Digital Governance & Safety Committee

Wed 11 August 2021, 13:00 - 16:00

MS Teams

Agenda

13:00 - 13:05
5 min

1. PRELIMINARY MATTERS

1.1. Welcome & Introductions

For Noting *Chair*

1.2. Apologies for Absence

For Noting *Chair*

1.3. Declarations of Interest

For Noting *Chair*

1.4. Forward Work Plan & Horizon Scanning

For Noting *Board Secretary*

- 1.4 Forward WorkPlan Report.pdf (4 pages)
- 1.4i DHCW DG&S Work Programme 21_22 v2.pdf (2 pages)

13:05 - 15:50
165 min

2. MAIN AGENDA

2.1. Minutes of the Last Meeting

2.1.1. Public Session

For Approval *Chair*

- 2.1.1 Digital Governance and Safety Committee Minutes 20210512 - PUBLIC.pdf (17 pages)

2.1.2. Private Session

For Approval *Chair*

- 2.1.2 Digital Governance and Safety Committee Minutes 20210512 - PRIVATE - Abridged.pdf (5 pages)

2.2. Action Log

For Discussion *Chair*

- 2.2 Action Log.pdf (1 pages)

2.3. Velindre Quality and Safety Committee Minutes

For Noting *Head of Information Governance on behalf of the Medical Director*

- 2.3 Velindre Quality and Safety Committee Minutes.pdf (19 pages)

2.4. Wales Informatics Assurance Report

For Assurance *Quality Manager (Regulatory Compliance)*

2.4 Wales Informatics Assurance Report.pdf (12 pages)

2.5. Information Governance Assurance Report

For Assurance *Head of Information Governance*

2.5 Information Governance Report Assurance.pdf (9 pages)

2.6. Information Services Assurance Report

For Assurance *Deputy Director of Information*

2.6 Information Services Report.pdf (4 pages)

2.7. Incident Review and Organisational Learning Report

For Assurance *Chief Operating Officer*

2.7 Incident Review and Organisational Learning Report.pdf (11 pages)

2.8. Information Governance Toolkit Update

For Discussion *Head of Information Governance*

2.8 Information Governance Toolkit Update.pdf (16 pages)

Comfort Break

15 Minute Comfort Break

2.9. Microsoft office 365/SharePoint update report

For Noting *Head of Information Governance on behalf of Director of Information and Communication Technology*

2.9 Microsoft office 365SharePoint Update Report.pdf (5 pages)

2.10. Putting Things Right Update

For Noting *Board Secretary*

2.10 Putting Things Right Update Report.pdf (4 pages)

2.11. Data Centre Transition Report

For Noting *Director of Information and Communication Technology*

2.11 Data Centre Transition Report.pdf (8 pages)

2.12. NHS Wales National Clinical Audit and Outcome Review Plan

For Approval *Head of Information Governance*

2.12 NHS Wales National Clinical Audit and Outcome Review Plan.pdf (6 pages)

2.13. Risk Management Report including Risk Register

For Noting *Board Secretary/Risk Owners*

2.13 Risk Management Report.pdf (9 pages)
2.13i RR_DHCW Corporate Jun 21.pdf (4 pages)

15:50 - 15:50
0 min

3. CLOSING MATTERS

3.1. Any Other Urgent Business

For Discussion *Chair*

3.2. Items for Chair's Highlight Report to the Board

For Noting *Chair*

3.3. Date of next Committee Meeting - Wednesday 10th November 2021 13:00 - 16:00

For Noting *Chair*

DIGITAL HEALTH AND CARE WALES
FORWARD WORKPLAN AND HORIZON SCANNING

Agenda Item	1.4

Name of Meeting	Digital Governance and Safety Committee
Date of Meeting	11 August 2021

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

Executive Sponsor	Chris Darling, Board Secretary
Prepared By	Sophie Fuller, Corporate Governance and Assurance Manager
Presented By	Chris Darling, Board Secretary

Purpose of the Report	For Noting
Recommendation	
The Digital Governance & Safety Committee is being asked to: **NOTE** the contents of the report.	

Acronyms			
DHCW	Digital Health and Care Wales	AW	Audit Wales
SHA	Special Health Authority	IA	Internal Audit
COPI	Control of Patient Information		

1 SITUATION/BACKGROUND

1.1 The Digital Governance and Safety Committee have a Cycle of Committee Business that is reviewed on an annual basis. Additionally, to that is a forward workplan which is used to identify any additional timely items for inclusion to ensure the Committee are reviewing and receiving all relevant matters in a timely fashion.

2 SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 Below are the additional items for the November Committee meeting:

- Eprescribing Welsh Government Review and approved DHCW business case
- Welsh Government Quality and Safety Framework
- Information Services Directorate Risks Deep Dive
- Information Governance Risks Deep Dive
- Control of Patient Information (COPI) requirements
- Health Technology Wales Strategic Plan 2021-25

2.2 The Chair of the Committee has requested additional horizon scanning is undertaken by officer members for the forward workplan including the large-scale projects identified within the Annual Plan with the highest potential to materially affect delivery of DHCW's strategic objectives. The Corporate Governance team will support the Executive Medical Director and Director of ICT to identify items for the forward workplan in addition to identifying items from the Annual plan for inclusion in the forward workplan.

3 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 The Welsh Government Quality and Safety Framework was originally planned for publication before summer recess however this is now planned for early September and a report on DHCW's responsibilities will be provided to the Committee in November.

3.2 Please see attached the updated forward workplan at Appendix 1.

4 RECOMMENDATION

The Committee is being asked to:
NOTE the content of the report.

5 IMPACT ASSESSMENT

STRATEGIC OBJECTIVE	Development of the new Digital Organsation

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:	

HEALTH CARE STANDARD	Governance, leadership and acccountability
If more than one standard applies, please list below:	

EQUALITY IMPACT ASSESSMENT STATEMENT	Date of submission: N/A
No, (detail included below as to reasoning)	Outcome: N/A
Statement: N/A	

APPROVAL/SCRUTINY ROUTE:

Person/Committee/Group who have received or considered this paper prior to this meeting

COMMITTEE OR GROUP	DATE	OUTCOME
Digital Governance and Safety Committee	May 2021	Initial workplan approved

IMPACT ASSESSMENT	
QUALITY AND SAFETY IMPLICATIONS/IMPACT	No, there are no specific quality and safety implications related to the activity outlined in this report.
	No, there are no specific legal implications related to the

LEGAL IMPLICATIONS/IMPACT	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

Digital Health and Care Wales Digital Governance and Safety Work Programme 21/22

Meeting Date	*Standing items*	*Assurance Reports*	*Additional items*
11th August 2021	• Welcome and Introductions • Minutes • Declarations of interest • Action log • Review of risk register relevant to committee • Forward Work Programme • Committee Highlight Report to Board	• Information Governance • Informatics Assurance • Information Services • Incident Review and Learning Report • Cyber Security – Private • Cyber Security Highlight of previous private session	• Data Centre Transition Report • Velindre Quality and Safety Committee Minutes • Microsoft office 365/SharePoint Closure Report • Audit Wales Cyber Report- Private • Information Governance Toolkit • Putting Things Right (CD/RH) • NHS Wales National Clinical Audit and Outcome Review Plan Darren Griffiths (AW) observing meeting as part of structured assessment work James Quance (IA) observing meeting.
10th November 2021	• Welcome and Introductions • Minutes • Declarations of interest • Action log • Review of risk register relevant to committee • Forward Work Programme • Committee Highlight Report to Board	• Information Governance • Informatics Assurance • Information Services Assurance • Incident Review and Learning Report • Cyber Security – Private • NIS Compliance Update Report - Private • Cyber Security Highlight of previous private session • EU Settlement Status Update • Information Services Directorate Risks Deep Dive • Information Governance Risks Deep Dive	• E-prescribing Welsh Government Review and approved DHCW business case • Welsh Government Quality and Safety Framework • Control of Patient Information (COPI) requirements • Health Technology Wales Strategic Plan 2021-25

16th February 2022	• Welcome and Introductions • Minutes • Declarations of interest • Action log • Review of risk register relevant to committee • Forward Work Programme • Committee Highlight Report to Board	• Information Governance • Informatics Assurance • Information Services Assurance • Incident Review and Learning Report • Cyber Security – Private • NIS Compliance Update Report • Cyber Security Highlight of previous private session	

DIGITAL GOVERNANCE AND SAFETY COMMITTEE MEETING - PUBLIC

MINUTES, DECISIONS & ACTIONS TO BE TAKEN

13:00 to 16:00 12/05/2021

Location of Meeting

Chair	Siân Doyle

Present (Members)	Initials	Title	Organisation
Siân Doyle	SD	Independent Member, Chair of the Digital Governance and Safety Committee	DHCW
Rowan Gardner	RG	Independent Member, Vice Chair of the Digital Governance and Safety Committee	DHCW
David Selway	DS	Independent Member	DHCW
Rhidian Hurle	RH	Medical Director	DHCW
Carwyn Lloyd Jones	CLJ	Director of Information and Communication Technology	DHCW
Rachael Powell	RP	Deputy Director of Information	DHCW
Chris Darling	CD	Board Secretary	DHCW
Darren Lloyd	DL	Head of Information Governance	DHCW

In attendance	Initials	Title	Organisation
Julie Ash	JA	Head of Corporate Services	DHCW
Sophie Fuller	SF	Corporate Governance and Assurance Manager	DHCW

Apologies	Title	Organisation
None	N/A	N/A

Acronyms			
DHCW	Digital Health and Care Wales	NWIS	NHS Wales Informatics Service
SHA	Special Health Authority	DG&S	Digital Governance and Safety
WIAG	Wales Informatics Assurance Group	CAB	Change Advisory Board
IG	Information Governance	ISD	Information Service Directorate
NEAG	Notifiable Events Assurance Group		

Item No	Item	Outcome	Action to Log
1	**PART 1 – PRELIMINARY MATTERS**	**Outcome**	**Action to Log**
1.1	**Welcome and Introductions** The Chair welcomed the members and officers to the first meeting of the Digital Governance and Safety Committee outlining Digital Health and Care Wales' commitment to open and transparent meetings. Meeting papers are published to the DHCW website 7 days in advance of the meeting for the public to review and the minutes of the meeting will be published as part of the pack for the next meeting in August. The Chair highlighted the busy agenda and outlined the expectations for the meeting, emphasising that should items need to be explored further, follow up sessions will be arranged to ensure good time keeping for this meeting.	Noted	None to note
1.2	**Apologies for Absence** There were no apologies for absence received.	Noted	None to note
1.3	**Declarations of Interest** There were no declarations of interest received.	Noted	None to note
2	**PART 2 – MAIN AGENDA**	**Outcome**	**Action to Log**
2.1	**Digital Governance and Safety Terms of Reference** The Chair outlined that as a new Committee with new Terms of Reference, an evolution is expected as the Committee's understanding of its role and remit develops. The Chair noted that it would be important to understand in more detail the potential overlaps with the Audit and Assurance	Approved	None to note

	Committee. The Chair reiterated the purpose of the Committee is assurance on behalf of and advice for the Board. Doing the right thing for the patients and stakeholders and providing advice to the Board for improvement. The Chair asked the Board Secretary, Chris Darling (CD) to talk members through the Terms of Reference. CD referenced the relevant sections of the Standing Orders within the remit of the Committee. CD noted the remit of the Committee outlined may be further developed as the roles and responsibilities becomes clearer, this in part due to the fact there is no equivalent Committee within NHS Wales to benchmark against. Work has been undertaken to date to establish the DHCW processes that are within the remit of the Committee in order to provide assurance to the Board, resulting in the Terms of Reference presented to the members and officers present. The Chair asked members for their comments or questions on the Terms of Reference. Members had been given opportunity to review the Terms of Reference prior to the meeting and there were no further comments or questions received. **The Committee resolved to:** Approve the Terms of Reference		
2.2	**Committee Annual Cycle of Business and Forward Work Plan and Associated Dates** The Chair asked CD to talk through the Annual Cycle of Committee Business and Forward Work Plan. CD explained the purpose of the Annual Cycle of Business, that was developed annually to outline the core items that the Committee can expect to see on a regular basis as well as on an annual or one-off basis. The item covers the next 12 months activity to help the Committee plan its meetings. CD explained that the Forward Work Plan is expected to be a fluid document to aid in work planning. CD has asked colleagues to do some horizon scanning within their areas of responsibility to help guide the content of this document for the next 6 to 9 months. This would highlight areas that this Committee should be sighted on and review any areas that might be missing. CD outlined the different sections of the Annual Cycle of Business, highlighting the Committee Chair's Report for Board, received by the SHA Board following a Committee meeting. This report is an avenue to escalate issues and	Approved	Update Annual Cycle of Business to reflect accurate leads of each item.

	outline the actions taken by the Committee. The Digital Governance and Safety Performance and Assurance Section sets out the assurance reports in high-level terms and it is important for Committee members to consider content requirements for these reports in order for them to provide assurance to the Committee. The Chair asked Committee members for any comments or questions on the Annual Cycle of Business/Forward Work Plan. The Deputy Director of Information, Rachael Powell (RP) commented that in the table included in the paper, The Medical Director, Rhidian Hurle's (RH) lead areas of responsibility need to be switched so that RH is the lead for the Informatics Assurance report and RP is the lead for the Information report. **ACTION – 20210512-A01** Update Annual Cycle of Business to reflect accurate leads of each item. **The Committee resolved to:** Approve the Annual Cycle of Business and note the Forward Work Plan.		
2.3	**Velindre Quality, Safety and Performance Committee Closure Report** The Chair asked RH to talk members through the report. RH explained any incidents recorded during the governance period under Velindre University NHS Trust when formally closed are to go to their Quality, Safety and Performance Committee with the appropriate assurance and the learning from those events having been captured. RH invited CD to add any pertinent information for the Committee. CD outlined the historic governance processes in place for NHS Wales Informatics Service (NWIS), DHCW's predecessor. NWIS was established on 1 April 2010 and under the hosting arrangement with Velindre University NHS Trust, part of the agreement was for NWIS to provide evidence of assurance through Velindre's Audit Committee and Quality, Safety and Performance Committee. Items went to Velindre Board meetings as necessary. CD explained that as part of the SHA transition project, a Committee structure had been developed to reflect DHCW's Standing Orders and the previous assurance activity will now sit under the new structure. CD informed the Committee the DHCW Chair, Bob Hudson had met both Velindre Committee Chairs and no issues/risks had been identified regarding the handover of Committee arrangements from	Noted	

	Velindre to DHCW. CD highlighted within item 2.3i, table 3.1 was helpful for understanding previous reporting lines to Velindre University NHS Trust. Those items reported to the Velindre Audit Committee would now fall under the remit of the DHCW Audit and Assurance Committee and others would come to DHCW Digital Governance and Safety Committee. CD explained that item 2.3i section 4.1 summarises no outstanding Velindre Audit Committee actions at the point of transfer to DHCW. But several actions would remain on the DHCW Audit Tracker and be monitored and managed by the DHCW Audit and Assurance Committee moving forward. CD noted two audit reports not reported to the Velindre Audit Committee, but both were reported through the DHCW Audit and Assurance Committee meeting on 11th May 2021. They will also be received by the Velindre University NHS Trust Audit Committee as the work formed part of the plan for NWIS whilst under hosting arrangements. The handover report did highlight an action regarding the Microsoft Teams tenancy issues. CD invited Darren Lloyd (Head of Information Governance) to provide a verbal update. DL explained that Microsoft 365 covers the majority of NHS Wales services. The issue raised is that tenancy access settings meant Health Board and Trusts were able to see information outside their organisation but still within the tenancy. There was an expectation that documents saved on SharePoint sites were private, but it was discovered that access was wider than the organisation. DL informed Committee members that a large amount of work had been carried out in order to understand the extent of the problem and the issue had affected over 600 sites across NHS Wales so work was underway to make sure that they were made private and that the organisations affected were made aware of the issue. The incident had been reported to the Information Commissions Office. DL stated that the team had been asked to complete a closure report, this will be provided to Velindre Quality, Safety and Performance Committee in readiness for their next meeting. The closure report for this action would also come back to the next Digital Governance and Safety Committee meeting. The Chair asked whether that was the only outstanding action pertaining to this committee to which DL confirmed it was. **ACTION – 20210512-A02:** Update and closure of Microsoft Tenancy issue to come back to the next DG&S Committee		Update and closure of Microsoft Tenancy issue to come back to the next DG&S Committee meeting

	meeting. **The Committee resolved to:** Note the contents of the report		
2.4	**Wales Informatics Assurance Presentation** The Chair invited RH to talk members through the presentation. RH outlined the assurance process involved in systems readiness for the live environment. This included the settings in which this process applied, the personnel and areas involved in the Wales Informatics Assurance process including the Wales Informatics Assurance Group (WIAG), a collection of different disciplines who provide assurance for the proposed systems. WIAG use a number of templates and approval processes to provide robust scrutiny and review of proposed systems as outlined in the slide pack. The Chair asked RH where the DG&S Committee would slot into that process in terms of approval and go live. The Chair stated that it would be good to understand better the timelines, key milestones and approvals within the process. RH explained there are a number of initiators for the assurance process, one of those being a change to a system. This would be actioned as part of the service's own Change Advisory Board (CAB) if the service is live. They are variable in terms of frequency, depending on the product but that there are currently over 70 live systems running across NHS Wales. Regarding the sign off of the Safety Case and Readiness Report, this operational sign off lays with the DHCW Medical Director. This would involve ensuring the appropriate steps had been undertaken throughout the process to assure the product was in readiness for go-live and providing that feedback to DHCW Directors. RH explained that, if for any reason he was not willing to sign off a release, it would be escalated to the Chief Executive. WIAG does not only consist of DHCW members, it is important to note that there is external scrutiny through a number of pathways that would flag any issues and risks as it goes through the process. The Chair asked Committee members for any questions or comments on the presentation. David Selway (DS) commented that when going through the presentation, there was no mention of verification of	Discussed	Board Secretary to meet with the Chair of the Audit and Assurance Committee and Digital Governance and Safety to define the reporting requirements for each Committee to ensure efficiency of reporting.

	validation. RH commented that Slide 5 of the presentation highlighted this and the individuals that have responsibility as part of the assurance process. DS asked whether there is software that requires independent validation. RH replied that currently DHCW are considered able to self-validate the software it produces, but the Quality and Regulatory team are working to understand what the potential impact of the Medical Devices Regulation may have in terms of future validation of software. The current understanding is that the UK Regulation will be closely aligned to the European regulation. It is understood that algorithms having a diagnostic function will have to be independently regulated. Carwyn Lloyd-Jones (CLJ) responded to DS that one of our systems has extended validation and we undertake that work for that system as part of the Medicines and Healthcare Products Regulatory Agency (MHRA) regulations for pathology systems. Rowan Gardner (RG) commented that this was a challenging area as the regulations are always changing and as the UK has now left the EU, parity may not continue. RG also commented that the EU had announced a new directive on regulating Artificial Intelligence and logical knowledge-based systems so the type that might be used in the future. RG suggested that this might be something to be reviewed regularly on the work plan. CD commented that the role of the DG&S Committee in relation to informatics assurance is to assure that the systems and processes are operating as they should. **ACTION – 20210512 – A03:** Board Secretary to meet with the Chair of the Audit and Assurance Committee and Digital Governance and Safety to define the reporting requirements for each Committee to ensure efficiency of reporting. **The Committee resolved to:** Note and discuss the content of the presentation		
2.5	**Information Governance Presentation** The Chair invited DL to talk Committee members through the presentation. DL set out the role of Information Governance in DHCW. The approach is three tiered. DHCW has a role to ensure that in relation to national information governance, there is a strategy and a model moving forward. DHCW's responsibility is to ensure that services and systems and the associated stakeholders are assured a model is in place that	Approved	None to note

	ensures confidentiality, data protection and the rights of individual residents and patients in Wales. Welsh residents and patients need to be assured that their information is safe and secure. DL explained that there have been and continue to be a large amount of discussion with various groups and stakeholders such as the Information Commissions Office, stakeholders, GPC Wales, BMA, Health Boards and Trusts, in order to provide confidence in the system. DL explained in order to share information at the point of care, DHCW are required to have an assurance model that gives confidence within the system that information being shared across many services and systems is secure. Confidence in the robust management of Information Governance allows information sharing to take place more robustly and routinely. The second element is to have tools available to make sure that assurance is transparent and well documented. DHCW will be making sure that tools are available to health and social care and those delivering NHS Wales services. The third element is corporate compliance. DHCW can perform to those requirements and is complying with the information agenda as an organisation. In terms of assurance process, DL explained that when designing a system, it is with privacy in mind i.e. the Welsh Patient Administration system. DL explained that systems are designed with access control and auditability as an underlying pillar because information sharing has to be routine and multi-faceted and not geographically constrained in anyway. DL relayed the complexity of information management and the fine line of balancing promoting information sharing but also promoting the protection of the information that is being shared at the point of contact. DL then referenced item 2.5ii the Information Governance Strategy. The paper outlined to the Committee the roles and responsibilities and how products and services are delivered as the organisation responsible for them. DL explained that the statutory functions are quite high level and responsibilities around information governance have not been policy led or mandated by Welsh Government to date. DL informed the group that the main pillars of the strategy are: • Continuity of products and assurance models to make sure that the service can use them. • Information sharing with Health Boards, Trusts and Primary Care, it is key for DHCW to understand the		

	wider requirement of the services to provide the definition of DHCW's wider NHS roles and responsibilities. The Chair suggested that it would be helpful to have a deeper understanding of this over the next couple of meetings, particularly with compliance to the standards and support. The Chair thanked DL for his presentation. The Chair stated that it would be beneficial to understand more about the compliance process and how that would be measured. The Chair also stated that it would be very helpful to understand the ultimate ownership and data governance. RG commented that DL had said that the systems were designed for privacy and asked about privacy standards. DL replied that the main standard DHCW respond to is the data protection regulations. There are areas of compliance that are around the individual and what safeguards are in place when information being shared. DL was assured that DHCW compliance around General Data Protection Regulations (GDPR) which had been measured by internal audit is robust. Julie Ash (JA) noted that we do hold ISO 27001 certification for our infrastructure systems and would be happy to provide any background on that at future meetings. The Chair stated that it would be good to get an understanding of the workload and risks over the next 6 months. DL explained he is working with Welsh Government to confirm our information responsibilities and what DHCW are legally and formally responsible for. It would be important for Independent Members to be sighted on risks and challenges going forward and DL would be happy to have another item on the Committee agenda in future to discuss in more detail. The Chair commented that from a transparency perspective Independent Members need to understand the risks and compliance concerns, ownership and remit in directing versus advising other NHS bodies. **The Committee resolved to:** Approve the strategy and note the presentation		
2.6	**Comfort break**		
2.7	**Information Services Presentation** The Chair asked Rachael Powell to take Committee members through the Information Services presentation. RP outlined that she would provide an overview of what	Discussed	None to note

