giving clinicians and patients the requisite assurance that digital enables resilient, safe ways of working.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Sustaining Our Future
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals 150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	A Resilient Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (Ilyw.cymru)) / Link to Enablers of Quality (Duty of Quality Statutory Guidance (gov.wales))	Whole-systems Perspective
	If more than one applies please list below:



Objectives / Strategy	
Dolen i Feysydd Ansawdd <i>(Canllawiau Statudol Dyletswydd Ansawdd (Ilyw.cymru)) /</i> Link to Domains of Quality <i>(Duty of Quality Statutory Guidance (gov.wales))</i>	Equitable
	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /</i> Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: <input type="checkbox"/>	No: <input checked="" type="checkbox"/>
	Outcome:	If no, please include rationale below: Not Required
Cydraddoldeb a'r Gymraeg <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /</i> Equality and Welsh Language <i>Have you undertaken an Equality and Welsh Language Impact Assessment Screening?</i>	Yes: <input type="checkbox"/>	No: <input checked="" type="checkbox"/>
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below: Not Required
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau <i>(Pobl /Ariannol) /</i> Resource Impact <i>(People / Financial)</i>	Yes (Include further detail below)	
	Staff & Capital required to deliver the full ambition of the digital programme	

Impact Assessment		
Ansawdd	Yes: <input type="checkbox"/>	No: <input checked="" type="checkbox"/>



Impact Assessment		
Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? / Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Outcome:	If no, please include rationale below: Not required
Cydraddoldeb Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? / Equality <i>Have you undertaken an Equality Impact Assessment Screening?</i>	Yes: <input type="checkbox"/>	No: <input checked="" type="checkbox"/>
	Outcome:	If no, please include rationale below: Not required
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau <i>(Pobl / Ariannol) / Resource Impact</i> <i>(People / Financial)</i>	Yes (Include further detail below)	
	Staff & Capital required to deliver the full ambition of the digital programme	

5. Recommendation

- 5.1 **NOTE** the projects both system and infrastructure completed this year.
- 5.2 **NOTE** the progress made with the Bridgend disaggregation.
- 5.3 **NOTE** the challenges with the current level of capital and revenue funding to sustain a digital programme.
- 5.4 **NOTE** the increase of National systems without local business cases and related funding.