	DHCW do with information, the team responsibilities and the assurance and governance arrangements in place to oversee the information function. RP explained that the Information Services Directorate role is to give context and scope around information handling and processing within DHCW. The Information Services Directorate (ISD) is made up of almost 60 information professionals with responsibility for data collection/acquisition; storage and warehousing of data; processing of data. Analysis, modelling and reporting of information that includes all Wales data flows for a range of purposes is undertaken. ISD also produce a range of data products and visualisations such as dashboards, health maps, web apps and portals. In terms of scope, RP explained that the DHCW data warehouse holds over 30 years of data sets, which include a range of activity from maternity to primary and community pre-hospital data. Covid-19 has been significant from a data perspective, not just due to the information we were expected to provide, but the frequency of the provision. Some information going from monthly requirement to daily reporting. Access to timely information became a necessary and vital part of key decision making for the pandemic response on a national level. The Information Services Directorate has transformed into a 7 day a week real time information service. RP explained that the Information Services Directorate Assurance Group acts as the main reviewing body. This includes a range of disciplines and feeds into the Wales informatics Assurance process. The group's part in the assurance process aims to identify information requirements at an early stage and to review throughout the project. Areas for focus are identifying data storage requirements, what relevant data and information standards already exist, data quality improvement opportunities and advising on the selection of the right data and information standards to improve the project outcome. In addition to the ISD Assurance Group, ISD have other groups that oversee the processing arrangements with regard to information, an indicative list is on slide 3 of the presentation. As the new organisation grows and expands, ISD will develop the group further to ensure more data products are taken through the group for assurance. Including the Microsoft 365 Power BI tool and the information used to create those		

	dashboards. RP explained risk is managed through the ISD Management Group via a risk register working with the Risk Management Group to escalate to a corporate level where appropriate. RP informed the Committee of the specific information assurance and governance work required with the development of a dedicated research and innovation function. RP suggested bringing the proposed assurance and governance processes for this new workstream to the Committee for information. Lastly RP explained that DHCW became an official statistics producing body when the new body came into being on 1 April 2021. The Chair asked whether there is a clear Service Level Agreement (SLA) with regard to the responsibilities of DHCW in this new role? RP stated that they work closely with stakeholders and will continue to do so but in new territory as an official statistics producing body, the onus is on DHCW to be clear and consistent in terms of defining risks and responsibilities and being clear on what our role and remit is within the Committee. The Chair reiterated the work ahead in understanding the remit and responsibility of the Committee and being able to measure DHCW's compliance in order to give assurance that the organisation is governing appropriately for patients. RG raised the approach to risk management. RG commented that we can't assure what we can't see so there is a missing piece about what elements need to be brought to this Committee. It would be helpful to see a policy on this in the future. RP explained the Board Secretary will be further developing the Risk Management process for DHCW but the Information Services report will contain the risks and details of their management for review by the Committee. CD responded to RG to say item 2.10 should address the proposed question. CD agreed that it would be important that DG&S Committee members are sighted on the risks and the mitigating actions that are being taken. The Chair thanked RP for the presentation. **The Committee resolved to:** Note and discuss the content of the presentation		

2.8	**Notifiable Events Assurance Presentation** The Chair asked RH to present item 2.8. RH gave an overview of the report, item 2.8 highlighting section 1.2 which outlines the assessment of incidents from a local level and escalated to subject matter experts when they meet criteria as defined in the localised area procedure. This triggers the notifiable events assurance procedure. The purpose of the notifiable events assurance process is to ensure the appropriate review, notification and investigation and communication of the learning from investigations. Communications are received through a number of different mechanisms for example service point/service desk. An assessment is made based on what is known at the time on how the incident should be categorised. RH explained that there were agreed mechanisms for escalation to Welsh Government. RH explained that there are performance indicators in terms of timeframes when certain things should be done. RH stated that the aim is to complete documentation and learning within 60 days but there are occasions when the problem is identified but investigations into whether there was harm caused can take longer than 60 days to reach a conclusion. RH explained that this is dependent on a number of factors including the number of people / health boards that were affected by the issue. The Chair asked in relation to slide 5, whether the incident management process has various severity to them? On the process where do the captured learnings and actions get reported to? RH replied that information is shared with the individual/organisation with those affected but is also shared through the clinical structures such as Welsh Clinical Informatics Council. There are some incidents where wide engagement is required. CLJ explained that historically there have been two parallel processes. One dealing with incidents that affect the patients or where there is a clinical risk associated, they have been managed through the process that Welsh Government have for notification of clinical incidents. In parallel to that there is an incident management process, for technical faults with systems. The outcomes from reports for the notifiable events are recorded on the Quality Improvement Action List and tracked until closed. The purpose of the new Notifiable Events Assurance Group (NEAG) is to provide management and assurance that the	Discussed	RH to give RG access to the log of notifiable events

	process is being managed to conclusion and lessons learned are identified and acted upon. RG asked how many notifiable events would be routinely be dealt with through this process in twelve months? RH replied that they are usually low figures, often single figures, but the complexity of the events varied. RH stated that he can share access to that information. RG also asked whether, because we are deploying complex integrated systems across different organisations that may have different infrastructure, there are deployment challenges in terms of chasing down root causes. RG asked whether that was because we are supporting a number of different operating systems? CLJ replied we don't have much diversity in terms of the operating systems being used as most of the NHS network uses Microsoft Windows. However, there was much more diversity in relation to the versions used within organisations with some using older versions. RH commented that if the infrastructure within the Health Boards used internet explorer versions for example, our operational software needs to maintain compatibility with a range of years which is additional pressure on the infrastructure resources. The Chair stated that understanding the range of versions in place through the NHS network would be something that should be highlighted for this Committee. This will be picked up as one of the areas for review, it would highlight where we might not be able to assure ongoing support and safety. ACTION – **20210512 – A04:** RH to give RG access to the log of notifiable events **The Committee resolved to:** Note and discuss the presentation.		
2.9	**EU Settlement Status Report** DL was asked by the Chair to talk to the prepared report. DL outlined the emerging requirement at the end of 2019/20 for Wales to assimilate data from the Home Office on an individual's settled status so consideration could be made if charges for NHS treatment applied or not. This information is routinely made available by the Home Office because it is part of a settled status requirement for any person coming to the UK. Our status within the EU has changed due to Brexit and the assessment for charging is changing due to transition arrangements. Health Boards and Trusts do not	Discussed	DL to provide status update at next Committee meeting

	currently have robust processes in place to check on the settled status of individuals in order to apply any charges that may be required. Welsh Government asked DHCW to be the responsible body for Wales for receiving the relevant information from the Home Office (via NHS Digital in England) to be relayed to Health Boards and Trusts in Wales. DL explained to date the issue had been that DHCW were not a Statutory Body. Now DHCW has established as a Statutory Body, the appropriate governance arrangements have been actioned and the final sign off process is in motion. The Section 255 requires NHS Digital approval before signing off by the DHCW Chief Executive and the data transfer can be actioned. A Memorandum of Understanding will be in place between the Home Office, NHS Digital and DHCW in order to sign off the technical and financial arrangements and to take receipt of that data. DL outlined the data transformation requirements in order to share with the Health Boards and Trusts, this work is underway. In terms of the Committee's roles and responsibilities, DL proposed it would be assurance the process is progressing, and the appropriate technical and governance arrangements are signed off and finalised. The Chair asked DL to give an update at the next Committee meeting on where we are with the process. **ACTION – 20210512-A05:** DL to provide status update at next Committee meeting **The Committee resolved to:** Note the content of the report and discuss the item		
2.10	**Risk Management Report** CD stated that the purpose of this item was to update Committee members on the proposed approach to risk management. CD explained that as an organization, DHCW has adopted the approach to risk management previously used by NWIS through Velindre's risk management policy. This was adopted by the DHCW Board on 1st April 2021. CD talked through the Risk Management and Board Assurance Framework Strategy recently developed and discussed and endorsed by the Audit and Assurance Committee on 11 May 2021. The strategy builds on the foundations that were in place for risk management in NWIS	Discussed	Present a draft version of the risk report to the Chair for review before the next Committee meeting

	but expands the remit of risk management recognising that DHCW is now a statutory body. It identifies the roles and responsibilities for Board and Committees within DHCW and extends from risk to include risk and Board assurance. CD explained that section 2.2 within the report, showed the Audit and Assurance Committee having a specific role in reviewing the effectiveness of the systems and internal controls for the management of risk and Board assurance. However, the Strategy sets out that all Committees have a role to play in ensuring effective risk management and the escalation arrangements with risks being assigned to Committees. CD also highlighted the journey that the organisation would need to go on in relation to defining the organisation's risk appetite and its approach to defining and managing the key risks to DHCW's strategic objectives. CD indicated section 2.10i is an indicative list of potential risks that could be assigned to this Committee extracted from the current Corporate Risk Register. The Chair commented that it would be helpful to understand the methodology on how the risks were selected and the criteria going forward and some thoughts as to how they would be presented and the frequency. DS commented that he had found the Risk Management and Board Assurance Framework Strategy a useful document that describes how we arrive at the ranking of 1 – 25 and would share the link to the document with the Chair and RG. JA commented that DHCW has a Corporate Risk Register and there are other registers that are held at different levels within the organization i.e. at Department and Directorate level. JA explained that currently, anything that effects the organisation as a whole, such as a reputational issue or something that can't be managed at the Directorate level, would be escalated on to the Corporate Risk Register. JA stated that there were here are currently 21 risks at the corporate level. In response to the Chair's question on how the risks were identified, JA reviewed the Corporate Risk Register and identified areas within the remit of the Committee including clinical, information governance and service interruption. JA and Leads briefly went through the Risks before the Chair opened it up for questions and discussions from Committee members. RG commented about how the risks were currently presented and some suggested changes including 'date the		

	risk was entered on the risk regiser'. It was noted that if known mitigating actions are not chosen for action, for example, should financial support be able to mitigate the risk, it would be helpful to add that detail in order to provide a fuller picture The Chair commented that it would be useful to know the size of the risk i.e. how many people would be affected by something. The Chair asked if JA, with others, could start thinking about making the document more comprehensive. CD commented that the Datix system that captures the risks has a lot of information that could be pulled through so between now and the next Committee meeting, work would be done to test out different formats of presenting the information. **ACTION – 20210512-A06:** Present a draft version of the risk report to the Chair for review before the next Committee meeting **The Committee resolved to:** Note the content of the report and endorse the proposed approach.		
3	**CLOSING MATTERS**		
3.1	**Any other Urgent Business** No other urgent business was raised.	Discussed	None to note
3.2	**Items for Chair's Report to the Board** Items for inclusion in the Chair's report were noted as per the actions taken for each item. The Chair highlighted the three key themes emerging from the Committee meeting: Work is required to ensure the remit of the Committee is clear to create compliance and assurance going forward. Working to understand the authority of DHCW going forward and how this Committee supports that authority in terms of identifying concerns, highlighting non-compliance, highlighting risk due to potential funding or resource issues. As a team it would be good to understand how we can help to get clarity in a complex environment. Defining the reporting rhythm that will be provided in the planned assurance reports from the officer members.	Noted	None to note

3.3	Date and Time of Next Meeting – Wednesday 11th August 1-5pm	Noted	None to note

DIGITAL GOVERNANCE AND SAFETY COMMITTEE MEETING – PRIVATE

MINUTES, DECISIONS & ACTIONS TO BE TAKEN

16:00 to 17:00 12/05/2021

Teams

Chair	Siân Doyle

Member present	Initials	Title	Organisation
Siân Doyle	SD	Independent Member, Chair of the Digital Governance and Safety Committee	DHCW
Rowan Gardner	RG	Independent Member, Vice Chair of the Digital Governance and Safety Committee	DHCW
David Selway	DS	Independent Member	DHCW
Rhidian Hurle	RH	Executive Medical Director	DHCW
Carwyn Lloyd Jones	CLJ	Director of Information and Communication Technology (ICT)	DHCW
Rachael Powell	RP	Deputy Director of Information	DHCW
Chris Darling	CD	Board Secretary	DHCW
Darren Lloyd	DL	Head of Information Governance	DHCW

In attendance	Title	Organisation
Julie Ash	Head of Corporate Services	DHCW
Jamie Graham	Acting Head of Cyber Security and Infrastructure Operations Programme Manager	DHCW
Elizabeth Dier	Project Manager	DHCW
Sophie Fuller	Corporate Governance and Assurance Manager	DHCW

Apologies	Title	Organisation
None	N/A	N/A

Acronyms			
DHCW	Digital Health and Care Wales	NWIS	NHS Wales Informatics Service
SHA	Special Health Authority	DG&S	Digital Governance and Safety
NIS	Network and Information Systems	VMS	Vulnerability Management System
ESR	Electronic Staff Record	IMS	Integrated Management System
OES	Operator of Essential Services	CRU	Cyber Resilience Unit

Item No	Item	Outcome	Action to Log
1	**PART 1 – PRELIMINARY MATTERS**		
1.1	**Welcome and Introductions** The Chair welcomed the members and attendees of the Committee to the private session.	Noted	None
1.2	**Apologies for Absence** None were received.	Noted	None
1.3	**Declarations of Interest** None were received.	Noted	None
2	**PART 2 – MAIN AGENDA**	**Outcome**	**Action to Log**
2.1	**DHCW Cyber Security Report** The Chair invited the Director of ICT, Carwyn Lloyd-Jones (CLJ) to talk to the report. CLJ talked to the contents of the report which gave an overview of the activity undertaken by the Cyber Security team to manage and ensure the safety and security of the NHS Wales network and systems. CLJ talked through the remainder of the report focused on the operational security controls, the advice and assurance the team provide and the associated metrics that would be reported to the Committee on an ongoing basis. David Selway (DS) asked if there was the scope for the wider deployment of ISO 27001, for example the certification doesn't currently apply to applications we develop? CLJ responded stating that the availability of resources to	Approved	None

	implement more widely across the organisation and the requirements for maintaining the certification were out of reach for the organisation currently and it would take a significant increase of dedicated resource to enable a decision to do that. DS enquired as to the additional resources required to fund the Cyber Resilience Unit and the advisory role expected. CLJ explained the Cyber Resilience Unit is funded, with the sole scope to help Welsh Government with their roles as the competent authority. The Cyber Resilience Unit Team is completely separate to our Cyber Security team; they will be required to audit the whole NHS suite of organisations. Due to that, the team will report into the Director of Finance to ensure complete autonomy from the DHCW Cyber Security Team. CLJ indicated JG would provide a full overview of the Cyber Resilience Unit in the next item. **The Committee resolved to:** **Note** the content of the report and approved the items within the report identified to be reported at the next private session of the Digital Governance and Safety Committee.		
2.2	**DHCW Cyber Resilience Unit – Network and Information Systems (NIS) Report** CLJ introduced Jamie Graham (JG) and Elizabeth Dier (ED). JG talked to a presentation that gave an overview of the purpose, hierarchy and status of the Cyber Resilience Unit. The unit was launched in April 2021 via Welsh Government Funding to manage the implementation of the Network and Information Systems (NIS) Directive (2018). The Unit is a response to discussions with Welsh Government as to their role and response to the NIS Directive. DHCW (NWIS at the time) offered to support in developing the appropriate support to ensure qualifying NHS Wales organisations are compliant with the Directive. Welsh Government is the competent authority, DHCW is the delegated authority. The unit will report to the Director of Finance, Claire Osmundsen-Little to ensure the required autonomy is in place. The unit will work with all operators of essential services (OES) of which DHCW is one, to evaluate their Cyber Security Posture in relation to the NIS Directive and make recommendations and set timeframes for completion with the ability to sanction organisations that don't meet those	Noted	None to note

	timelines. It is of similar structure and power to the Information Commissioners Office. CLJ reiterated that the purpose of the unit will be predominantly an audit function but will include the creation of service improvement standards for each qualifying NHS organisation. The Cyber Security team will still be responsible for the response to Cyber Security threats to the national systems. The distinction in responsibilities with regard to managing the operational Security of the network is clear, this lays with the Cyber Security Team. The Chair thanks JG and ED for their report. **The Committee resolved to:** **Note** the content of the report.		
2.3	**Cyber Security Internal Audit Report** CLJ presented the report that was also reported to the Audit and Assurance Committee by Internal Audit colleagues from NHS Wales Shared Service Partnership. It was pleasing to report to the Committee the overall rating was a substantial level of assurance. There were two identified areas for action both of which relate to Covid-19. The Chair thanked CLJ for the report. **The Committee resolved to:** Note the content and receive the Internal Audit report for Assurance	Received for Assurance	None to note
2.4	**Corporate Risk Register – Cyber Security Risks** The Chair invited CLJ to present the report. CLJ gave an overview of the 5 items included in the risk register related to Cyber Security including their current status and the mitigating action undertaken to date to reduce the risk and where further action is required. Questions were taken and responded to by CL-J. **The Committee resolved to:** **Note** the content of the report.	Noted	None to note
3	**PART 3 – CLOSING MATTERS**	**Outcome**	**Action to Log**
3.1	**Any other Urgent Business** The chair noted that it would take work for the members and officers to finalise the requirements for all the reports	None to note	Note to note

	required for submission to the Committee in readiness for the August meeting.		
3.2	**Items for Chair's Report to the Board** The Chair noted points to include in the report to Board.	Noted	None to note
3.3	**Date and Time of Next Meeting** Wednesday 11th August 4-5pm	Noted	None to note

Reference	Date of Meeting	Action/Decision	Action Lead	Due Date	Status/Outcome Narrative	Status	Revised action	Revised due date	Session Type
20210512-A01	12/05/2021	Update Annual Cycle of Business to reflect accurate leads of each item	Chris Darling (DHCW – Board Secre	13/05/2021	20/06/21 Updated - Informatics Assurance Report now assigned to Rhidian Hurle and Information Services Assurance Report assigned to Rachael Powell.	Complete			Public
20210512-A02	12/05/2021	Update and closure of Microsoft Tenancy issue to come back to the next DG&S Committee meeting.	Carwyn Lloyd-Jones (DHCW – Direc	11/08/2021	30/07/21 On agenda for the August DG&S Committee - item 2.9	Complete			Public
20210512-A03	12/05/2021	Board Secretary to meet with the Chair of the Audit and Assurance Committee and Digital Governance and Safety to define the reporting requirements for each Committee to ensure efficiency of reporting.	Chris Darling (DHCW – Board Secre	11/08/2021	20/06/21 proceeding meetings have taken place, this will be finalised with the Chair's at the Audit and Assurance paper review and the Digital Governance and Safety Agenda setting session. 02/07/2021 This is now finalised	Complete			Public
20210512-A04	12/05/2021	RH to give RG access to the log of notifiable events	Rhidian Hurle (DHCW - Medical Dir	11/08/2021	04/08/21 Committee members will receive details of notifibale events within the Incident review and organisational learning report that will be a standing item on the DG&S agenda.	Complete			Public
20210512-A05	12/05/2021	DL to provide update on EU Settlement Status at next Committee meeting	Darren Lloyd (DHCW - Information	11/08/2021	30/07/21 This will be presented at the Committee meeting in November.	Underway			Public
20210512-A06	12/05/2021	Present a draft version of the risk report to the Chair for review before the next Committee meeting	Chris Darling (DHCW – Board Secre	11/08/2021	30/07/21 Risk Report has gone to the Chair prior to publishing papers for quality assuring, including proposed deep dive risk template.	Complete			Public

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Minutes

Public Quality, Safety & Performance Committee

Velindre University NHS Trust

Date: 13th May 2021
Time: 10:00 – 12:30
Location: Microsoft Teams
Chair: Janet Pickles, Independent Member

ATTENDANCE		
Stephen Harries	Independent Member	SH
Prof Donna Mead	Velindre University NHS Trust Chair	DM
Steve Ham	Chief Executive Officer	SH
Hilary Jones	Independent Member	HJ
Carl James	Director of Strategic Transformation, Planning and Digital	CJ
Dr Jacinta Abraham	Executive Medical Director	JA
Nicola Williams	Executive Director of Nursing, Allied Health Professionals & Health Scientists	NW
Annie Evans	Deputy Director of Nursing, Quality & Patient Experience	AE
Cath O'Brien	Interim Chief Operating Officer	COB
Mark Osland	Executive Director of Finance	MO
Lauren Fear	Director of Governance	LF
Sarah Morley	Executive Director of Workforce & Organisational Development	SfM
Stuart Morris	Deputy Chief Digital Officer	SM
Alan Prosser	Interim Director of Welsh Blood Service	AP
Paul Wilkins	Director, Velindre Cancer Centre	PW
Emma Stephens	Head of Corporate Governance	ES
Kay Barrow	Corporate Governance Manager	KB
Jade Coleman	Quality & Safety Facilitator	JC
Kyle Page	Business Support Officer	KP

0.0.0	PRESENTATIONS	Action Lead
0.0.1	**Velindre Cancer Centre, Patient Story** Led by Viv Cooper, Head of Nursing, Quality, Patient Experience and Integrated Care, Velindre Cancer Centre The Committee received a patient story presentation that had been developed in conjunction with the family of a patient of Velindre Cancer Centre who has sadly passed away. The story provided an overview of the patient's background and experience of attending a Velindre clinic held at an Outreach location. Concerns had been raised by the family in relation to sharing of the clinic outcomes and ongoing plan between Velindre and the patient's GP and the general poor experience and communication with the patient by the clinician, including lack of urgency in the provision of palliative care.	

	The family had welcomed a formal meeting with the team at Velindre to receive a response to the complaint/concerns they had raised and were keen that the story be presented to the Trust Quality, Safety and Performance Committee forum, to ensure that their mother's experience was heard and understood by the committee members. The family was keen that failures in communication and processes that they experienced are improved so that other patients do not have the same experience and to avoid further similar incidents. The Committee thanked VC for the sensitive presentation of the story and discussed / highlighted areas for improvement which were: • The importance of Clinicians receiving feedback (also to inform appraisals with line managers). • Continue to deliver training in advanced communication skills. • Delivery of integrated Digital Health Record (to enable visibility of information across the health system in its entirety). • Clearer documentation of telephone contact to be audited by the Health Records Manager. • Assurance that lessons learnt from the incident are ingrained in the future outreach work programme. • Assurance that the Clinician involved has undertaken a reflective review of the process and identified areas for improvement. NW reiterated the importance of hearing such incidents and it was agreed that the following should be included in the next Velindre Cancer Centre Committee report: • Assurance that all actions and learning have been completed. • Consistency of delivery of outreach services for current patients. • Consistency of standards regarding provision of services and our minimal consultation standards. JA advised and reiterated that discussions had been undertaken around how lessons can be learnt in terms of follow up and communication for patients seen only once in their treatment pathway. The outreach work is key to monitoring inequities in the services and providing support where possible. The development of Partnership Boards with other Health Boards will provide a route for more constructive discussions in relation to pathways going forward. DM requested that a report regarding the mechanism of transferring patients to palliative care following a one off consultation with Oncologists be brought back to the Committee when appropriate. It was suggested that communication and management of correspondence could be immediately improved via the IT system to mitigate patients becoming lost in the system. SM advised that this would require standardisation of the system and removal of variation. The Chair requested the following requires consideration:	**VC** **PW**

	• Feedback to the next Committee on the areas for improvement identified above and work being undertaken currently in relation to the culture within the Trust's outreach settings. • Assurance to the Committee as part of the next Velindre Cancer Centre report that all agreed actions / recommendations have been fully implemented. • Potential sampling to investigate the possibility of further similar incidents within the digital system. The Chair asked that PW pass on the Committee's sincere condolences for their loss and to advise how grateful the Committee were that they had shared this story with us as it provided a number of opportunities for improvement.	**PW** **PW** **PW** **PW**
1.0.0	**STANDARD BUSINESS**	
1.1.0	**Apologies** had been received from: • No apologies received.	
1.2.0	**In Attendance:** • Stephen Allen (SA) - Chief Officer, South Glamorgan Community Health Council • Amy English (AE) – Deputy Chief Officer, South Glamorgan Community Health Council • Katrina Febry (KF) – Audit Wales – Audit Lead • Nathan Couch (NC) – Audit Wales – Senior Auditor • Tom Stephenson (TS), Relationship Manager, Healthcare Inspectorate Wales • Peter Gorin (PG) – Head of Corporate Planning, Planning & Performance • Hayley Jeffreys (HJ), Infection Prevention & Control Senior Nurse • Jason Hoskins (JH), Assistant Director of Estates, Environment & Capital Development • Viv Cooper (VC), Head of Nursing Velindre Cancer Centre • Nathan Couch • Malcolm Lewis - Medical Director, Legal & Risk Services (NWSSP) • Stuart Blackmore - Consultant in Donor Medicine, WBS • Barry Williams - Financial Management Graduate Trainee	
1.3.0	**Declarations of Interest** Led by Stephen Harries, Independent Member, Quality, Safety and Performance Committee Chair • No declarations of interest were raised.	
1.4.0	**Review of Action Log** Led by Nicola Williams, Director of Nursing, AHPs and Health Sciences The Action Log was reviewed and the following was highlighted:	

	• The Committee ***agreed*** all closed actions. • **Legacy Q&S –** NW suggested the addition of a date field to the action log to facilitate a plan for progressing/completing actions. LF advised that discussions are actively underway and SH will confirm when subsequent conversations have been undertaken. • **Ref 2.1.2 (18/1)** – Policy review will be undertaken with the aim to close the item at July's Committee meeting.	**KP** **SH** **ES/LF**
2.0.0	**CONSENT ITEMS** (The consent part of the agenda considers routine Committee business as a single agenda item. Members may ask for items to be moved to the main agenda if a fuller discussion is required). JA requested that item 2.2.6 (Medical Examiner Service and Velindre University NHS Trust) be removed from consent items to the main agenda, allowing for discussion. The Chair also requested that item 4.3.0 (Velindre Trust Revalidation Updates 2019/20) was moved to consent items due to the absence of Andrea Gwilliam, Medicine Directorate Manager.	
2.1.0	**ITEMS FOR APPROVAL**	
2.1.1	**Minutes from the meeting of the Public Quality, Safety & Performance Committee held on 15th March 2021** Led by Jan Pickles, Independent Member, Quality, Safety and Performance Committee Chair DM requested an update on three items included in the minutes of the 15th March 2021 not captured in the action log: • ***2.2.6 - Assurance regarding mandatory fire training in the Estates Report -*** JH advised that this has been addressed with a compliance level of 85% at the end of April. This will improve further to as close to 100% as possible. • ***3.1.0 - No agreed plan to undertake infection control and decontamination work in the cancer centre theatre suite -*** NW advised that there is now a clear plan in place and we are currently out to tender, with a view to commencing work in June 2021. • ***3.1.0 – Changing Facilities update -*** Velindre Cancer Centre Senior Management Team are currently reviewing options for increasing changing room facilities at Velindre Cancer Centre. The minutes of the Public Quality & Safety Committee held on the 15th March 2021 were **APPROVED** as a true reflection of the meeting.	

2.1.2	**Respect and Resolution Policy** Led by Sarah Morley, Executive Director of Workforce and Organisational Development The Committee **APPROVED** the Respect and Resolution Policy for implementation within Velindre University NHS Trust that had been developed nationally and agreed by the Welsh Partnership Forum on the 17th March 2021.	
2.2.0	**ITEMS FOR NOTING**	
2.2.1	**Summary of the Minutes from the meeting of the Private Quality & Safety Committee held on 15th March 2021** Led by Jan Pickles, Independent Member, Quality, Safety and Performance Committee Chair The Committee **NOTED** the summary of the minutes from the Quality, Safety & Performance Committee held in Private on the 15th March 2021.	
2.2.2	**Highlight Report from the Datix Project Board** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Sciences The Committee **NOTED** the Trust Datix Project highlight report that included the progress and exceptions against the Datix project plan and the current national deferral of the implementation of the Once for Wales Datix Programme.	
2.2.3	**Highlight Report from the COVID-19 Cells** • **Test, Trace & Protect Cell** Dr Jacinta Abraham, Executive Medical Director • **COVID-19 Vaccination Programme/Cell** Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Sciences The Committee **NOTED** the COVID-19 Cell: Test Trace & Protect and COVID-19 Vaccination Highlight Reports.	
2.2.4	**Smoking in Public Places Briefing** Led by Cath O'Brien, Interim Chief Operating Officer NW advised that although no smoking has been witnessed on Velindre hospital site, instances have occurred on the land between the hospital and Whitchurch. Clarification regarding regulations is required in addition to potential communication to staff. The Committee **NOTED** the action being taken by the Trust to meet the revised regulatory requirements.	**COB**
2.2.5	**Healthcare Inspectorate Wales (HIW) Work Plan 2021-22**	

	Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Sciences The Committee **NOTED** the Healthcare Inspectorate Wales Work Plan for 2021-22.	
2.2.6	**Medical Examiner Service and Velindre University NHS Trust** Led by Dr Jacinta Abraham, Executive Medical Director *Item moved from consent items to the main agenda for discussion.* JA asked for this item to be removed from consent to facilitate an opportunity for Committee members to gain an understanding of the Medical Examiner Service due to its significance. The paper detailed the Trust's provision of a consistent approach to death certification, ensuring independent scrutiny of all deaths, including identifying those requiring investigation. JA advised that the Trust has reviewed the process for mortality reports and currently has a systematic approach for reviewing all deaths relating to Velindre patients. The next stage determines interaction with the medical examiner, including the allocation of an external individual to assist with development of the system over the next quarter ahead of the official launch in September 2021. The Committee were advised that an implementation plan has been developed that is currently being scoped in a paper for consideration by Velindre Cancer Centre Senior Management Team. The Committee will receive an update once the implementation plan is agreed. The following questions were raised by Committee members: • ***Will this result in any delays to families being issued with a death certificate?*** JA advised this should not result in a delay but should create a consistent process for completing certificates which should in turn avoid some of the previous delays which have occurred historically. Communication with families is key and additional resourcing such as a bereavement expert to coordinate this element may be required. ML advised that the main purpose is to apply independent scrutiny to the certification process and the benefits of explaining to families why certain things may have happened offers great benefit. A presentation by Daisy Shale (NWSSP Lead Medical Examiner Officer) regarding the current position may be of advantage in the future. • As this refers to patients passing away on Velindre premises, ***what is the outcome of these reviews in relation to Velindre patients who pass away at home or in a different hospital setting?*** JA confirmed that in terms of deaths occurring outside of Velindre, references within the paper indicate that pathways should be in place to allow the introduction of the Medical Examiners Service for Velindre, but also to allow information on deaths of our patients that occur outside the premises. Currently, the Trust is not sighted on this area and data via Coroners communicating with Velindre will be included in future. This will feed into an internal report	**JA** **JA** **JA**

	(currently an evolving process) which will be brought to this Committee as part of mortality feedback. • ***Will the Medical Examiner Service report back to this Committee with an update re identified concerns or learning, with a possible report on how they are resolving this from a public point of view?*** The Committee accepted the offer of a presentation from Daisy Shale at an appropriate point in the future. The Committee **NOTED** the detailed Medical Examiners Service report and **AGREED** to receive the implementation plan and outputs at a future meeting.	
2.2.7	**Trust Estates Assurance Highlight Report** Led by Jason Hoskins, Assistant Director of Estates The Committee **NOTED** the Trust Estates Assurance Meeting Terms of Reference and Highlight Report following the meeting held on the 23rd April 2021. There were no items to alert or escalate.	
2.2.8	**Digital Health and Care Wales (DHCW) Velindre University NHS Trust Committee Actions Handover Report** Led by Lauren Fear, Director of Corporate Governance The Committee **NOTED** the Digital Health and Care Wales comprehensive Handover report.	
3.0.0	**RISK MANAGEMENT AND SAFE SERVICES** (This section supports the discussion of provision of patients/donors with safe, high quality, compassionate care within the Trust and that are financially sustainable).	
3.1.0	**Shared Services Transforming Medicines Unit (TMU) Report** Led by Malcolm Lewis, Medical Director, Legal & Risk Services, NWSSP The Committee received the TMU report, introducing the previous Temporary Medicines Unit in Newport but more recently renamed CIVAS@IP5. ML advised that this Unit had been requested by Welsh Government to produce a centralised facility for various intravenous drug additives during the COVID pandemic. Main productions to date have been adrenaline, morphine and fentanyl (producing up to 2,000 units per month). The paper outlined the methodology for obtaining approval from the Medicines and Healthcare products Regulatory Agency (MHRA) and accreditation has been awarded to TMU/CIVAS@IP5 by the MRHA following a recent review. SH advised that the report would be sighted at this Committee for endorsement before presentation at the NWSSP Partnership Committee followed by Trust Board to provide final approval. DM indicated a preference for a regular report to Committee due to the recent implementation of the service and significant clinical implications. ML advised	

	that a report can be provided whenever necessary. ES/KP to add to the Committee work plan. The following questions were asked: • ***Would complaints managed through Datix and QPulse be received by the Trust?*** ML confirmed this would be dependent on the nature of the complaint and potential outcome. This would be managed internally at a low level; however any serious issues would require a level of sharing. Complaints would come from Health Boards as opposed to patients. Reporting of yellow cards would also be undertaken at Health Board level. • ***There are no specific Q&S implications related to impact assessments. Is this the case?*** ML indicated that if contaminated products are identified in the production line, an adequate quality management system would prevent these being released into the system. The process involves the production of medications in a secure contained environment as opposed to clinical decisions in terms of dosage or administration. • Although Health Boards would assume responsibility for clinical decisions, delays in the provision of medication may result in patient harm and subsequent complaints. ***Would the complaint be received by Velindre or does a separate complaints system exist?*** ML confirmed the complaint would be processed via the relevant Health Board due to patients' unawareness of where Health Boards procure medication. A risk register reflecting an up and running service is available if required. The committee **REVIEWED** the report and appendices and **ENDORSED** the paper with the view to present to the NWSSP Partnership Board followed by Velindre Trust Board.	**ES/KP**
3.2.0	**Shared Services Future Quality & Safety Reporting Arrangements** Led by Lauren Fear, Director of Corporate Governance The Committee received a paper that detailed proposed future Quality & Safety Reporting Arrangements in respect of Quality and Safety within Shared Services. The recommended approach involves the addition of a section within the Trust Quality, Safety & Performance Committee agenda to cover NWSSP Quality & Safety Business. Initial endorsement at Quality, Safety & Performance Committee would be followed by approval at the NWSSP Partnership Committee and Velindre Trust Board. The Committee **ENDORSED** the proposed additional role of the Committee in relation to the assurance of quality and safety NWSSP business on the basis that this is a work in progress. This proposal will now be submitted to NWSSP Partnership Board and Velindre Trust Board respectively.	**ML/LF**
3.3.0	**Quarter 4 Concerns Report: Incidents** Led by Annie Evans, Deputy Director of Nursing, Quality & Patient Experience	

	The Committee received the Quarter 4 Concerns Report that detailed the number and types of incidents received and closed across the Trust during Quarter 4. AE highlighted the following: • 350 incidents were raised (329 at VCC, 20 at WBS and 1 at Corporate). • The majority were classified as 'no harm' or 'low harm' and raised for recording purposes only. • 3 level 5 incidents were raised during the quarter, relating to patient deaths from COVID which occurred during quarter 3. • Trust performance relating to the management of incidents in a timely manner has shown improvement with 65% being closed within 30 days of reporting. • Ongoing work is being undertaken to refine and strengthen the Trust's approach to incident management, including improvements to the content of quarterly reports in terms of narrative around investigations and learning. The following questions were raised: • For incidents closed outside the 30 day period, how much longer than 30 days elapsed before closure and can this be included in future reporting? AE advised that work is currently being undertaken around audit metrics in Datix and this information can be reported in future. • Incidents by category – Due to the nature of incidents reported (4 medication prescription and 1 medical equipment), it was confirmed that this was due to increased reporting as opposed to a systemic issue. NW also indicated that a deep dive analysis was undertaken in relation to medicines incidents (identified in January's Committee), which has subsquently been completed and is progressing through the Quality Group before being presented at the next Committee. • Pressure damage occurring during patients' admission – It was queried whether this had had been identified on admission or had occurred due to the admission process. AE advised that 16 pressure ulcers had been reported during the quarter; 13 of which were present on admission and the remaining 3 developed whilst in Velindre's care. The avoidability of these are considered in the pressure ulcer scrutiny panel that is held each month. AE will include this detail in future reports. • VCC COVID-19 incidents graph relating to 'serious incidents by severity' – It was acknowledged that the graphic representation was misleading and as an evolving report, will be addressed going forward. The Committee **NOTED** the contents of the Trust Quarter 4 2020/21 Concerns Report.	**AE** **AE** **AE**
3.4.0	**Service User Feedback System** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Sciences The Committee received the Service User Feedback System report and slide deck that detailed the plans to implement the national Once for Wales Service	

	User Feedback System – Civica. The report detailed plans to implement the system across both Divisions this year, within implementation within Velindre Cancer Centre planned for early summer 2021. Discussions took place in respect of URL and logo options for the system so that any requests for completion of surveys are easily recognisable for both Welsh Blood Service Donors and Velindre Cancer Centre patients. It was agreed that further work was required in respect of these using forwarding URL hierarchies. The risk of the Trust being excluded from the cross fertilisation of patient views for those patients who also recieve care, treatments and services from Health Boards was discussed as the system, although a national system, is not currently mandated across all NHS organisations in Wales and, therefore possible missed opportunities. How the Community Health Council may be able to have access to system outputs will need to be deterined as part of the implementation plan. The Committee **NOTED** the contents of the slide deck detailing the system functionalities and the Trust's implementation plans.	
3.5.0	**Health & Care Standards** Led by Annie Evans, Deputy Director of Nursing, Quality & Patient Experience The Committee received a comprehensive report that included: • Details of the 2020/21 self-assessment outcome of a level 4. • The status of the 2020/21 Health Care Standard Improvement Plan detailing the improvement actions not completed due to the pandemic that are being transferred to the 2021/22 improvement plan. It was noted that the COVID-19 pandemic had an impact on delivery of some of the agreed improvement actions. • The Draft 2021/22 improvement plan. A summary of the deep dive submission provided to internal audit as part of their 2020/21 Health & Care Standards Audit review. • Divisional and overarching corporate assessments that had been completed and approved by the relevant Executive Leads. • It was noted that the overarching Trust compliance for each standard varied between a level 3 and level 5. The Committee: • **NOTED** the report and the draft 2021/22 improvement plan; • **APPROVED** the overall 2020/21 Health & Care Standards status as a level 4; and, • **APPROVED** the status of the 2020/21 improvement plan.	
3.6.0	**Nurse Staffing Level (Wales) Act 2016** Led by Annie Evans, Deputy Director of Nursing, Quality & Patient Experience	

	The Committee received the Nurse Staffing Level (Wales) Act 2016 2020 /21 annual report and the 2018/21 3 yearly report. AE highlighted the following: • The Trust is required to undertake a 6 monthly review of establishment levels. These were not undertaken earlier this year as the national acuity review in January 2021 was cancelled due to the pandemic. • Up until March 2021, the Trust was only required to report under section 25A of the Act but the Board agreed that from 1st April 2021 the ward will nationally to undertake an annual review of staffing levels. First floor ward will become part of the wider act under the definition of a wider medical ward. • No additional staffing resource is required at present to meet the Act requirements. • There had been no incidents on first floor ward in the last year attributable to insufficient staffing levels. • The three yearly report does not need to be provided to Welsh Government as the Trust is only reporting under section 25A of the Act at present. The Committee **NOTED** and **APPROVED** the Nurse Staffing (Wales) Act 2016 2020/21 Annual Report and 2018/21 3 yearly report.	
3.7.0	**For the Assessment of Individualised Risk (FAIR) Implementation Progress Report** Led by Dr Stuart Blackmore, Consultant, Welsh Blood Service The Committee received a comprehensive paper in relation to the requirements of a new Welsh Blood Service assessment process 'FAIR' following revised UK Government guidance regarding eligibility of men who have sex with men donating blood. SB highlighted the following: • Historically, donors have been assessed in terms of lifestyle risks relating to blood donation on a population basis, automatically precluded some people from donating regardless of their individual behaviours. • The revised guidance has been provided following a two year study that was undertaken assessing donors for lifestyle risks without impacting adversely on the safety of blood supply and the collection of sufficient blood to meet hospital demand. The Advisory Committee on the Safety of Blood, Tissues and Organs (SaBTO) and the four UK Governments have approved the changes. • Donors will no longer be questioned in terms of their gender or sexual orientation, instead questions will be targeted around sexual behaviours. This has been welcomed by the low risk Men who have sex with Men (MSM) population who wish to donate blood and blood products. • A potential risk was identified in relation to the new screening questions that could be deemed more intrusive to existing donors. In order to mitigate this, communications have been circulated, including leaflets and 'pop ups'	

	informing donors of changes to screening, supplemented by information published on the Trust's / Welsh Blood Service intranet and website. All staff involved in the collection process are required to have full training and understanding of the requirement for the change and potential impact on donors. WBS has developed a training package for donor facing staff due for roll out prior to the planned go live of the 14th June 2021. The following questions were raised: • ***When attending a donation session, are conversations being held out of earshot?*** SB advised initial screening of donors will be carried out via an iPad. Should any queries arise, the conversation with continue with a nurse and donor in a private booth out of earshot of other donors. • ***Will the announcement be ready to be made in alignment with World Blood Donor Day?*** SB confirmed that this is the plan with the aim for all four UK nations to go live simultaneously. The Committee extended their thanks to SB, congratulated him and the Welsh Blood Service Team for all their work in respect of this and **NOTED** the plans to implement the 'For the Assessment of Individualised Risk' (FAIR) Implementation within the Welsh Blood Service.	
3.8.0	**Highlight report from the Infection Prevention and Control Management Group** Led by Hayley Jeffreys, Interim Lead Infection Prevention and Control Nurse The Committee received the Highlight report from the Infection Prevention and Control Management Group, providing details of the key issues considered by the Group during the meeting held on the 18th March 2021. HJ highlighted the following: • ***For escalation*** - No Water Safety or Estates reports had been received at the meeting. However, the Committee was advised that following the meeting, discussions were held with the new Assistant Director for Estates in relation to requirements moving forward and a cycle of reporting agreed. • There was an increasing inability to socially distance in several departments at Velindre Cancer Centre due to the significant space constraints which is exacerbated by staff returning from shielding. Operational Services are undertaking a further review of the Velindre Cancer Centre site, aligning signage on office doors with desk numbers. The Senior Management Team is overseeing this and will ensure appropriate management action is taken. • The Velindre Cancer Centre theatre decontamination refurbishment schedule of work is agreed. It is planning that work will commence on the 1st June 2021. A cleaning cupboard will be created within the theatre suite as well as reconfiguration of the decontamination facilities.	

	• The Cancer Centre Senior Management Team are looking at options currently to provide additional staff changing facilities. • The low rate of hospital acquired infections continues with no reportable healthcare associated infections during February 2021. • The group approved the Trust 2021/22 Infection Control Audit Framework. • The new Head of Infection Prevention & Control has not yet commenced and NW advised of the excellent work being undertaken under the current leadership of HJ and commended her and the team for their sterling efforts. The Committee **NOTED** the Infection Prevention and Control Management Group Highlight report and the actions being taken by the Estates Team and Velindre Cancer Centre Senior Management Team to mitigate the highest areas of risk.	
4.0.0	**STRATEGY, POLICY AND PERFORMANCE**	
4.1.0	**Divisional Quality and Performance Reports (March 2021)**	
4.1.1	**Velindre Cancer Centre Divisional Quality and Performance Report** Led by Paul Wilkins, Director, Velindre Cancer Centre The Committee received the Velindre Cancer Centre Divisional Quality, Safety & Performance Report. The comprehensive report provided a summary of the key Quality, Safety & Performance outcomes and metrics for the Cancer Centre during the period 1st February – 31st March 2021. PW highlighted the following key areas: • The reactivation of treatment for some deferred patients has had a significant impact on demand for SACT services. • Continued pressure on Outpatient Services, particularly Phlebotomy due to current lack of provision at Health Boards / GP surgeries. • Physical capacity restrictions (reduced to 30-40%) due to COVID-19 social distancing requirements. • An agreement has been reached with Rutherford Cancer Centre, who will provide additional radiotherapy capacity. • Due to complex pathway issues, SACT and the Medicines Management Leadership Team will undertake a complete review of the pathways due to the pilot undertaken around the 36 hour rule for prescribing chemotherapy not achieving anticipated results. A full update will be provided in the next Cancer Centre report to the Committee. • Outpatient numbers have risen from 3,912 to 6,333 over the course of a year, with a considerable rise in virtual clinics. A potential piece of work around face to face video consultations will be undertaken going forward. Phlebotomy has also increased exponentially (from 950 to 2,290 over the course of a year). • Breaches in Radiotherapy waiting times have emerged; however the service has seen a 12% increase in activity in month.	**PW**

	• SACT waiting times have improved by 11% in month. • In terms of outreach services, active conversations with Health Boards are underway to re-introduce as many outreach services that were paused during COVID as possible. • The current non-compliance issue with manual handing training is due to its face-to-face nature. Training has now been sourced and frontline staff with expired manual handling passports are being prioritised. • Three retrospective severe incidents were reported retrospectively between 1/2/21 and 31/3/21, relating to patients who died with COVID-19 during wave 1. • 30 day mortality reviews – numbers remain low and no trends identified. • 175 projects in train focusing on Health and Care Standards. • Hand hygiene compliance is an average of 95% and training has been implemented and management action taken in lower compliance areas. • Digital Health Care Records –Teams responsible for delivery have been structured and project plans worked up in all areas, assisted by a move from variation to standardisation of ways of working. • Vaccination programme – over 13,000 vaccines administered. • Staff social space – social breakout area for staff has been secured, requiring capital for commencement of work. • SSTs have undertaken work on all areas and provided reports regarding achievements over the course of the year. Trends will now be identified via deep dive exercises. • Positive feedback has been received from patients across a number of services. • Despite working from home, good compliance has been achieved in terms of PADR. • Mitigation is being implemented for all risks and monitored. The following questions / comments were raised /made: • NW sought clarity across the board in terms of Radiotherapy analysis and measures undertaken by the Trust to prevent recurrences. It was agreed that this would be re-presented in a plain English format within the next Committee report. • Site Specific Team Annual appraisals/reports – NW requested that all site specific team annual reports contain details of benchmarking, patient experience feedback score and changes made as a result and patient outcome analysis. • Phlebotomy – Due to the significant number of patients currently attending the Cancer Centre for blood tests, it was queried whether patients would be repatriated to their relevant Health Board or if they would continue to be received by Velindre. PW confirmed that there are ongoing discussions with Health Boards due to the unsustainability of the current situation. • Radiotherapy targets for palliative care – It was suggested that breaches of two weeks is not acceptable and although this is a result of 3D treatment plans devised with the patient at the time, further investigation is required.	**PW** **PW** **PW**

	DM requested this this item is addressed at a future meeting when appropriate. • Phlebotomy – COB advised that discussions with Health Board around how the Trust can facilitate easy access to phlebotomy have been progressive and could include drop in services already in place on some hospital sites, with the aim to improve on already existing services. • SH indicated that established Partnership Board meetings with Health Board will enable escalation of the phlebotomy issue. The Committee **NOTED** the content of the Velindre Cancer Centre Divisional Report and the work being undertaken to mitigate against the current capacity and service delivery risks.	**PW**
4.1.2	**Divisional Performance Reports**	
4.1.2.1	**March Performance Report Overview** Led by Cath O'Brien, Chief Operating Officer The Committee received the March Performance Report Overview, providing an update with respect to performance against key performance metrics through to the end of March for the Welsh Blood Service. The following was highlighted by COB: • Ongoing challenge in recruitment of new donors, both in terms of stem cell volunteers and whole blood donors. Visits to colleges and universities have been postponed due to COVID. Active recruitment will be enabled upon reopening of these. • Quality incidents – Closure has been challenging. Work has been undertaken to stratify the tiers of incidents to ensure focus on more important issues as opposed to those resulting in lesser impact. The Committee was asked to note that this change is being made in the system and will feed through in the data over the coming months. The Committee **NOTED** the content of the report.	
4.1.2.2	**Workforce and Organisational Development Performance Report** Led by Sarah Morley, Executive Director of Workforce and Organisational Development The Committee received the Workforce and Organisational Development Performance Report, which provided an overview of key performance indicators for sickness, PADR and mandatory and statutory training across both Divisions and corporate services. SfM highlighted the following: • Sickness levels have improved, with four staff members remaining on COVID-19 related absence. Workforce team members are liaising closely with line managers and individuals in respect of each. All areas of absence continue to be monitored.	

	• PADR rates have improved and emphasis is now on working with teams to ensure necessary conversations are undertaken. • Statutory and Mandatory Training – The figures reported indicate the level 1 core statutory training framework compliance levels. Level 2 training, which often requires face to face contact is where there is particular emphasis and focus with the educational development team working in partnership with training delivery experts. The Committee **NOTED** the Workforce and Organisational Development Performance Report.	
4.1.3	**Financial Report** Led by Mark Osland, Executive Director of Finance The Committee received the Financial Report, outlining the current financial position and performance for the period ending the 31st March 2021. MO highlighted the following: • Confirmation that the Trust has met its core financial targets. • Revenue – A challenging year resulted in significant variances. These were managed effectively and brought the Trust into line with the small underspend reported. • Savings targets have been affected by COVID-19. The £700,000 underachievement against the 2020/21 savings target will be carried forward into 2021/22 as an underlying deficit, which will form part of the Trust's funding request for 2021/22. • COVID-19 expenditure – The Trust reported spend of just under £6.3 million. • Capital – The Trust reported a total underspend of £5,000 for the Capital Programme. • The 2021/22 financial position is not yet fully complete and the final outcome of the audit will be reported on 8th June 2021 at Trust Board. The Committee **NOTED** the content of the Financial Report.	
4.1.4	**Digital Service Operational Report - Review of Strategic Informatics Programme** Led by Stuart Morris, Associate Director of Informatics The Committee received a comprehensive Digital Service Operational Report, detailing key projects / programmes of work currently underway for Digital Services. SM highlighted the following: • The Welsh Nursing Care Record (WNCR) has been successfully implemented within the Cancer Centre Assessment Unit and First Floor Ward. SM extended his thanks to the Nursing Team and Digital Team for facilitating the transition from paper nursing documentation to a digital platform.	

	• NW requested integration of digital opportunities for automated audit out of the WNCR system into our dashboard reporting as soon as possible. SM indicated that this would be achievable following alignment of work plans. • CJ reinforced that automation will enable colleagues to progress higher value work wherever possible. A discussion will take place at Board to move forward in this direction. The Committee **NOTED** the content of the Digital Service Operational Report.	**SM** **CJ**
4.2.0	**Progress Report against Quarter 4 Delivery Plan** Led by Peter Gorin, Head of Corporate Planning, Planning & Performance The Committee received the Quarter 4 Delivery Plan Progress Report that detailed the progress against the Trust's operational planning intentions by quarter for the last financial year. PG highlighted the following: • The report covered quarterly actions in totality for the last year and is to close the governance loop on the actions which form part of last year's quarterly action plans. • 185 of the 235 actions had been completed with 50 remaining outstanding. Some (16) had been identified as being no longer relevant, superseded by events, or paused due to COVID. The remaining 34 relate to ongoing work and have been modified or built upon. These actions will be brought forward for inclusion in discussions in the IMTP before presenting to Trust Board on the 8th June 2021. The Committee **NOTED** the Progress Report against the Quarter 4 Delivery Plan.	
4.3.0	**Velindre Trust Revalidation Updates 2019/20** Led by Dr Jacinta Abraham, Medical Director *Item moved to consent items to note.* The Committee ***agreed*** to move this item to consent for noting and **NOTED** the report.	
4.4.0	**Transforming Cancer Services Programme Scrutiny Sub Committee Highlight Report** Led by Stephen Harries, Vice Chair and Chair of the Transforming Cancer Services Scrutiny Committee The Committee received the Transforming Cancer Services Programme Scrutiny Sub Committee Highlight Report, detailing key issues considered by the Sub Committee at its public meeting held on the 19th April 2021. For noting only. The Committee **NOTED** the contents of the Transforming Cancer Services Programme Scrutiny Sub Committee Highlight Report.	

4.5.0	**At Your Service: A Good Practice Guide** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Sciences The Committee received the Good Practice Guide, providing the GAP analysis undertaken against the Public Services Ombudsman Thematic Report. NW confirmed the themes of the report in relation to the Trust's current position, along with proposed actions to be taken forward as an organisation, to include proposed recommendations and implementation plans. The Committee **NOTED** the report Good Practice Guide and **AGREED** the recommendations arising from the Trusts gap analysis.	
5.0.0	**INTEGRATED GOVERNANCE** (The integrated governance part of the agenda will capture and discuss the Trust's approach to mapping assurance against key strategic and operational risks)	
5.1.0	**Analysis of meeting outputs** Led by Jan Pickles, Independent Member, Quality, Safety and Performance Committee Chair It was identified that the impact of COVID remained a theme but now in relation to capacity versus demand and recovery plans.	
6.0.0	**HIGHLIGHT REPORT TO TRUST BOARD**	
	Members identified items to include in the Highlight Report to the Trust Board: Given time constraints it was agreed that the Chair and Executive Director of Nursing would agree items for inclusion in the Board highlight report. It was agreed that there were no items for alerting or escalating and that details of the patient story should be provided. Attendees were asked to notify NW of any items they wished to be included in other sections of the report.	**All**
7.0.0	**ANY OTHER BUSINESS**	
	KF advised that Audit Wales will be undertaking a review of Quality Governance Arrangements within Velindre University NHS Trust commencing in July 2021 involving assessment of assurance around Quality & Safety, governance, oversight of clinical audit and the tracking of regulation and inspection finding and recommendations. This review is being undertaken across all Trusts and Health Board in Wales and will be based on the methodology used during the Cwm Taf Morgannwg review. The full brief will be provided to the Committee at the next meeting.	**KF**
8.0.0	**DATE AND TIME OF THE NEXT MEETING**	

	The Quality, Safety & Performance Committee will next meet on **Thursday the 15th July 2021 10:00 – 12:30 via 'Microsoft Teams'.**	
CLOSE		
The Committee is asked to adopt the following resolution: That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960 (c.67).		

DIGITAL HEALTH AND CARE WALES
WALES INFORMATICS ASSURANCE REPORT

Agenda Item	2.4

Name of Meeting	Digital Governance and Safety Committee
Date of Meeting	11 August 2021

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

Executive Sponsor	Rhidian Hurle, Medical Director
Prepared By	Paul Evans, Quality Manager (Regulatory Compliance)
Presented By	Paul Evans, Quality Manager (Regulatory Compliance)

Purpose of the Report	For Assurance
Recommendation	
The Digital Governance and Safety Committee is being asked to: **NOTE** the contents of the report for **ASSURANCE.**	

Acronyms			
WIAG	Wales Informatics Assurance Group	WIS	Welsh Immunisation System
WAST	Welsh Ambulance Service NHS Trust	CaNISC	Cancer Network Information System Cymru
WCCIS	Welsh Community Care Information System	ABUHB	Aneurin Bevan University Health Board
WCP	Welsh Clinical Portal	WPAS	Welsh Patient Administration System
WNCR	Welsh Nursing Care record	WRRS	Welsh Results Reporting Service
MPI	Master Patient Index	WCRS	Welsh Care Records Service
ePCR	Electronic Patient Care Record	AQP	Assurance Quality Plan
SCRR	Safety Case Readiness Report		

1 SITUATION/BACKGROUND

1.1 Wales Informatics Assurance Process

The Wales Informatics Assurance Process will provide the Digital Governance & Safety Committee ***assurance*** that where appropriate, services developed or procured by Digital Health and Care Wales have been proportionally assured. That where interfaces to the national architecture have been developed, they have been appropriately assured and that cloud hosted services have been risk assessed.

The Wales Informatics Assurance Process has been in place since 2015 and is reviewed bi-annually (SOP-WIA-001) by Quality Manager (Regulatory Compliance), the next scheduled review is to be completed by 23/09/2021. The process involves a two-stage check point: Assurance Quality Plan and Safety Case & Readiness Report, Wales Informatics Assurance Group (WIAG) may assure minor changes via a Request for Change submission (for definitions of document types see Appendix A). There are 15 work streams associated with the process. Details of the workstreams are included in Appendix B.

2 SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 Overview of Activity

The following is a breakdown of activity reviewed by WIAG in the period April 2021 to June 2021

Go-Live Compliance – Breakdown of compliance of the go-lives within the reporting period

Status	Rating
In Progress/Completed	
Project/Programme Delay/No Confirmed Go-Live date	
Overdue/Not Completed prior to Go-Live	

Activity	AQP	SC&RR	WIAG review sign off	Director sign off
WNCR v2.1			Project Manager working with Security on one requirement. Go-Live currently planned for September	
Welsh Hospital Pharmacy Service full roll out			14/05/2021	14/05/2021
Welsh Results Reports Service (WRRS): Cwm Taf Morgannwg UHB's MediLogik Endoscopy results			14/05/2021	14/05/2021
Cegedim Health Services (CHS) Change to Data Centre Hosting			30/06/2021	09/07/2021
WCCIS release 2016.2			Roll out delayed (no dates available at this time). Project Manager working with Architecture Design and Information Governance Assurance Leads on outstanding issues	
Eye Care digitisation – Interfacing Ph1			Project Manager following up on a number of outstanding issues prior to submission to Directors for approval	

Assurance Quality Plans within the reporting period

Activity/Project	Date received by WIAG	Ref Number	Outcome of WIAG
Colposcopy Screening	12/04/2021	AQP-WIA-0012	Approved
Welsh Immunisation System (WIS)	12/04/2021	AQP-WIA-0013	Approved
111 Service Integration	26/04/2021	AQP-WIA-0014	Approved
WAST TerraPACE ePCR Service Interfacing	26/04/2021	AQP-WIA-0015	Approved
CaNISC Palliative Care replacement	26/04/2021	AQP-WIA-0016	Approved
CaNISC replacement Radiotherapy Requests	07/06/2021	AQP-WIA-0017	Approved
Eye Care Digitisation Programme – Cloud Hosting	07/06/2021	AQP-WIA-0018	Approved
Eye Care Digitisation Programme – User Access	07/06/2021	AQP-WIA-0019	Approved
(WCCIS) application (CareDirector) version 5.2016.1	07/06/2021	AQP-WIA-0020	Approved

- Colposcopy Screening AQP covers –
  - Replacing existing Colposcopy functionality provided by CaNISC and create Colposcopy Clinic e-form (Minimum Viable Product - MVP) for use to enter Clinic patient information as part of the patient record, also –
  - Retrieve clinical data and Colposcopy images from the current system Mediscan and make these available within the Clinic form, at time of patient in clinic.
- WIS
  - The Welsh Immunisation System (WIS) was developed to create, schedule and record COVID-19 vaccination appointments. The system was developed by NWIS in-house in partnership with colleagues across NHS Wales and Welsh Government and it is supporting the roll out of the national vaccination programme across Health Boards, GP Practices and Pharmacies in Wales.
- 111 Service Integration
  - This project is managed jointly between Aneurin Bevan University Health Board (ABUHB) and Welsh Ambulance Service Trust (WAST). DHCW has a responsibility to provide secure 3rd party hosting arrangements, system integration and long-term operational support arrangements for the agreed hosting arrangements and integrated systems/services
- WAST TerraPACE ePCR Service Interfacing
  - DHCW has a responsibility for providing TerraPACE ePCR Software interfacing with an agreed set of systems/services held within the NHS Wales National Architecture. DHCW will provide access to resources to undertake the integration activities, test system integration, provide long term operation support for the integrated systems and services and provide means for facilitating changes [requests for change] post implementation.
- CaNISC Palliative Care replacement
  - This workstream is to replace CaNISC functionality for Palliative Care Groups in WCP and the various instances of Welsh Patient Administration System (WPAS) related to their specific Health Boards. This will ensure business continuity in terms of delivering

care and managing the cancer patient's pathway during their palliative care treatment. The digital form and supporting functionality that will be developed will contain the exact functionality that is currently available in CaNISC. The intention of the accelerated program is not to limit the functionality that clinicians already have and has been termed the Minimal Viable Product (MVP) for the initial deployment.

- CaNISC replacement Radiotherapy Requests
  - Development and implementation of a new radiotherapy requesting and planning solution for Velindre Cancer Centre (VCC) which replaces paper of the current Cancer Network Information System Cymru (CANISC).
- Eye Care Digitisation Programme – Cloud Hosting
  - The DHCW objective is to support Cardiff and Vale University Health Board [C&V] with their implementation of the OpenEyes Electronic Patient Record [EPR]. DHCW have a specific responsibility to arrange connectivity, hosting and interfacing and facilitate but not manage the C&V Implementation.
  - This particular paper will focus on connectivity.
- Eye Care Digitisation Programme – User Access
  - The DHCW objective is to support Cardiff and Vale University Health Board [C&V] with their implementation of the OpenEyes Electronic Patient Record [EPR]. DHCW have a specific responsibility to arrange connectivity, hosting and interfacing and facilitate but not manage the C&V Implementation.
  - This particular paper will focus on connectivity for end users.
- (WCCIS) application (CareDirector) version 5.2016.1
  - The aim of the project is to Implementation of the Welsh Community Care Informaiton System (WCCIS) application (CareDirector) version 5.2016.1 on the Microsoft Dynamics CRM 2016.

Requests for Change within the reporting period

No Requests for Change were submitted in this period.

Safety Case and Readiness Reports within the reporting period

Activity/Project	Date received by WIAG	Ref Number	Current Status	Outstanding Actions
WNCR v2.1	12/04/2021	SCRR-WIA-0012	On Hold	Project Team placed release on hold pending further assurance work
Welsh Hospital Pharmacy Service Full roll out	26/04/2021	SCRR-WIA-0013	Approved 17/05/2021	None
Welsh Results Reports Service (WRRS): Cwm Taf	10/05/2021	SCRR-WIA-0014	Approved 17/05/2021	None

Morgannwg UHB's MediLogik Endoscopy results				
Cegedim Health Services (CHS) Change to Data Centre Hosting	10/05/2021	SCRR-WIA-0015	Approved 09/07/2021	None
WCCIS release 2016.2	07/06/2021	SCRR-WIA-0016	Under review	Project Leads working on remaining issues prior to paper being submitted to Directors for review/approval
Eye Care digitisation – Interfacing Ph1	07/06/2021	SCRR-WIA-0017	Under review	Project Leads working on remaining issues prior to paper being submitted to Directors for review/approval

- WNCR v2.1
  - The aim of the project is to implement v2.1 of WNCR
- Welsh Hospital Pharmacy Service
  - The Objective of the Project is to implement a replacement pharmacy system for secondary care across Wales. Hospital Pharmacies will now be working from a national core system and will have a national drug file which will be managed by the Hospital Pharmacy central team at DHCW
- Welsh Results Reports Service (WRRS): Cwm Taf Morgannwg UHB's MediLogik Endoscopy results
  - The objective of the project is to make PDF diagnostic results reports from the MediLogik EMS Endoscopy system in Cwm Taf Morgannwg University Health Board, available to WCP users via Welsh Results Reporting Service (WRRS).
- Cegedim Health Services Change to Data Centre Hosting
  - To support Cegedim Health Services in transitioning the infrastructure and services they provide to Primary Care to alternative data hosting arrangements.
- WCCIS release 2016.2
  - The objective of this phase and submission to WIAG is to seek approval for a technical build and test from WCCIS to the two remaining Master Patient Index system (MPI) interfaces, in readiness for a go-live activation in September 2021
    - PIX: Patient Indexing Cross Referencing
    - PIM: Patient Identity Management ("MPI inbound" demographics messaging from WCCIS -> to MPI).
- Eye Care digitisation – Interfacing Ph1
  - The DHCW objective is to support Cardiff and Vale University Health Board [C&V] with their implementation of the OpenEyes Electronic Patient Record [EPR]. DHCW have a specific responsibility to arrange connectivity, hosting and interfacing and facilitate but not manage the C&V Implementation.
  - This particular paper will cover interfacing to Welsh Care Records Service (WCRS) and Master Patient Index (MPI).

3 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 Services which have not gone through which will need retrospective assurance are:

- TTP (MVP and releases)
- Lateral Flow
- Wales Immunisation Service
- COVID results in WLIMS
- English COVID results

The above services were requirements in the NHS Wales response to Covid-19, the urgent nature of the work and reallocation of staff to deliver these services meant using the organisational command structure to deliver these services at pace. The relevant assurance leads from each of the 15 workstreams were involved in the work to provide oversight and risks were highlighted and escalated via the usual Project and Programme process and the corporate risk management policy. The attention of the committee is brought to the list in section 3.1, noting areas of work that did not follow the usual process. In order to ensure full retrospective assurance takes place, the Project and Programme leads are preparing the AQP's for WIAG which we will expect to see in the coming months.

4 RECOMMENDATION

The Digital Safety and Governance Committee is being asked to:

NOTE the contents of the report

5 IMPACT ASSESSMENT

STRATEGIC OBJECTIVE (Please place an 'X' next to relevant objective/s)	
Mobilising digital transformation and ensuring high quality health and care data	
Expanding the content, availability and functionality of the Digital Health and Care Record	X
Delivering High Quality Digital Services	X
Driving value from data for better outcomes	X

CORPORATE RISK (ref if appropriate)	N/A

WELL-BEING OF FUTURE GENERATIONS ACT (Select relevant theme/s)							
A Prosperous Wales		A Resilient Wales		A More Equal Wales	X	A Healthier Wales	
A Wales of Cohesive Communities		A Wales of Vibrant Culture and Thriving Welsh Language		A Globally Responsible Wales			

QUALITY STANDARDS (Select relevant standard/s)							
ISO 20000		ISO 27001		ISO 9001	X	ISO 14001	
BS 76000:2015		BS 76005		BS 10008		ISO 13485	X
SDI (Service Desk Institute) Standard							

HEALTH CARE STANDARD (Select relevant standard/s)							
Staying Healthy		Safe Care	X	Effective Care		Dignified Care	
Timely Care		Individual Care		Staff & Resources			

EQIA STATEMENT (Select as appropriate)		
Not Applicable	Date of submission: N/A	Outcome: N/A
Statement: N/A		

APPROVAL/SCRUTINY ROUTE: Person/Committee/Group who have received or considered this paper prior to this meeting		
COMMITTEE OR GROUP	DATE	OUTCOME
None		

IMPACT ASSESSMENT	
QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes The WIAG process supports Quality & Safety by providing relevant assurance for new and changed developments. Serious incidents are considered to have an impact on quality, equality, safety, and patient experience and will vary for each reported incident.
LEGAL IMPLICATIONS/IMPACT	Yes Serious incidents may have legal implications and if so will be identified on the Trust Risk Register. Serious incidents are investigated under the requirements of Putting Things Right.
FINANCIAL IMPLICATION/IMPACT	Yes Serious incidents may have financial implications since they may lead to payments of financial redress or subject to litigation.
WORKFORCE IMPLICATION/IMPACT	No N/A
SOCIO ECONOMIC IMPLICATION/IMPACT	No N/A

Appendix A

Assurance Quality Plan (AQP)

If the initial review identifies the service development needs to undertake the assurance process, or it is clear that assurance will be required an Assurance Quality Plan will be completed by the project manager/ release manager and assurance leads. The plan will follow the template provided. The following process will apply: -

- Proposer to complete Intended use statement within the plan (as agreed by the WIAG review)
  detailing the: -
  - Proposed scope
  - Previous assurance etc.
- Draft plan to be submitted to Quality Manager (Regulatory Compliance) for review (as per published time scales),
- Proposer to present draft plan to WIAG, members will review the document on SharePoint prior to the meeting and provide advice where possible in advance, or complete the check list at WIAG meetings,
- Once complete the Wales Informatics Assurance Facilitator will circulate to WIAG via an e-vote for approval of the Assurance Quality Plan (unless WIAG advise the plan should be escalated to Directors for approval)

Safety Case & Readiness Report (SCRR)

The Safety Case and Readiness report is the primary vehicle for presenting a statement concerning the safety of the informatics service at a defined point in the service's life cycle e.g. prior to use in the live environment for the approved scope. It includes the outcomes of the assurance work streams; identifies residual risks, mitigations that have been deployed to address significant and high risks, related operational constraints, and limitations, and includes recommendations regarding informatics service deployment. This report is developed by the project manager / release manager.

A Safety Case and Readiness Report could be presented to the directors at three stages; either prior to the release to an early adopter site, prior to a change of scope where Directors have previously only approved a limited scope, or after the first site implementation and prior to roll out to the NHS in Wales. It must firstly be submitted to the WIAG for review and the addition of the independent assurance leads statements prior to submission to the Directors for approval. The report will follow the

template document provided.

Request for Change (RFC)

Minor changes to a Service/Application may be assured using a request for Change submission. All Assurance Leads retain oversight of the change and can highlight workstreams required to assure the proposed change. WIAG makes a decision as a group as to whether or not a RFC is sufficient to assure a proposed change.

Appendix B

Assurance Areas within the Wales Informatics Assurance Process

ARCHITECTURE DESIGN & Delivery Assurance

FINANCIAL AND BUSINESS ASSURANCE

CLINICAL/ USER REQUIREMENTS

EVALUATION

IMPLEMENTATION PLAN

INFORMATION GOVERNANCE

INFORMATION SERVICE

INFRASTRUCTURE REQUIREMENTS

PATIENT SAFETY

PRIMARY CARE SERVICE SUPPORT

SECURITY

SERVICE MANAGEMENT & SUPPORT

SERVICE DESK

TESTING

VALIDATION & VERIFICATION

DIGITAL HEALTH AND CARE WALES
INFORMATION GOVERNANCE UPDATE REPORT

Agenda Item	2.5

Name of Meeting	Digital Governance and Safety Committee
Date of Meeting	11 August 2021

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

Executive Sponsor	Rhidian Hurle, Medical Director and Caldicott Guardian
Prepared By	Marcus Sandberg, DHCW Information Governance
Presented By	Darren Lloyd, Head of Information Governance and Data Protection Officer

Purpose of the Report	For Assurance
Recommendation	
The Digital Governance and Safety Committee is being asked to: NOTE the contents of this report for ASSURANCE.	

TŶ GLAN-YR-AFON 21 Heol Ddwyreiniol Y Bont-Faen, Caerdydd CF11 9AD

TŶ GLAN-YR-AFON 21 Cowbridge Road East, Cardiff CF11 9AD

Acronyms			
DHCW	Digital Health and Care Wales	IG	Information Governance
IMTP	Integrated Medium-Term Plan	WG	Welsh Government
ICO	Information Commissioner's Office	GDPR	General Data Protection Regulation
GMP	General Medical Practitioners	DPIA	Data Protection Impact Assessment
WIAP	Wales Informatics Assurance Process	FOIA	Freedom of Information Act

1 SITUATION/BACKGROUND

1.1 This report is presented to Committee to provide **assurance** of the way in which Digital Health and Care Wales (DHCW) manages its information about patients and staff and highlights compliance with Information Governance (IG) legislation and standards.

1.2 This report complements the DHCW IG three-year IG strategy, which sets out how the Information Governance Team will support the delivery of DHCW's statutory functions and contribute to its Integrated Medium-Term Plan (IMTP) and associated business plans.

1.3 The core responsibilities of the Information Governance Team are:

- To shape and maintain an effective national governance structure for data protection/Information Governance related issues;
- To provide, maintain and develop external facing services, tools and standards aimed at underpinning DHCW's IMTP and supporting NHS Wales organisations and stakeholders; and
- Supporting DHCW to meet its own corporate responsibilities in relation to 'information rights' legislation, common law and associated standards and guidance.

1.4 This report outlines key assurance activities to the Committee for the reporting period of **1st May 2021 to 21st July 2021**. The following activities are highlighted to Committee in this report:

- IG Incidents and Complaints;
- Audit & Information Assurance Actions;
- Number of calls into DHCW Information Governance Actionpoint System;
- Data Protection Impact Assessments; and
- Information Governance Requests for Information.

2 SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 IG Incidents and Complaints

2.1.1 All IG incidents are reported using the DHCW Datix system. All IG incidents are risk assessed using the DHCW Standard Operating Procedure - *SOP-IG-004 Personal Data Breach Reporting and Management v7.0* and reported to Welsh Government (WG) and the Information Commissioner's Office (ICO) when required. The below table provides an outline of any IG incidents within the reporting period.

Category	Sub Category	Number of incidents	Self-Reported to ICO / WG	Complaints made to the ICO
Data Protection & Confidentiality	Breach of Data Protection Principle	0	0	0
	Code of Practice Breach	0	0	0
	Inappropriate disclosure of confidential information	1	0	0
Freedom of Information	Request over 20-day limit to respond	0	0	0
	Request not processed	0	0	0
	Information requestor compliant	0	0	0
Records Management	Inaccurate Information	0	0	0
	Information lost or deleted	0	0	0
Total		1	0	0

2.2 Audit & Information Assurance Actions (including any relevant internal or external audits to include ongoing IG assurance requirements)

2.2.1 Actions from General Data Protection Regulation (GDPR) Internal Audit by NHS Wales Shared Services Partnership:

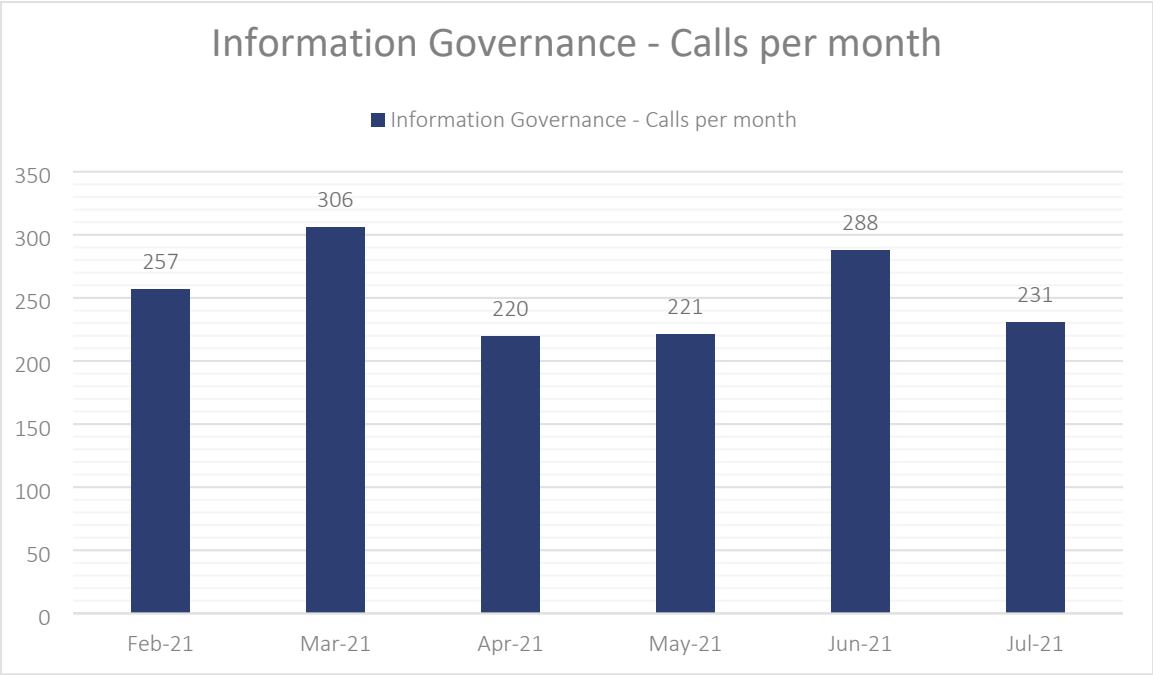
Reference	Description	Rating	Action	Action Owner	Owner	Target	Progress	Comments
GDPR1	The organisation should prioritise work to map what information is held by NWIS. This information should be collated centrally to form a complete information asset register.	High	We will be considering this in parallel with our work in implementing British Standard BS10008 to ensure that its requirement for Data Standards is aligned with the need for Information Asset Owners.	Rhidian Hurle/Darren Lloyd	Helen Thomas	Mar-21	Green - Action complete	Complete - Sharepoint site now contains a register of Corporate Information Systems.

GDPR2	Information asset owners and administrators should be identified for each department. Once identified they are to act as champions for information governance and facilitate the population of local information asset registers with the intention of feeding into the central organisational asset register.	High	The transition of NWIS into a Special Health Authority will secure formal structures and reporting formality in respect of GDPR compliance. Work is ongoing as part of the SHA transition to recognised the additional groups and committees required to ensure appropriate governance and assurance.	Rhidian Hurle/Darren Lloyd	Helen Thomas	Apr-21	Green - Action complete	The information asset owner/stewardship role implementation is underway and there are plans in place for these to be supported by activities including awareness raising, training, amendments to job descriptions and setting up of a support network.
GDPR3	Review of the ICO Data Protection Register notes that there is one registration for Velindre NHS Trust, naming NIWS Head of IG at the DPO. This needs review in light of NWIS transitioning to a Special Health Authority.	Low	This has been highlighted as part of the Transition work and a position has been agreed with the Trust.	Rhidian Hurle/Darren Lloyd	Helen Thomas	Apr-21	Green - Action complete	We reviewed the ICO registrations available on their website and confirm the organisation has registered with the ICO.

2.3 Number of calls into DHCW Information Governance Actionpoint System

2.3.1 The below chart shows the number of calls (e-mails) received via the Information Governance ActionPoint system. The ActionPoint system is used to record, log, triage and reply to calls from General Medical Practitioners (GMPs), NHS Wales Health Boards and Trusts and members of the public for work areas including the Data Protection Officer Service for GMPs, IG primary care support, Wales Accord on the Sharing of Personal Information, internal IG queries from staff, Freedom of Information Act and other requests for information.

2.3.2 All calls are handled in accordance with the DHCW Standard Operating Procedure – SOP-IG-002 Logging IG Work Activities in ActionPoint. A graph has been provided below to show the number of calls received in the last 6 months.



2.4 Data Protection Impact Assessments (DPIA) worked on during the reporting period

2.4.1 A Data Protection Impact Assessment (DPIA) is a process to help identify and minimise the data protection risks of a project, system or programme. DPIAs are a legal requirement for processing that is likely to result in a high risk to individuals and good practice when processing personal data. The DPIA process is embedded within DHCW via the Wales Informatics Assurance Process (WIAP) and are signed off by the Head of Information Governance

2.4.2 DPIAs are managed in accordance with the DHCW Standard Operating Procedure – SOP-IG-006 Data Protection Impact Assessment Process. A summary of DPIAs commenced within the reporting period and those signed off are provided below. The tables below note whether the DPIA is on a project, programme or system for NHS Wales (external) or for DHCW purposes (internal).

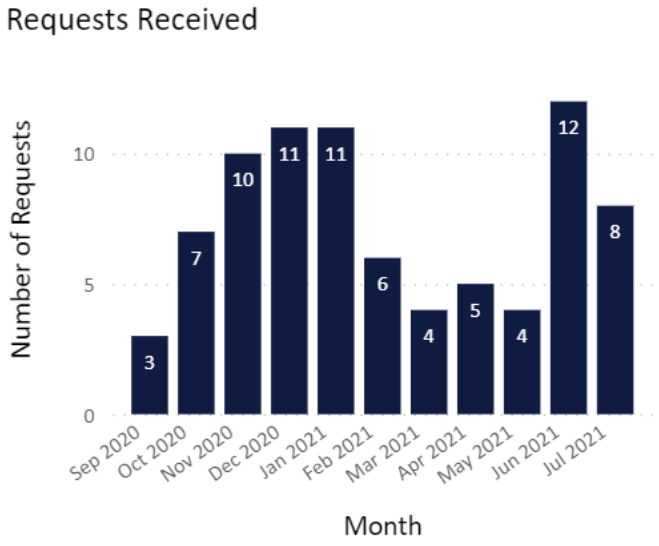
DPIAs started within reporting period				
Project	Internal/External	Date Started	Progress	Last update
105 Welsh Ambulance Service Trust Electronic Patient Clinical Record	External	07/05/2021	with the project	13/05/2021
106 Linking of Choose Pharmacy Data to SAIL	External	24/05/2021	with the project	10/06/2021
107 Covid PASS	External	17/05/2021	With IG Team	24/05/2021

108 Welsh Care Records Service PDF upload e-form	External	03/06/2021	with the project	15/06/2021
109 Cancer e-form	External	09/07/2021	Not started	15/07/2021
110 VBHC Inflammatory Bowel Disease Dashboard	External	19/07/2021	With IG Team	19/07/2021

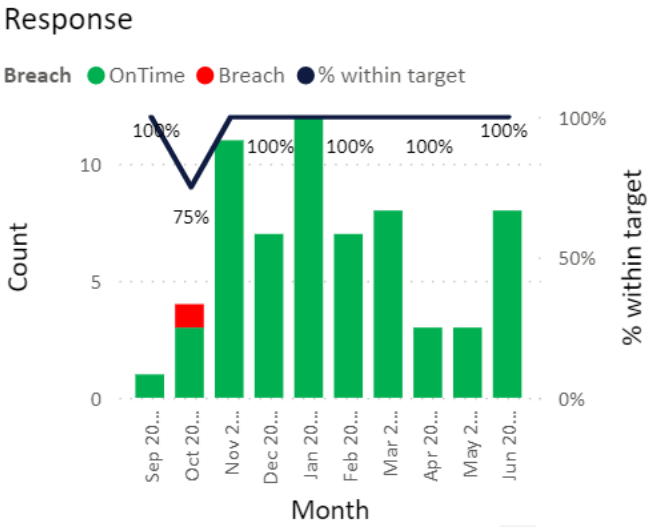
DPIAs signed off in reporting period				
Project	Internal/External	Date Started	Progress	Last update
083 Welsh Clinical Data Repository - openEHR Treatment Repository	External	15/12/2020	signed off	13/05/2021
088 Data Centre Transition: DMZ to Azure	Internal	08/02/2021	signed off	04/05/2021
095 Cegedim to London move	Internal	19/03/2021	signed off	10/05/2021
102 Radiotherapy Treatment Summary into Welsh Care Records Service	External	24/04/2021	signed off	19/07/2021
103 SACT Treatment Summary into Welsh Care Records Service	External	24/04/2021	signed off	19/07/2021

2.5 Information Governance Requests for Information

2.5.1 Members of the public are entitled to request information from public authorities. This includes information about themselves (Subject Access Requests) or information held by public authorities (Freedom of Information Act and Environmental Information Regulations requests). DHCW are required to respond to any requests in line with the requirements of the legislation.



2.5.2 24 Freedom of Information Act (FOIA) requests were received by DHCW between 1st May to 23rd June 2021.



2.5.3 All FOIA requests within this time period were answered in within the statutory timescales.

2.5.4 One FOIA response in October 2020 was answered outside of the statutory timescales and has been previously discussed at NWIS Executive Board. The breach was a result of Covid-19 workloads and breached by 5 working days.

Outstanding Requests

10

Open

2.5.5 There are currently 10 FOIA requests outstanding, all of which are within the statutory timescale to respond.

FOIA Requests within the reporting period by rating*			
	Major	Amber	Minor
May 2021	0	0	4
June 2021	0	5	7
July 2021	0	1	7

2.5.6 * A ratings legend has been created by the Information Governance team to explain each rating category.

Rating	Explanation
Minor	Little or no reputational, political, commercial or media sensitivity.
Amber	Some reputational, political, commercial or media sensitivity
Major	Major reputational, political, commercial or media sensitivity.

2.5.7 DHCW also received 1 Subject Access Request within this period, which was also responded within the statutory timescales and 1 request from the Police for CCTV footage to aid investigations, which is to be released.

3 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 No issues of escalation to Committee.

4 RECOMMENDATION

The Digital Governance and Safety Committee is being asked to:

NOTE the contents of this report from the DHCW Information Governance team.

5 IMPACT ASSESSMENT

STRATEGIC OBJECTIVE	All Objectives apply

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:	

HEALTH CARE STANDARD	N/A
If more than one standard applies, please list below:	

EQUALITY IMPACT ASSESSMENT STATEMENT	Date of submission: N/A
No, (detail included below as to reasoning)	Outcome: N/A
Statement: No equality impact on the information provided above	

APPROVAL/SCRUTINY ROUTE:
Person/Committee/Group who have received or considered this paper prior to this meeting

COMMITTEE OR GROUP	DATE	OUTCOME

IMPACT ASSESSMENT	
QUALITY AND SAFETY IMPLICATIONS/IMPACT	No, there are no specific quality and safety implications related to the activity outlined in this report.
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

DIGITAL HEALTH AND CARE WALES
INFORMATION SERVICES REPORT

Agenda Item	2.6

Name of Meeting	Digital Governance and Safety Committee
Date of Meeting	11TH August 2021

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

Executive Sponsor	Rachael Powell Deputy Director of Information Services
Prepared By	Trevor Hughes Information Programmes and Planning Lead
Presented By	Rachael Powell Deputy Director of Information Services

Purpose of the Report	For Assurance
Recommendation	
The Digital Governance and Safety Committee is being asked to: NOTE the current position in relation to the ongoing work to enhance the assurance around the management and reporting of data. Receive the report for ASSURANCE.	

Acronyms			
ISD	Information Services Directorate	WIS	Welsh Immunisation System
ONS	Office for National Statistics	SAIL	Secure Anonymised Information Linkage
DEA	Digital Economy Act	ISDAG	Information Services Directorate Assurance Group
WIAG	Welsh Information Assurance Group		

1 SITUATION/BACKGROUND

1.1 This report outlines the current position regarding some of the key priorities being progressed in relation to internal assurance processes for the acquisition, management, reporting and sharing of data.

2 SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 The Information Services Directorate (ISD) have formalised the Welsh Immunisation System (WIS) Data Group to meet weekly in order to provide assurance around the work being undertaken in relation to COVID-19 vaccinations.

2.2 The ISD Assurance Group (ISDAG) has reviewed and provided feedback on all new developments in respect of the impact on Information Services prior to consideration at the Welsh Information Assurance Group (WIAG).

2.3 The Terms of Reference for ISDAG are under review, with the intention to expand the remit to cover assurance of all internal ISD developments.

2.4 Once the process for the assurance of new developments is in place, there will be a period of retrospective assurance for key products that are already established.

2.5 DHCW are currently undergoing an assessment in order to gain accreditation by the UK Statistics Authority under the requirements of the Digital Economy Act (DEA). This is in respect of a specific area of work that will assure potential suppliers of data to the Secure Anonymised

Information Linkage (SAIL) database (established within Swansea University), such as the Office for National Statistics (ONS), that DHCW are able to act as a Trusted Third Party.

3 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 A risk (DHCW0260) remains on the Corporate risk register in relation to the manual intervention that is required in producing and maintaining the Shielded Patient List. This risk will continue to be monitored at the corporate level until the ongoing work with a third-party supplier to automate and quality assure the process is complete, with a timeframe of mid to late August to facilitate parallel running and complete pre-production work.

3.2 A second risk (DHCW0269) has been escalated to the Corporate risk register covering the need to replace the current NHS Wales Data Switching Service (NWDSS) which is used to acquire much of the national health data from Welsh Health Boards and NHS England. This risk will be monitored through the internal ISD Enablement Report Out meetings.

4 RECOMMENDATION

The Digital Governance and Safety Committee are being asked to:

NOTE the contents of this report

5 IMPACT ASSESSMENT

STRATEGIC OBJECTIVE	Driving value from data for better outcomes

CORPORATE RISK (ref if appropriate)	DHCW0260, DHCW2069

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

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

HEALTH CARE STANDARD	Effective Care
If more than one standard applies, please list below: Safe care	

EQUALITY IMPACT ASSESSMENT STATEMENT	Date of submission: N/A

No, (detail included below as to reasoning)	Outcome: N/A
Statement: N/A	

APPROVAL/SCRUTINY ROUTE:

Person/Committee/Group who have received or considered this paper prior to this meeting

COMMITTEE OR GROUP	DATE	OUTCOME
ISD Senior Management Team	27/08/2021	Approved

IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes, please see detail below
	The formalisation of internal assurance processes for information will have a positive impact on the organisation. The DEA accreditation ensures safe and secure management of information which will have a positive impact.
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

DIGITAL HEALTH AND CARE WALES
INCIDENT REVIEW & LEARNING GROUP REPORT

Agenda Item	2.7

Name of Meeting	Digital Governance and Safety Committee
Date of Meeting	11th August 2021

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

Executive Sponsor	Rhidian Hurle – Medical Director
Prepared By	Keith Reeves – Service Management Team Manager
Presented By	Michelle Sell – Chief Operating Officer

Purpose of the Report	For Assurance
Recommendation	
The Digital Governance and Safety Committee is being asked to: N**OTE** the Report for **ASSURANCE.**	

Acronyms			
IRLG	Incident Review & Learning Group	NEAG	Notifiable Events Assurance Group
OLG	Organisational Learning Group	MHRA	Medicines and Healthcare products Regulatory Authority
DHCW	Digital Health & Care Wales	WLIMS	Welsh Laboratory Information Management System
WRIS	Welsh Radiology Information Service	WIS	Welsh Immunisation Services

Additional definitions are included in the Glossary of Terms and Definitions

1 SITUATION/BACKGROUND

1.1 The purpose of the Incident Review and Learning Group (IRLG) is to have a single reporting group which covers all aspects of incident review and associated learning across the organisation, and to make and take forward recommendations for improvement. The finalised terms of reference for the group will be shared at the Committee meeting in November for noting.

1.2 The outcome of reviews. This will support the work of the Board in the Shared Learning approach.

1.3 The IRLG acts as a replacement function of the predecessor organisation's Notifiable Events Assurance Group (NEAG) and the Organisational Learning Group (OLG), and for governance purposes reports to the Digital Governance and Safety Committee.

1.4 This report will include information on all National Reportable Incidents by Digital Health and Care Wales (DHCW), as well as any ad hoc reviews undertaken, the purpose to provide assurance to the Committee that all appropriate processes are being followed.

1.5 The first meeting of the group was held on 9th July 2021 and is chaired by the Chief Operating Officer. The group meets monthly, and the next meeting is scheduled for the 17th August 2021.

1.6 The terms of reference for the group are currently under review and will be agreed at the next meeting and will be reviewed annually.

1.7 As this is a new group formed within the organisation, the report will be expanded on over time to include additional trending and analysis to provide further assurance to the Digital Governance & Safety Committee.

2 SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 Incident Review

The following report covers the **Quarter 1 period 1st April 2021 to 30th June 2021**

2.1.1 Notification Period Compliance Summary

This table provides a summary of all incidents where there is a legislative / regulatory requirement to notify an appropriate body (typically known as National Reportable Incidents).

The compliance parameters for notifying appropriate bodies of National Reportable Incidents are listed in the table below:

Status	Definition	Next Steps
Red	Notification was issued outside of timescale	Escalate through IRLG report
Amber	Notification was issued at end of timescale	Consider improvements in reporting
Green	Notification was issued within timescale	No action

Timescales are defined by the relevant body, for further information see the Glossary of Terms and Definitions

Incident Type	Lead	Timescale	Total Notifications	Notification within timescales		
Business Continuity	Business Continuity Manager	See Glossary	0	-	-	-
Clinical	Serious Clinical Incidents Investigation Manager	7 days	1	1	0	0
Cyber Security	Interim Head of Cyber Security	3 days	0	-	-	-
Health & Safety	Head of Corporate Services	10 days	0	-	-	-
Information Governance	Head of Information Governance	72 hours	0	-	-	-
Information Services	Head of Information & Health Records Programmes	See Glossary	0	-	-	-
MHRA Reportable Event	Quality Manager (Regulatory Compliance)	2 days	0	-	-	-
		10 days	0	-	-	-
		30 days	0	-	-	-
Patient Safety	Serious Clinical Incidents Investigation Manager	7 days	0	-	-	-
Technical	Service Management Team Manager	See Glossary	0	-	-	-
Welsh Language Standards	Board Secretary	See Glossary	0	-	-	-
Total			0	1	0	0

There was 1 notification as a No Surprises / Sensitive Issue relating to Integration Services disc space issues impacting the Welsh Laboratory Information Management System.

2.1.2 Review Progress Report **(within reporting period)**

This table provides a summary of review activity and consists of all reports that were either started (open) **or** closed within the reporting period. This includes ad hoc reviews which were undertaken but were not necessarily required to be notified to an appropriate body (typically internal DHCW technical reviews)

Type	Total Reviews in Quarter			Open Reviews	Closed Reviews		
	Q1	Previous Quarter	Change		Downgraded	Completed	Breached
Business Continuity	1	-	-	1	0	0	0
Clinical	8	-	-	1	0	7	0
Cyber Security	-	-	-	-	-	-	-
Health & Safety	-	-	-	-	-	-	-
Information Governance	-	-	-	-	-	-	-
Information Services	-	-	-	-	-	-	-
MHRA Reportable Event	-	-	-	-	-	-	-
Patient Safety	-	-	-	-	-	-	-
Technical	6	-	-	2	0	4	0
Welsh Language Standards	-	-	-	-	-	-	-
Total	**15**	**0**	**0**	**4**	**0**	**11**	**0**

The 6 technical reviews that were undertaken relate to incidents impacting National Services. Impact assessments determined that these incidents did not trigger external notification requirements.

The 7 Clinical reviews completed relate to historic incidents undertaken prior to the formation of DHCW on 1st April 2021. These and the 4 Technical reviews were closed within the reporting period but prior to the formation of the Incident Review & Learning Group.

2.1.3 Complaints & Redress **(within reporting period)**

Type	Total Reviews in Quarter			Open Reviews	Total Reviews in Quarter		
	Q1	Previous Quarter	Change		Downgraded	Completed	Breached
Complaints	1	-	-	1	0	0	0
Redress	-	-	-	-	-	-	-
Total	**1**	-	-	**1**	**0**	**0**	**0**

1 complaint relates to a joint investigation being undertaken between DHCW and Cardiff and Vale University Health Board.

2.1.4 Cumulative Review Progress Report **(Financial Year April 21 – March 22)**

This is the number of reviews undertaken within the fiscal year and their status

Type	Total Reviews in Year	Open Reviews	Closed Reviews		
			Downgraded	Completed	Breached
Business Continuity	1	1	0	0	0
Clinical	8	1	0	7	0
Cyber Security	-	-	-	-	-
Health & Safety	-	-	-	-	-
Information Governance	-	-	-	-	-
Information Services	-	-	-	-	-
MHRA Reportable Event	-	-	-	-	-
Patient Safety	-	-	-	-	-
Technical	6	2	0	4	0
Welsh Language Standards	-	-	-	-	-
Total	**15**	**2**	**0**	**11**	**0**

The 6 technical reviews that were undertaken relate to incidents impacting National Services. Impact assessments determined that these incidents should not be notified to relevant bodies.

The 7 Clinical reviews that were completed relate to historic incidents undertaken prior to the formation of DHCW on 1st April 2021. These and the 4 Technical reviews were closed within the reporting period but prior to the formation of the Incident Review & Learning Group

2.1.5 Cumulative Complaints & Redress **(Financial Year April 21 – March 22)**

This table summarises the number of complaints received relating to The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 (commonly referred to as Putting Things Right)

Type	Total Reviews in Year			Open Reviews	Total Reviews in Quarter		
					Downgraded	Completed	Breached
Complaints	1	-	-	1	0	0	0
Redress	-	-	-	-	-	-	-
Total	**1**	-	-	**1**	**0**	**0**	**0**

1 complaint relates to a joint investigation being undertaken between DHCW and Cardiff and Vale University Health Board.

2.2 Lessons Learned, Recommendations, and Actions

2.2.1 Closed Incident Report Actions Identified

This table provides a summary of the number of actions identified across reviews completed

Corrective Actions Identified	In Progress	Implemented	Rejected[1]
0	0	0	0

Preventative Actions Identified	In Progress	Implemented	Rejected
0	0	0	0

Other Recommendations Identified	In Progress	Implemented	Rejected[1]
14	14	0	0

Once a review is completed actions and recommendations are recorded on the Quality Improvements Actions List. The monitoring of progress of completion and implementation of these actions and recommendations, will be the responsibility of the IRLG.

[1] Recommendations and actions may be rejected following further assessment, such as not meeting strategic direction of the organisation, too costly, resource intensive etc.

2.2.2 Implemented Improvements

This table provides a summary of the learning and improvements identified and / or implemented across the year

Report ref:	Learning	Action	Implementation Lead	Implementation Timescale	Status
<<report ref>>	*<<description of learning identified>>*	*<<description of actions undertaken>>*	*<<area with responsibility for implementation>>*	*<<suggested length of implementation>>*	*<<current status>>*

This section will be built upon as the IRLG becomes more established and improvements are identified and implemented to also include common themes and other findings

3 KEY RISKS/MATTERS FOR ESCALATION TO BOARD / COMMITTEE

3.1 Items for Escalation

Observation	Escalation	Impact	Suggested approach

There are no matters or risks for escalation

3.2 Additional activities of the Incident Review and Learning Group

This section will be built upon as the IRLG becomes established.

4 RECOMMENDATION

The Digital Governance and Safety Committee is being asked to:

NOTE the contents of this report for **ASSURANCE.**

5 GLOSSARY OF TERMS AND DEFINITIONS

Term	Definition
Business Continuity Reporting Timescales	There are no defined timescales for the notification of business continuity incidents to appropriate bodies, however where a business continuity incident has additional impact (for instance Health & Safety or Security) then the most appropriate notification model should be used. The leads for reporting are the **Head of Corporate Services** and **Service Management Team Manager**
Clinical Incident Reporting Timescales	Incidents falling under the NHS Wales National Incident Reporting Policy should be reported to the NHS Delivery Unit within 7 days The lead for reporting is the **Serious Clinical Incident Investigations Manager**
Complaint	Any expression of dissatisfaction;
Concern	Any complaint; notification of an incident concerning patient safety or, save in respect of concerns notified in respect of primary care providers or independent providers, a claim for compensation;
Corrective Action	Action to eliminate the cause of a nonconformity and to prevent recurrence
Cyber Security Timescales	Incidents falling under EU Security of Networks & Information Systems (NIS) Directives - Incidents that occur should be reporting to the National Cyber Security Centre (NCSC) within 72 hours The lead for reporting is the **Interim Head of Cyber Security**
Fix Applied	A fix has been implemented through Change control which has resolved the underlying technical issue
Fix Identified	A fix has been identified but not implemented but is awaiting deployment through Change control
Health & Safety Executive Reporting Timescales	Schedule 1 of RIDDOR states that notification of an incident to the relevant enforcing authority is by the quickest practicable means without delay. A full report is then required within 10 days of the incident. There is one exception where the person is incapacitated for more than 7 days. This is known as a 7-day injury, in which case notification is 7 days from date of accident, and 15 days for the full report to be issued The lead for reporting is the **Head of Corporate Services**
Incident Concerning Patient Safety	Any unexpected or unintended incident which did lead to or could have led to harm for a patient

Information Governance Timescales	Incidents falling under General Data Protection Regulations 2018 (GDPR) – Incidents that occur should be reporting to the Information Commissioners Office (ICO) within 72 hours The lead for reporting is the **Head of Information Governance**
Information Services Timescales	There are no defined timescales for the notification of technical incidents to appropriate bodies, however where a technical incident has additional impact (for instance Information Governance) then the most appropriate notification model should be used. The lead for reporting is the **Head of Information & Health Records Programmes**
MHRA	Medicines and Healthcare products Regulatory Authority
MHRA Reportable Event	Incidents falling under the Medical Devices Regulations should be reported to the MHRA as soon as possible. Serious cases should be reported by the fastest means possible. Timescales are based on severity and reportable within 2, 10 and 30 days. The lead for reporting is the **Quality Manager (Regulatory Compliance)**
Notification Period	The period of time to report an incident to the most appropriate body
Patient Safety Incident Reporting Timescales	Incidents falling under the NHS Wales National Incident Reporting Policy should be reported to the NHS Delivery Unit within 7 days The lead for reporting is the **Serious Clinical Incident Investigations Manager**
Preventative Action	Action to eliminate the cause of a potential nonconformity or other potential undesirable situation
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013. Incidents that happen should be reported to the Health and Safety Executive (HSE)
Technical Reporting Timescales	There are no defined timescales for the notification of technical incidents to appropriate bodies, however where a technical incident has additional impact (for instance Clinical or Security) then the most appropriate notification model should be used. The lead for reporting is the **Service Management Team Manager**
Welsh Language Standards Reporting Timescales	Complaints received under the Welsh Language Standards should be managed in line with the organisations complaints policy. The lead for reporting is the **Board Secretary**

6 IMPACT ASSESSMENT

STRATEGIC OBJECTIVE	Delivering High Quality Digital Services

CORPORATE RISK (ref if appropriate)	**N/A**

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

DHCW QUALITY STANDARDS	ISO 20000
If more than one standard applies, please list below: ISO 27001, ISO 13485, ISO 9001, ISO 14000, BS 10008	

HEALTH CARE STANDARD	Governance, leadership and acccountability
If more than one standard applies, please list below:	

EQUALITY IMPACT ASSESSMENT STATEMENT	Date of submission: N/A
No, (detail included below as to reasoning)	Outcome: N/A
Statement: This report is a summary of all incidents reviewed under the organisation's review processes. No requirement for EQIA	

APPROVAL/SCRUTINY ROUTE:

Person/Committee/Group who have received or considered this paper prior to this meeting

COMMITTEE OR GROUP	DATE	OUTCOME
Notifiable Events Assurance Group	23/06/2021	Approved

IMPACT ASSESSMENT	
QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes, please see detail below
	Report provides summary of all reportable incidents and any quality and safety activities undertaken as remediation. Should the remedial required action not be undertaken there could be a detrimental impact on quality and safety.
LEGAL IMPLICATIONS/IMPACT	Yes, please see detail below
	Report provides summary of all reportable incidents include any which meet out legal, regulatory, and statutory requirements. Should corrective and remedial action not be undertaken appropriately there could be a legal impact.
FINANCIAL IMPLICATION/IMPACT	Yes, please see detail below
	Report contains summary of any incidents where redress is required. Some incidents may result in financial penalties for the organisation.
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

DIGITAL HEALTH AND CARE WALES
WELSH INFORMATION GOVERNANCE TOOLKIT ASSURANCE PROCESS 2020/21

Agenda Item	2.8

Name of Meeting	Digital Governance and Safety Committee
Date of Meeting	11TH August 2021

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

Executive Sponsor	Rhidian Hurle, Medical Director and Chief Clinical Information Officer Wales
Prepared By	Marcus Sandberg, National Information Governance Assurance and Support Lead
Presented By	Darren Lloyd, Head of Information Governance and Data Protection Officer

Purpose of the Report	For Discussion/Review
Recommendation	
The Digital Governance and Safety Committee is being asked to: **REVIEW** the Information Governance team's submission of the IG Toolkit for 2020/21 and **SUPPORT** and **OWN** the management actions identified, which the Information Governance team will carry out and update the Committee on periodically.	

Acronyms			
IG	Information Governance	DHCW	Digital Health and Care Wales
NWIS	NHS Wales Informatics Service		

1 SITUATION/BACKGROUND

1.1 The Welsh Information Governance Toolkit (IG Toolkit) is a self-assessment tool enabling organisations to measure their level of compliance against national Information Governance standards and legislation (including UK General Data Protection Regulation, Data Protection Act 2018, Freedom of Information Act and Privacy and Electronic Communications Regulations).

1.2 The assessment helps identify areas which require improvement and assist in informing organisations' Information Governance improvement plans. The aim is to demonstrate that organisations can be trusted to maintain the confidentiality and security of both personal and business information. Completion of the IG Toolkit provides re-assurance to staff and patients that information held about them is processed securely and appropriately, and to assure other organisations when sharing information that appropriate arrangements are in place.

1.3 Digital Health and Care Wales (DHCW) have two responsibilities in relation to the IG Toolkit:

- Responsibility for the maintenance and development of the IG Toolkit, which is a requirement for all GP Practices, Welsh Health Boards and Trusts to complete annually; and
- DHCW to complete and submit the IG Toolkit annually based on their own compliance to national Information Governance standards and legislation.

1.4 This paper focuses on NHS Wales Informatics Service (NWIS)/ DHCW's 2020/21 completion of the IG Toolkit.

2 SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 The deadline for submission of the 2020/21 IG Toolkit was 31st March 2021, therefore the evidence provided was in relation to NWIS' Information Governance compliance (i.e. before NWIS transitioned to DHCW on the 1st April 2021).

2.2 The IG Toolkit consists of a range of questions split up by sections (including areas such as information sharing, Data Protection Impact Assessments and reporting of data breaches) and

levels which require evidence to meet the compliance within the required area. A full diagram of the sections of the IG Toolkit is provided at Appendix A.

2.3 Evidence can be provided by uploading documents or adding a description. **Please note, the IG Toolkit only recognises that there has been an input of evidence, it does not currently, recognise the quality of the evidence provided.**

2.4 Therefore, the scoring provided should only be used as a guide of the organisations Information Governance compliance.

3 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 The scoring of NWIS/DHCW's IG Toolkit for 2020/21 are as follows:

	Level 1	Level 2	Level 3	Overall
Compliance Percentage	95%	100%*	86%	94%

*The IG Toolkit is intended to be completed incrementally (i.e. you should not achieve Level 2 in an area where you have not achieved Level 1). However, it was decided for one particular section NWIS/DHCW could provide evidence for the Level 2 questions but not for Level 1 question.

3.2 NWIS/DHCW's scoring shows a high level of compliance. Although this scoring can only be used as a guide, it provides assurance to staff, patients and other stakeholders that information held by DHCW is processed securely and appropriately. Organisations completing the IG Toolkit are not expected to achieve 100% across all three levels as the self-assessment is intended to be used to identify areas of improvement. Therefore, where DHCW has not scored 100% in some sections, this does not indicate that the organisation does not meet the legal requirements for these sections, more so it identifies where these areas can be improved upon.

3.3 To that extent, actions for each section have been identified to improve DHCW's compliance with legislation and standards and its submission for 2021/2022. A full breakdown of each

section's scoring is provided at Appendix A including a summary of each of the identified actions.

3.4 A summary of the identified IG Toolkit actions by area and priority determined by the Information Governance team is provided below.

IG Toolkit Section	High	Medium	Low	Total
Business Responsibilities	0	3	2	5
Business Management	0	1	0	1
Managing and Securing Records	0	2	0	2
Individual's Rights and Obligations	0	1	1	2
Technical Security, Physical Security and Organisational Measures	0	0	1	1
Information Governance Incident Management	0	0	0	0
Total	**0**	**7**	**4**	**11**

A detailed action plan describing the progress made, the current position and risk is provided at Appendix B. The DHCW Information Governance team will be taking these forward and will provide updates to the Committee periodically.

4 RECOMMENDATION

5 The Digital Governance and Safety Committee is being asked to:

REVIEW the Information Governance team's submission of the IG Toolkit for 2020/21 and SUPPORT and OWN the management actions identified, which the Information Governance team will carry out and update the Committee on periodically.

6 IMPACT ASSESSMENT

STRATEGIC OBJECTIVE	Delivering High Quality Digital Services

CORPORATE RISK (ref if appropriate)	N/A

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

DHCW QUALITY STANDARDS	Choose an item.
If more than one standard applies, please list below:	

HEALTH CARE STANDARD	Governance, leadership and acccountability
If more than one standard applies, please list below:	

EQUALITY IMPACT ASSESSMENT STATEMENT	Date of submission: N/A
No, (detail included below as to reasoning)	Outcome: N/A
Statement: N/A	

APPROVAL/SCRUTINY ROUTE:

Person/Committee/Group who have received or considered this paper prior to this meeting

COMMITTEE OR GROUP	DATE	OUTCOME

IMPACT ASSESSMENT	
QUALITY AND SAFETY IMPLICATIONS/IMPACT	No, there are no specific quality and safety implications related to the activity outlined in this report.
LEGAL IMPLICATIONS/IMPACT	Yes, please see detail below
	As identified above, completion of the IG Toolkit helps assess and improve DHCW's compliance with Information Governance legislation, guidance and standards.

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

7 APPENDIX A

Welsh Information Governance Toolkit

Business Responsibilities

Results: Level 1 **86%** / Level 2 **100%** / Level 3 **86%**

- Information Governance Management
- Policies and Procedures
- Information Sharing
- Contracts and Agreements
- Data Protection Impact Assessments
- Freedom of Information and Environmental Information Regulations
- Privacy Electronic Communications Regulations

Actions:

- ensure appropriate Information Governance reporting arrangements
- develop of a DHCW Information Governance action plan
- sign up to WASPI and the Welsh Control Standard
- develop a Publication Scheme
- Consider how Privacy and Electronic Communications Regulations applies

Technical Security, Physical Security and Organisational Measures

Results: Level 1 **100%** / Level 2 **100%** / Level 3 **100%**

- Physical Security
- Technical Security
- Organisation Measures (Training and Awareness)
- Mobile Working and Remote Access
- Secure Destruction and Disposal of IT Equipment
- Surveillance Systems

Action:

- specific training around the use of CCTV footage.

Business Management

Results: Level 1 **100%** / Level 2 **100%** / Level 3 **100%**

- Business Continuity Plan
- IG Risk Register
- Auditing

Action:

- consider how Information Governance risks are recorded and managed following the transition to DHCW

Managing and Securing Records

Results: Level 1 **100%** / Level 2 **100%** / Level 3 **71%**

- Record Management
- Information Asset Register
- Data Accuracy
- Retention Schedules, Secure Destruction and Disposal

Actions:

- support work on the development of a new Information Asset Register
- ensure DHCW has suitable policies in place

Individual's Rights and Obligations

Results: Level 1 **100%** / Level 2 **100%** / Level 3 **75%**

- Right of Access
- Right to be Informed
- Right to object, to erasure, to rectification and portability
- Rights related to profiling and automated decision making that has significant impact on the data subject

Actions:

- Review privacy information
- review of the Data Protection Impact Assessment template

Cyber Security

An organisations Cyber Security controls are assessed in Welsh Cyber Assurance Process (WCAP).

Information Governance Incident Management

Results: Level 1 **100%** / Level 2 **100%** / Level 3 **100%**

- Reporting Data Breaches

8 APPENDIX B

IG Toolkit section: Business Responsibilities - Information Governance Management	
Action 1 – Reporting Arrangements	**Risk**
NWIS' transition into DHCW requires assurances that Information Governance will continue to be reported to senior level. The move to a Special Health Authority will formalise reporting to a Board which includes independent members and Directors. This action was also identified as part of the internal audit conducted by NHS Wales Shared Services Partnership 2019/2020 and formally responded to in a follow up.	Lack of review and scrutiny of DHCW's level of IG compliance and assurance.
Recommendation	**Priority Level**
Ensure there are appropriate Information Governance reporting arrangements in place once DHCW is established as a Special Health Authority.	**Medium**
Management Response	**Responsible Officer /Deadline**
Following DHCW's establishment, DHCW's Board governance was created with Information Governance reportable into the DHCW SHA Board via the Digital Governance and Safety Committee. Management Board are also sighted on IG requests for information (Freedom of Information Act requests, Subject Access Requests etc) and IG incidents.	**Action** – Ensure there are appropriate Information Governance reporting arrangements in place once DHCW is established as a Special Health Authority. **Darren Lloyd – Head of Information Governance** Target date – **Complete**

IG Toolkit section: Business Responsibilities - Information Governance Management	
Action 2 – Action Plan	**Risk**
Developing an action plan from the submission of the IG Toolkit is a key part to ensuring	Not addressing areas of improvement

compliance with IG legislation and standards. Actions should be identified, monitored, progressed and reported to ensure the level of compliance in these areas are improved. This will result in improving next year's submission of the IG Toolkit, and in turn, improving the organisations compliance with IG legislation and standards. The previous submission of the IG Toolkit was particularly pertinent, as the deadline for submission was 31st March 2021. Therefore, the evidence provided was in relation to NWIS' Information Governance compliance (i.e. before NWIS transitioned to DHCW on the 1st April 2021). The actions identified will take into account any actions required as a result of DHCW's transition from a hosted organisation to a Special Health Authority (ie where the organisation was reliant on Velindre University NHS Trust for policies etc).	from a previous IG Toolkit entry reduces DHCW's compliance with IG legislation and standards.
Recommendation	**Priority Level**
Develop and implement a DHCW Welsh IG Toolkit action plan.	**Medium**
Management Response	**Responsible Officer /Deadline**
This document forms the DHCW Welsh IG Toolkit action plan. Further thought needs to be given as to how the IG monitor these actions. IG have considered whether these actions should be recorded and monitored as risks (see Action 6). **Current Action:** DHCW Welsh IG Toolkit action plan to be provided to the Digital Governance and Safety Committee for support and ownership of the identified actions.	**Action** – DHCW Welsh IG Toolkit action plan to be provided to Committee for support and ownership of the identified actions. **Marcus Sandberg – Information Governance** Target date – August 2021

IG Toolkit section: Business Responsibilities – Information Sharing	
Action 3 – IG Framework commitment	**Risk**
DHCW Information Governance manage and encourage organisations to sign up to the Wales Accord on the Sharing of Personal Information (WASPI) and the Welsh Control Standard for	DHCW could be challenged for hosting these frameworks and encouraging others

Electronic Health and Care Records (The Welsh Control Standard). DHCW was previously covered, as NWIS, under Velindre University NHS Trust's sign ups. Therefore, it is advised that DHCW commit to these frameworks. • The Wales Accord on the Sharing of Personal Information (WASPI) is a framework to help public service providers share personal information safely, effectively and lawfully. • The Welsh Control Standard for Electronic Health and Care Records (The Welsh Control Standard) describes the principles and common standards that apply to systems that share electronic health and care records in Wales for the purpose of providing 'direct care'.	to sign up without being signed up themselves.
Recommendation	**Priority Level**
DHCW to sign up to the WASPI and the Welsh Control Standard.	**Low**
Management Response	**Responsible Officer /Deadline**
WASPI and the Welsh Control Standard are key parts of DHCW's National Information Governance framework, which provides NHS organisations and external stakeholders services, tools and standards to improve and maintain their information governance responsibilities. Signing up to these frameworks will commit DHCW to following the principles set out in the WASPI Accord and Welsh Control Standard, which DHCW already meet. Sign up will require sign off by a designated person (the Chief Executive and the Caldicott Guardian) and the Data Protection Officer (Head of Information Governance). **Current Action:** DHCW IG team to arrange DHCW to sign up to these frameworks.	**Action** – DHCW to sign up to WASPI and Welsh Control Standard **Darren Lloyd – Head of Information Governance** Target date – September 2021

IG Toolkit section: Business Responsibilities - Freedom of Information Act and Environmental Information Regulations	
Action 4 - Publication Scheme	**Risk**
In addition to responding to requests for information, the Freedom of Information Act 2000 outlines that public authorities must publish information proactively in the form of a	DHCW may be subject to notices or fines from the ICO for not complying with the

publication scheme. The legislation requires public authorities to have a publication scheme, approved by the Information Commissioner's Office (ICO) and to proactively publish information covered by the scheme. The scheme must set out DHCW's commitment to make certain classes of information routinely available, such as policies and procedures, minutes of meetings, annual reports and financial information.	Freedom of Information Act 2000.
Recommendation	**Priority Level**
Develop and maintain a publication scheme and disclosure log.	**Medium**
Management Response	**Responsible Officer /Deadline**
Work has been undertaken setting out what is involved in creating a Publication Scheme. The IG team will require Committee support as this task will require assistance from other departments in creating and maintaining a publication scheme (including communications, corporate services, finance). **Current Action:** Further discussions to be held with the Board Secretary about creating a publication scheme.	**Action** – Further discussions to be held with the Board Secretary about creating a publication scheme. **Marcus Sandberg – Information Governance** Target date – October 2021

IG Toolkit section: Business Responsibilities - Privacy Electronic Communications Regulations	
Action 5 - Privacy and Electronic Communications Regulation	**Risk**
The Privacy and Electronic Communications Regulations (PECR) give individuals specific privacy rights in relation to electronic communications. The extent to which PECR affects DHCW's activity needs consideration as DHCW does not undertake electronic communications such as marketing calls, emails, texts and faxes. The main PECR area for DCHW's consideration is website cookies. DHCW's position on cookies not only affects DHCW websites but also websites for NHS Wales organisations or affiliates, such as Health Boards and Trusts that use the national content management system. DHCW's	The ICO can take action against organisations that are non-complaint with PECR including enforcement action.

current position on cookies needs to be reviewed to ensure this is compliant.	
Recommendation	**Priority Level**
Consider Privacy and Electronic Communications Regulation applies	**Low**
Management Response	**Responsible Officer /Deadline**
DHCW's main consideration in relation to PECR is cookies. DHCW's compliance with cookie legislation was first questioned in 2019 via Software Development. An options paper was jointly developed and shared with NHS Wales Information Governance leads and Mura SMB, agreeing on which recommendation was most suited. Next actions on procuring/developing a cookie management tool are on the Software Development team, although this has slowed due to workload/COVID-19. It was noted that any software to manage cookies would be procured 'off-the shelf'. **Current Action:** Software development to move this forward by looking into procurement/development for a cookie tool to meet the agreed option.	**Action** – Awaiting update from software development. **John Sweeney – Information Governance** Target date – October 2021

IG Toolkit Section: Business Management – IG Risk Register	
Action 6 - Information Governance risks	**Risk**
DHCW has a risk management policy, setting out how it manages information risk, how it monitors compliance and a process for staff to report and escalate information governance or data protection concerns and risks. The DCHW Information Governance team needs to review the policy to ensure they are delivering the policy requirements	IG team to ensure it delivers policy requirements
Recommendation	**Priority Level**
Consider how Information Governance risks are recorded and managed.	**Medium**
Management Response	**Responsible Officer /Deadline**
The DHCW IG team need to consider developing a risk register for their team and a process on how these are escalated.	Action – DHCW IG team to consider position.

Current Action: DHCW IG team to consider position.	**John Sweeney – Information Governance** Target date – September 2021

IG Toolkit Section: Managing and Securing Records – Information Asset Register	
Action 7 – Information Asset Register	**Risk**
As identified in the internal audit conducted by NHS Wales Shared Services Partnership in 2019/2020, asset registers are an essential element of GDPR compliance. While DHCW has documented the key systems it provides as a service through the service catalogue, further work is needed to identify information assets including appointing information asset owners to understand what information is held corporately.	If DHCW are not fully aware of what information it holds, its information flows and lawful basis for processing and there is a risk of non-compliance with UK GDPR.
Recommendation	**Priority Level**
Support work on the development of a new Information Asset Register.	**Medium**
Management Response	**Responsible Officer /Deadline**
Work has been undertaken on this action, as identified in the follow up to the GDPR internal review including expanding the DHCW SharePoint site, containing a register of Corporate Information Systems, the alignment of the roles of Information Asset Owners and Data Stewards and work on the British Standard BS10008 (Evidential weight and legal admissibility of electronic information) implementation. To ensure information assets are accurately collected, stored and maintained on the Information Asset Register, information asset owner/stewardship roles are to be identified. A project manager has been recruited as part of the Operational Services Development directorate to lead on this work with planned support activities to be undertaken. The IG team are assisting in this work, to ensure it meets UK GDPR requirements. **Current Action:** Support the development of the Information Asset Register and Information Asset owner roles.	**Action** – Support work on the development of a new Information Asset Register **Darren Lloyd – Head of Information Governance** Target date – January 2022

IG Toolkit Section: Managing and Securing Records – Management of Records

Action 8 – Information Governance Policies	Risk
As a Statutory organisation, DHCW needs to ensure there are policies in place for certain activities such as records retention and managing individual rights under data protection legislation. Before the transition to DHCW, NWIS relied on Velindre University NHS Trust for certain policies and fell under their implementation of the All Wales Information Governance policies.	The lack of policies could lead to a staff members not understanding and following IG legislation and good practice. In turn, this could cause data breaches and enforcement from the ICO for not having correct IG governance in place.
Recommendation	**Priority Level**
Ensure DHCW has suitable IG polices in place.	**Medium**
Management Response	**Responsible Officer /Deadline**
All 'All Wales' Information Governance policies and two DHCW policies (Information Asset and Access to Information) were approved by Board on 1st April 2021.	**Action** – Ensure DHCW has suitable IG polices in place. **Andrew Fletcher – Information Governance** Target date - **Complete**

IG Toolkit Section: Individual's Rights and Obligations – Right to be Informed	
Action 9 - Privacy information	**Risk**
Under UK GDPR, individuals have the right to be informed about the collection and use of their personal data. This includes how we process personal information about both members of the public and our own staff. One method of informing is through privacy policies/notices. In light of the change to a Special Health Authority, DHCW will need to review their existing privacy policies/notices to ensure they are still appropriate.	Not being transparent about how we collect and use personal data would be non-compliant with data protection legislation.
Recommendation	**Priority Level**
Review privacy information.	**Medium**
Management Response	**Responsible Officer /Deadline**

DHCW's privacy information has been updated including: • Privacy notice for members of the public • Privacy notice for staff • Privacy notice for members of the public specifically in relation to information held during the pandemic.	**Action** – Review and publish privacy information **Marcus Sandberg – Information Governance** Target date – **Complete**

IG Toolkit Section – Individual's Rights and Obligations - Rights related to profiling and automated decision	
Action 10 - Data Protection Impact Assessment template	**Risk**
Data Protection Impact Assessment (DPIA) is a process to help organisations identify and minimise the data protection risks of a service, system or project. It is a legal requirement to complete a DPIA for processing that is likely to result in a high risk to individuals and good practice for any major projects which requires the processing of personal data. The DPIA process is well established within DHCW with the need for a DPIA being identified through the Welsh Informatics Assurance Group (WIAG) process It was identified, through completion of the IG Toolkit, that the DPIA template could be updated to reflect some of the questions asked within the IG Toolkit, in particular, questions concerning the Right to Automated Decision Making.	Result in a lower score in the IG Toolkit, where not aligning with the DPIA template.
Recommendation	**Priority Level**
Review Data Protection Impact Assessment template.	**Low**
Management Response	**Responsible Officer /Deadline**
The ICO provided some feedback on the National DPIA template through a group of Information Governance leads for Health Boards and Trusts. The DPIA template was updated in line with the ICO's comments, the IG Toolkit questions and feedback from the Information Governance team.	**Action** – Review Data Protection Impact Assessment template **Marcus Sandberg – Information Governance**

	Target date - **Complete**

IG Toolkit Section - Technical Security, Physical Security and Organisational Measures	
Action 11 – CCTV Information Governance training	**Risk**
CCTV records personal data by capturing images of individuals. It was noted that security guards do not complete Statutory and Mandatory training, and therefore do not undertake the same IG training as the rest of DHCW staff. As security guards are responsible for CCTV, they should be aware of their IG responsibilities of dealing with personal data. Corporate Services are already involved in the process of CCTV footage and are aware that requests for disclosure should be checked with the Data Protection Officer (Head of Information Governance).	Staff not being appropriately IG trained could lead to non-compliance with legislation, IG incidents and data breaches.
Recommendation	**Priority Level**
Information Governance training for staff members using CCTV footage.	**Low**
Management Response	**Responsible Officer /Deadline**
Thought needs to be given to how this best can be implemented. **Current Action:** Consider how training can be implemented and discuss with Corporate Services.	**Action** – Provide Information Governance training to staff using CCTV footage such as security guards and Corporate Services. **Marcus Sandberg – Information Governance** Target date – January 2022

DIGITAL HEALTH AND CARE WALES
MICROSOFT OFFICE 365 / SHAREPOINT UPDATE REPORT

Agenda Item	2.9

Name of Meeting	Digital Governance and Safety Committee
Date of Meeting	11 August 2021

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

Executive Sponsor	Carwyn Lloyd-Jones Director of ICT
Prepared By	Darren Lloyd, Head of Information Governance
Presented By	Darren Lloyd, Head of Information Governance

Purpose of the Report	For Noting
Recommendation	
The Digital Governance and Safety Committee is being asked to: NOTE the highlighted areas of the previous incident and actions taken to rectify which has resulted in the incident being closed.	

Acronyms			
SIRO	Senior Information Risk Owner	MO	Microsoft Office
NWIS	NHS Wales Informatics Services	NHS	National Health Service
ICO	Information Commissioner's Office	M365	Microsoft Office 365

1 SITUATION/BACKGROUND

1.1 Health Boards and Trusts in Wales are party to the same Microsoft Office 365 (M365) contract and, broadly speaking (there are some differences in license types etc), enjoy the same benefits and services. This is referred to as the NHS Wales M365 tenant. In February 2021, a NHS Wales M365 user discovered an issue with access permissions for Teams and SharePoint across the tenant.

1.2 M365 allows user access to Microsoft applications through www.office.com (the web portal). Subject to the application of appropriate controls, this has benefits in terms of user accessibility to applications and information.

1.3 A user reported that searches via the M365 web portal allowed them to access information that did not appear intended for distribution across the tenant. For example, document created by other Welsh Health Boards and Trusts. This included some personal information about a limited number of staff.

1.4 The cause of issue was identified as a permission setting on Teams and SharePoint sites. Microsoft Teams is based on SharePoint technology. When a new Team is created, an associated SharePoint site manages information and documents, and allows it to be presented in a user-friendly view via Teams.

1.5 407 Teams / SharePoint sites had been set to 'public', meaning that users across the NHS Wales tenant (not outside – i.e. not in the public domain) could, if they searched via the web portal, find documents and information hosted on those sites. 6,931 other sites were set as 'private' meaning that they were only accessible to NHS Wales M365 users who had been given specific permission to access them.

1.6 Given the potential for corporate and personal information to have been inappropriately accessed or disclosed, SIROs were informed, as were Caldicott Guardians (although there was no evidence that patient data had been inappropriately disclosed or accessed), Associate Directors of Informatics, Information Governance and Security leads, and others. A list of 'public' sites was provided by NWIS. Members of the tenant were asked to review them and

change the settings to 'private' unless they were certain a site needed to remain as public (ie available across the tenant).

1.7 The Information Commissioner's Office (ICO) was informed as a precaution, as was Welsh Government, through its Serious Incident/No Surprises reporting process.

1.8 A high-level timeline is as follows

- 03/02/21 (9.38pm) – Health Board reported to NWIS the issue regarding the visibility of documents.
- 04/02/21 – cause of the issue identified. List of sites compiled by NWIS. NHS Wales SIROs, Caldicott Guardians, Information Governance and Security Leads briefed. Mitigating action agreed – set sites to private unless required to be public and update a central log as a record of reviews and changes. ICO notified as a precaution.
- 05/02/21 – Welsh Government notified via its 'No Surprises' reporting process.
- 11/02/21 – Follow up meeting with SIROs etc to review the central log. Most sites had been reviewed and updated by this time. The final update to the central log was recorded on 15/02/21.
- 19/02/21 – ICO closure letter received by NWIS (available on request). Confirmed no regulatory action being taken.

2 SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 There are multiple reasons for the creation of 'public' SharePoint Sites, although the majority were linked to the creation of new Teams (within Microsoft Teams). Users who are permitted to create a Team are, by default, given the choice to create a public or private Team.

2.2 Members of the NHS Wales M365 tenant adopted varying approaches to the creation of Teams; some routing requests to local service desks, others choosing to nominate a group of trusted users, and some adopting the application 'Teams Create' which only provides the option to create a private group. The context of the 'big bang' approach to the roll out of Teams, as response to the COVID19 pandemic, needs to be taken into consideration. Organisations had to roll out Teams rapidly to facilitate remote working with little time to implement business processes to support, for example, the creation of new Teams.

2.3 There was no evidence that patient data was included on any of the public facing sites. Any personal data of staff was contained within the NHS tenant and was not readily available to NHS Wales users; i.e. in order to access the sites and information/documents on the public

sites users needed to conduct a targeted search via the web portal view of M365, view the results and take an active decision to access a site / document

2.4 In addition to the review of the identified sites, previously described, a number of actions were taken across the tenant:

- Additional training and communication, highlighting the importance of not creating public sites/Teams, was provided to all stakeholders who have responsibility for progressing requests for new Teams on behalf of their organisation.
- Demonstrations of the Teams Create application for those organisations that had yet to adopt the toolset. This provided context and the basic steps to create private sites by default.
- Overview sessions and a review of access requirements to the SharePoint Delegate Admin Centre to allow tenant members to self-serve and adopt a review process for their own sites.

3 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 The Incident was previously reported to Velindre NHS Trust as the host body at that time

4 RECOMMENDATION

4.1 The Digital Governance & Safety Committee is asked to:

NOTE the highlighted areas of the previous incident and actions taken to rectify, which has resulted in the incident being closed.

5 IMPACT ASSESSMENT

STRATEGIC OBJECTIVE	Delivering High Quality Digital Services

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:	

HEALTH CARE STANDARD	Governance, leadership and acccountability
If more than one standard applies, please list below:	

EQUALITY IMPACT ASSESSMENT STATEMENT	Date of submission: N/A
No, (detail included below as to reasoning)	Outcome: N/A
Statement: Not applicable in these circumstances	

APPROVAL/SCRUTINY ROUTE:

Person/Committee/Group who have received or considered this paper prior to this meeting

COMMITTEE OR GROUP	DATE	OUTCOME
Velindre NHS Trust	February 2021	Noted – no outstanding actions

IMPACT ASSESSMENT	
QUALITY AND SAFETY IMPLICATIONS/IMPACT	No, there are no specific quality and safety implications related to the activity outlined in this report.
LEGAL IMPLICATIONS/IMPACT	Yes, please see detail below Potential for Information Commissioners enforcement action – Although ICO response stated no matters to be taken any further because of the immediate actions taken to protect data
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

DIGITAL HEALTH AND CARE WALES
PUTTING THINGS RIGHT REGULATIONS UPDATE REPORT

Agenda Item	2.10

Name of Meeting	Digital Governance and Safety Committee
Date of Meeting	11th August 2021

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

Executive Sponsor	Rhidian Hurle, Executive Medical Director
Prepared By	Sophie Fuller, Corporate Governance and Assurance Manager
Presented By	Chris Darling, Board Secretary

Purpose of the Report	For Noting
Recommendation	
The Digital Governance and Safety Committee is being asked to: NOTE the current position regarding the status of the Putting Things Right regulations as they currently apply to DHCW, and the on-going discussions with Welsh Government about potential changes to the regulations to recognise DHCW within the regulations.	

Acronyms			
DHCW	Digital Health and Care Wales	NWSSP	NHS Wales Shared Services Partnership
PTR	Putting Things Right	SHA	Special Health Authority

1 SITUATION/BACKGROUND

1.1 The NHS in Wales aims to provide the very best care and treatment with a focus on learning from people's experiences, good or bad. The vast majority of people are happy with the service they receive. Sometimes though, things might not go as expected and a member of the public may raise a concern or complaint.

1.2 Putting Things Right (PTR) is guidance created for NHS organisations for dealing with concerns about serviced received from the NHS that reflect the content of The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011, more information on the PTR can be found via the link: Putting Things Right Guidance

2 SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 Currently Special Health Authorities (SHA) are not named bodies within the Putting Things Right regulations, as the regulations were initiated before the establishment of any SHA in Wales.

2.2 DHCW worked with Welsh Government Policy Leads, and consulted NWSSP Legal and Risk Services and the Public Service Ombudsmen in developing a Policy for dealing with Concerns and Complaints, in the absence of being recognised by the PTR regulations, which was approved by the DHCW Board on the 1st April, this can be found via the link: Handling Concerns and Complaints.

2.3 Since the establishment of DHCW, the DHCW Medical Director and Board Secretary have met with NHS Wales Shared Services Legal and Risk Team and Welsh Government Policy Leads. These discussions confirmed the desire for DHCW (Special Health Authorities) to be named within the PTR legislation. Welsh Government Policy Leads are discussing this with Health Education and Improvement Wales (HEIW) as the other Special Health Authority in Wales. To progress this and recognise Special Health Authorities within the PTR regulations Welsh Government Quality and Safety Policy Leads are proposing to take the following steps:

- Putting advice to the Minister to gain permission to change the legislation
- If permission is given, instruct Welsh Government Legal Services to draft necessary amendment legislation
- 12-week public consultation on the regulations (if required)
- Get the Regulations checked, translated and laid

2.4 The inclusion of SHA's in the regulations would explicitly name a SHA as a Responsible Body (as a Welsh NHS Body) within the PTR regulations. The Welsh Risk Pool position is that it generally expects DHCW (Special Health Authorities), where they are involved in a complaint / claim / redress matter, to be a supporting body within an investigation. It is generally felt that the Health Board or Trust who is responsible for the provision of patient care to the patient(s) affected is best placed to be the lead body and these organisations are more likely to have complaints-handling infrastructure which is patient facing.

2.5 DHCW have committed to following the principles of PTR in the interim for managing concerns and complaints and have initiated work on creating a Putting Things Right Policy ready for publication for if the legislation amendments are made. This will include a consultation period in line with requirements for all DHCW policies. Until any changes are made, DHCW will continue to use the approved Policy for the Handling of Concerns and Complaints.

3 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 Special Health Authorities in Wales are not currently formally recognised within the PTR regulations.

4 RECOMMENDATION

The Digital Governance and Safety Committee is being asked to:

NOTE the current position regarding the status of the Putting Things Right regulations as they currently apply to DHCW, and the on-going discussions with Welsh Government about potential changes to the regulations to recognise DHCW within the regulations.

5 IMPACT ASSESSMENT

STRATEGIC OBJECTIVE	Delivering High Quality Digital Services

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:	

HEALTH CARE STANDARD	Safe Care
If more than one standard applies, please list below: Effective Care Timely Care Governance, Leadership and Accountability	

EQUALITY IMPACT ASSESSMENT STATEMENT	Date of submission: N/A
No, (detail included below as to reasoning)	Outcome: N/A
Statement: The EQIA will be undertaken on the finalised policy.	

APPROVAL/SCRUTINY ROUTE:

Person/Committee/Group who have received or considered this paper prior to this meeting

COMMITTEE OR GROUP	DATE	OUTCOME

IMPACT ASSESSMENT	
QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes, please see detail below Following a national approach to managing concerns and complaints will help ensure quality and safety are of the highest priority as a learning organisation.
LEGAL IMPLICATIONS/IMPACT	Yes, please see detail below The report highlights the potential for the PTR legislation to be amended to recognise Special Health Authorities.
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

DIGITAL HEALTH AND CARE WALES
DATA CENTRE TRANSITION ASSURANCE REPORT

Agenda Item	2.11

Name of Meeting	Digital Governance and Safety Committee
Date of Meeting	11 August 2021

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

Executive Sponsor	Carwyn Lloyd-Jones, Director of ICT
Prepared By	Sophie Kift – Principal Project Manager (Infrastructure)
Presented By	Carwyn Lloyd-Jones, Director of ICT

Purpose of the Report	For Assurance
Recommendation	
The Digital Governance and Safety Committee is being asked to: Be **ASSURED** of processes surrounding the Data Centre Transition Project.	

Acronyms			
DHWC	Digital Health and Care Wales	TESTDEV	Test and Development Systems
DC1	Data Centre 1	DC2	Data Centre 2
DCT	Data Centre Transition	DMZ	De militarized zone

1 SITUATION/BACKGROUND

1.1 DHCW designs, develops, and supports both clinical and non-clinical, digital health care systems for NHS Wales Health Boards and Trusts. These systems span across primary and secondary care settings helping staff to work safely and efficiently. They are delivered via a combination of servers in data centres (a.k.a. on-premises) and cloud services.

1.2 The on-premises infrastructure that supports NHS Wales' National Services is managed by DHCW and hosted in two data centres using co-location services. This is where the data centre provider supplies the power and cooling, but all other operational responsibilities are with DHCW. For the purpose of this report, these data centres will be referred to as Data Centre 1 (DC1) and Data Centre 2 (DC2).

1.3 In August 2020, the provider for DC1 indicated that they no longer wished to provide data centre services and the contract expires on Sunday, 31st October 2021. Therefore, DHCW required a replacement Data Centre co-location capacity (DC3) and a move all services from DC1 prior to this date.

1.4 In order for DHCW to combine efforts in the movement and modernisation of infrastructure and acceleration of cloud adoption, mandate was provided to commence with the Data Centre Transition (DCT) Project.

1.5 At the May Digital Governance and Safety Committee meeting there was a request to describe the assurance processes surrounding the DCT project. These are described in this document.

2 SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 PROJECT APPROACH

The Data Centre Transition (DCT) Project was formed in September 2020 and the decision was made to procure specialist consultancy that could assist with the strategy, approach and costs for the data centre transition. The recommended approach, which has been adopted, was to use a combination of physical data centre moves and the migration of some infrastructure to the cloud. The services moving to the cloud as part of the project are those that host DHCW public facing digital services (e.g. websites - referred to as DMZ services) and DHCW test and development systems (known as TESTDEV).

2.2 PROJECT STRUCTURES

The DCT Project Team swiftly commenced with the progression of plans and activities through three workstreams, enabled and focused on delivering a safe transition of DHCW systems from DC1 to a new Data Centre/Hybrid Cloud by 31st October 2021.

Data Centre Procurement

Architecture and Infrastructure

Cloud

2.2.1 The **Data Centre Procurement and Relocation** workstream oversees the procurement of the replacement Data Centre (DC3) and relocation from DC1. Example work packages within this workstream include Data Centre Tender, Application and Infrastructure Preparation & Transition, the decommissioning of DC1.

2.2.2 The **Architecture and Infrastructure** workstream coordinated and controls the procurement, implementation and assurance of new architecture and infrastructure which will support the transition from DC1 to DC3.

2.2.3 The **Cloud workstream** oversees the design, implementation, and assurance of the NWIS Hybrid Cloud approach, as DHCW plan to migrate first major workloads to the Cloud.

2.2.4 In order to coordinate all workstream activities amongst DHCW Teams and Third Parties involved in the DCT Project, a number of weekly project meetings are taking place to track progress and resolve issues as they arise. These include:

- DCT Applications Subgroup
- DCT Finances Subgroup
- DCT Technical Subgroup
- DC3 Contract Review Meeting

2.3 PROJECT BOARD

A Project board has been established to oversee the work. The Chair and Project SRO is the DHCW Director of ICT and the Board has representatives from Local Health Boards, Welsh Government and various teams in DHCW including Technical, Finance and Procurement.

The Project Board meets monthly and provide a forum for the Programme and Project Managers to present Highlight Reports to invested stakeholders. The Board members also review and approve all key decisions. The DCT Project Team maintain Risk, Action, Issue and Decision (RAID) Logs. 'Open'

Risks/Issues are reviewed on a monthly basis and the highest rated ones are reviewed in detail at project board meetings.

2.4 PROJECT REPORTING

In addition to the afore mentioned highlight reports, the DCT Project Team complete monthly reports for the DHCW Management Board. There is also an opportunity to raise any urgent issues at the weekly DHCW Directors meeting.

2.5 PROJECT APPROACH TO PHYSICAL TRANSITION

Within the remit of the Architecture and Infrastructure workstream's network research and design activities, the decision was made to commission and test a new network at DC3, rather than migrate the existing network at DC1, which was reaching the end of its life. The new design allows for implementation of improved bandwidth and resilience and a more modern network whilst also lowering risk to National Services as they transition from DC1. A specialist Third-Party organisation has been used to help design and implement the new network at DC3.

All infrastructure is to be transitioned over a series of weekends between August and October. The transition will be carried out by a Transition Team that will be made up of DHCW Project and Technical Resources, in conjunction with the professional Third-Party transition company that was procured as part of the Replacement Data Centre tender. As a result of extensive planning, the following documents have been created, circulated, and presented at Project Board and National Service Management Boards:

- A Transition Batch Plan, containing details of the infrastructure and the hosted National Services that will be moved on each Transition Weekend
- A Transition Schedule, depicting what specific activities will be carried out over the duration of the Transition Weekends

Several workshops have been conducted to-date to 'walk through' these documents, align them with supporting technical documentation and ensure that all involved resources are informed of key activities and timings. The Transition Team have scheduled the order of weekends to allow for 'lessons learned' from simpler transitions in advance of more-complex transitions.
Some managed service' providers whose infrastructure is housed in DC1 have opted to move their own equipment. All of this activity is being coordinated via the Data Centre Procurement and Relocation workstream.

In order to minimise disruption during the planned works, all services which are geographically resilient (critical services) will be operating from DC2 for the duration of the physical moves. Disaster Recovery Plans have been updated and tested in advance. Operating from the alternative Data Centre lowers the risk of service disruption during Transition and although there is still a level of risk present, a scheduled Change Deterrent will assist in keeping this as low as possible.
All service providers have been advised to ensure their security patching is up to date in advance of the Transition Weekends, however, the application of security patches will continue throughout the period.

2.6 PROJECT APPROACH TO THE CLOUD TRANSITION

Different approaches for the Cloud transitions have been adopted. These have been taken in order to provide a balance between risk and speed of migration. These are described further below.

2.6.1 DMZ TO CLOUD

Under the remit of the Cloud workstream' design work package, it was determined that the best course of action for the DMZ environment was to use native Cloud IaaS/PaaS services.

The DCT Project Team commenced with coordinating and completing configuration of the required platform and conducted discovery meetings with DHCW Teams whose services reside in the DMZ. As part of this discovery, service-specific requirements were discussed, and each Service Owner was asked to complete a Cloud Risk Assessment (CRA) to further detail hosted data and supplement the required Data Protection Impact Assessment (DPIA) and all design, information governance and security elements were reviewed and approved.

This approval subsequently enabled resources involved in the Cloud workstream to plan and conduct the DMZ migrations. 54 virtual machines managed by DHCW have been migrated to the Cloud. The remaining 10 (managed by Third Parties) are on-track to migrate within project timescales.

2.6.2 TESTDEV TO CLOUD

The TESTDEV environment will be migrated to a Managed Virtual Server Farm Service. This will simply the migration process and will allow a faster migration of the circa 400 virtual machines. Due to the sensitivity of some of the information that is processed and/or tested via National Services in the DHCW Test and Development environments, similar governance procedures will be followed to those conducted for the DMZ to Cloud work package – Discovery, CRA and DPIA submission and approval. All actions, risks or issues will be assessed by the Principal Project Manager and escalated to the appropriate Information Governance representative, where required.

It is expected that all TESTDEV to Cloud migration activity will complete within project timescales.

2.7 COMMUNICATIONS APPROACH

A comprehensive communications plan has been produced for the DCT Project. Communications are agreed by the Project Board at each meeting, translated and shared widely within NHS Wales.

A Project SharePoint Site is also available with all the communications, the Transition Batch Plans and Frequently Asked Questions.

3 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 The charts below show a summary of the Risks and Issues for the DCT project

Data Centre Transition RAID Dashboard

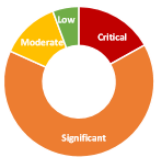
Risk
Assumptions
Issues
Dependencies

Risks Total 75

Original Score	#	Previous Month Percentage	Current Month Percentage	Percentage change
Critical	12	24%	18%	-6%
Significant	46	56%	63%	7%
Moderate	9	13%	12%	-1%
Low	4	8%	6%	-2%

Current Score	#	Previous Month Percentage	Current Month Percentage	Percentage change
Critical	2	7%	3%	-4%
Significant	38	46%	49%	4%
Moderate	27	37%	41%	4%
Low	8	10%	7%	-3%
Closed Risks	21			

Original Risk Score Profile



Mitigated Risk Score Profile

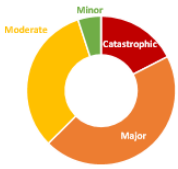
Impact score	
1	Insignificant
2	Minor
3	Moderate
4	Major
5	Catastrophic

Issues Total 40

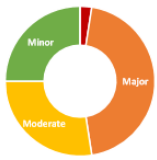
Original Score	#	Previous Month Percentage	Current Month Percentage	Percentage change
Catastrophic	7	18%	16%	-2%
Major	18	45%	44%	1%
Moderate	13	34%	35%	1%
Minor	2	5%	5%	0%
Insignificant	0	0%	0%	0%

Current Score	#	Previous Month Percentage	Current Month Percentage	Percentage change
Catastrophic	1	7%	0%	-7%
Major	18	41%	42%	1%
Moderate	11	30%	33%	3%
Minor	10	23%	26%	3%
Insignificant	0	0%	0%	0%
Closed Issues	8			

Original Issue Score Profile



Mitigated Issue Score Profile



3.2 There are two critical risks:

- Risk 1 - The COVID-19 pandemic could impact the resource available to continue the data centre transition project. This would impact our resourcing plans, timescales and quality management.
    - This risk particularly relates to the weekends of the physical moves.
- Risk 2 - Risk to the success of the Test/Dev migration due to outstanding ExpressRoute connectivity issues.
    - This is being actively progressed with Microsoft and BT (PSBA supplier).

The one issue with a score of 5 (Catastrophic) is: relating to the WCCIS system. The connectivity from the NHS network to the system is active via Data Centre 1. It is configured at Data Centre 2 but has not been tested. This work is now scheduled for Tuesday 3rd August. If successful, the impact of the issues will reduce significantly.

4 RECOMMENDATION

The Digital Governance and Safety Committee is being asked to:

Be **ASSURED** of processes surrounding the Data Centre Transition Project.

5 IMPACT ASSESSMENT

STRATEGIC OBJECTIVE	Mobilising digital transformation and ensuring high quality health and care data

CORPORATE RISK (ref if appropriate)	DHCW0268 - Data Centre Transition DHCW0205 - DMZ/Internet Failure at Data Centre

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

DHCW QUALITY STANDARDS	ISO 27001
If more than one standard applies, please list below:	

HEALTH CARE STANDARD	N/A
If more than one standard applies, please list below:	

EQUALITY IMPACT ASSESSMENT STATEMENT	Date of submission: N/A
No, (detail included below as to reasoning)	Outcome: N/A
Statement: N/A	

APPROVAL/SCRUTINY ROUTE:

Person/Committee/Group who have received or considered this paper prior to this meeting

COMMITTEE OR GROUP	DATE	OUTCOME

IMPACT ASSESSMENT	
QUALITY AND SAFETY	No, there are no specific quality and safety implications related to the activity outlined in this report.

IMPLICATIONS/IMPACT	
LEGAL IMPLICATIONS/IMPACT	Yes, please see detail below A competitive procurement was undertaken to select the new data centre provider and associated relocation services.
FINANCIAL IMPLICATION/IMPACT	Yes, please see detail below Additional funding has been secured from WG to support the procurement and transition activity. Differences in charges between the old and new data centre providers is being addressed from DHCW core funding. The funding of the cloud migration elements is being picked up from DHCW funds this financial year (savings due to phasing of recruitment) but on-going funding request will be included in the cloud business case that DHCW are producing.
WORKFORCE IMPLICATION/IMPACT	Yes, please see detail below There is a significant amount of activity associated with the DCT project – with impacts across many teams. This has been managed through the DHCW planning process. Additional contract resources have been used to supplement the staff in the core infrastructure and project management teams.
SOCIO ECONOMIC IMPLICATION/IMPACT	No. there are no specific socio-economic implications related to the activity outlined in this report

DIGITAL HEALTH AND CARE WALES
NHS WALES NATIONAL CLINICAL AUDIT AND OUTCOME REVIEW PLAN

Agenda Item	2.12

Name of Meeting	Digital Governance and Safety Committee
Date of Meeting	11 August 2021

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

Executive Sponsor	Rhidian Hurle, Medical Director and Chief Clinical Information Officer Wales
Prepared By	Darren Lloyd, DHCW Head of Information Governance and Data Protection Officer
Presented By	Darren Lloyd, DHCW Head of Information Governance and Data Protection Officer

Purpose of the Report	For Approval
Recommendation	
The Digital Governance and Safety Committee is being asked to: NOTE and ENDORSE the proposal, which will be presented to SHA Board in September, of DHCW acting as joint data controller with Healthcare Quality Improvement Partnership (HQIP) for the delivery of any project commissioned by HQIP as part of the National Clinical Audit and Patients Outcome Programme (NCAPOP).	

Acronyms			
HQIP	Healthcare Quality Improvement Partnership	DHCW	Digital Health and Care Wales
NCAPOP	National Clinical Audit and Patients Outcome Programme		

1 SITUATION/BACKGROUND

1.1 This paper sets out the Welsh Government proposed direction for the National Clinical Audit and Outcome Review Plan governance and data agreement responsibilities.

1.2 The management of the National Clinical Audit Programme is currently overseen within Population Healthcare Division in the Welsh Government. This includes obtaining Ministerial agreement to fund the programme, directing health boards regarding audit participation, working with NHS England and Healthcare Quality Improvement Partnership (HQIP) to oversee the arrangements of audit and ensuring health boards response to audit results.

1.3 Following developments between NHS England and HQIP, the management company overseeing the audit programme on behalf of England and Wales, it became apparent that a lack of joint data controller agreement between HQIP and a relevant national body with authority in Wales presents a significant risk. There is also a lack of documentation and formal governance between the various parties involved in the clinical audit process.

1.4 Extensive discussion with Welsh Government legal colleagues and information governance experts has determined Welsh Government cannot fulfil the role of data controller for the programme and that Digital Health and Care Wales (DHCW) would be the most appropriate body to perform this role.

1.5 To this end we are seeking to formalise this agreement and the roles and responsibilities required attached to this arrangement. Once formally agreed, DHCW will need to enter into discussions with HQIP as to the content of the data controller agreement and any logistical changes that accompanies this.

2 SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 Clinical audit is an integral component of the quality improvement process and is embedded within the Welsh healthcare standards. The requirement to participate and learn from audits is also a central component of condition specific guidance and frameworks across health.

2.2 The extant programme of audits for Wales includes the majority of audits currently supported by the National Clinical Audit and Patients Outcome Programme (NCAPOP) managed by the HQIP.

2.3 The Clinical Outcome Review Programme (formerly Confidential Enquiries) is commissioned by HQIP. The programme is designed to help assess the quality of healthcare and stimulate improvement in safety and effectiveness by systematically enabling clinicians, managers and policy makers to learn from adverse events and other relevant data.

2.4 As part of current arrangements, the programme is agreed by the Minister for Health and Social Services on an annual basis. The Welsh Government fund the cost of NHS Wales' participation in the National Clinical Audit and Clinical Outcome Review Programme and supports the process throughout the year. Welsh health boards and trusts provide the resources to enable their staff to participate in all audits, reviews and national registers included.

2.5 In England the programme is managed by their Executive, NHS England. As Wales has not historically had an Executive function, this role has been overseen by the Welsh Government. In 2021, NHS England signed a joint data controller agreement with HQIP. Following legal and governance advice, the Welsh Government has determined it cannot undertake this function. The creation of Digital Health and Care Wales allowed for provision within their functions for the responsibility of clinical audit.

2.6 The Welsh Government are looking to solidify the national approach to audit. This would include removing the annual agreement process and embedding national clinical audit as a key approach to NHS Wales, under the leadership of DHCW, ensuring those with the expertise and relevant powers oversee the programme and ensure any future programme works for Wales and the National Data Resource.

3 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 Action Required:

DHCW is being asked to:

- Act as joint data controller with HQIP for the delivery of any project commissioned by HQIP as part of the National Clinical Audit and Patients Outcome Programme;
- Provide national representation related to the audit programme;
- Approve pre-publication of data requests;
- Ensure health boards participate in mandatory audits relating to Wales;
- Identify data sharing opportunities to support clinicians and networks in Wales;
- Overcome information governance and data access issues; and
- Advise and support health boards in relation to audit matters.

3.2 Next steps:

- Paper presented to DHCW SHA Committee/Board for agreement
- WG to Write to HQIP to outline approach
- Welsh Health Circular issued to formalise the change

4 RECOMMENDATION

The Digital Governance and Safety Committee is being asked to:

NOTE and ENDORSE the proposal, which will be presented to SHA Board in September, of DHCW acting as joint data controller with HQIP for the delivery of any project commissioned by HQIP as part of the NCAPOP.

5 IMPACT ASSESSMENT

STRATEGIC OBJECTIVE	Driving value from data for better outcomes

CORPORATE RISK (ref if appropriate)	N/A

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:	

HEALTH CARE STANDARD	N/A
If more than one standard applies, please list below:	

EQUALITY IMPACT ASSESSMENT STATEMENT	Date of submission: N/A
No, (detail included below as to reasoning)	Outcome: N/A
Statement: N/A	

APPROVAL/SCRUTINY ROUTE:

Person/Committee/Group who have received or considered this paper prior to this meeting

COMMITTEE OR GROUP	DATE	OUTCOME
Digital Governance and Safety Committee	11/08/21	TBD
Management Board	19/08/21 or 16/09/21	TBD
SHA Board	30/09/21	TBD

IMPACT ASSESSMENT

QUALITY AND SAFETY	No, there are no specific quality and safety implications related to the activity outlined in this report.

IMPLICATIONS/IMPACT	
LEGAL IMPLICATIONS/IMPACT	Yes, please see detail below
	DHCW will be acting as joint data controller with HQIP. Welsh Government will be issuing a Welsh Health Circular.
FINANCIAL IMPLICATION/IMPACT	No, there are no specific financial implication related to the activity outlined in this report
WORKFORCE IMPLICATION/IMPACT	Yes, please see detail below
	As per 3.1.
SOCIO ECONOMIC IMPLICATION/IMPACT	No. there are no specific socio-economic implications related to the activity outlined in this report

DIGITAL HEALTH AND CARE WALES
RISK MANAGEMENT REPORT

Agenda Item	2.13

Name of Meeting	Digital Governance and Safety Committee
Date of Meeting	11th August 2021

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

Executive Sponsor	Chris Darling, Board Secretary
Prepared By	Chris Darling, Board Secretary
Presented By	Chris Darling, Board Secretary / Risk Owners

Purpose of the Report	For Discussion/Review

Recommendation

The Digital Governance and Safety Committee is being asked to:

NOTE the status of the Corporate Risk Register.
DISCUSS each of the Corporate Risks assigned to the Digital Governance & Safety Committee in detail.

Acronyms			
DHCW	Digital Health and Care Wales	ISD	Information Services Directorate
BAF	Board Assurance Framework	NDR	National Data Resource

1 SITUATION/BACKGROUND

1.1 Additionally, the DHCW Risk Management and Board Assurance Framework (BAF) Strategy was endorsed by the Audit and Assurance Committee, Digital Governance and Safety Committee and approved formally at the SHA Board on the 27th May. This outlined the approach the organisation will take to managing risk and Board assurance which highlighted that risks on the Corporate Register would be assigned to a Committee for further scrutiny.

2 SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 Committee members are asked to consider, in the context of DHCW Digital Government and Safety 'what could impact on the Organisation being successful in the short term (1 – 12 months) and in the longer term (12 – 36 months)'.

2.2 There are wider considerations regarding organisational factors which include, sector, stakeholder, and system factors, as well as National and International environmental factors.

2.3 In considering environmental factors members should note the: Global landscapes 2020 – World Economic Forum Long Term Global Risks Landscape (2020), and the HM Government National Risk Register (2020 edition), more can be found as Appendix A.

2.4 The below are extracts/summaries from the World Economic Forum Term Global Risks Landscape (2020) for international context and consideration by the Committee:

Consequences of Digital Fragmentation:

While digital technology is bringing tremendous economic and societal benefits to much of the global population, issues such as unequal access to the internet, the lack of a global technology governance framework and cyber insecurity all pose significant risk. Geopolitical and geo-economic uncertainty— including the possibility of fragmented cyberspace—also threaten to prevent the full potential of next generation technologies from being realized. Respondents to our survey rated "information infrastructure breakdown" as the sixth most impactful risk in the years until 2030.

Health Systems under new Pressures:

Health systems around the world are at risk of becoming unfit for purpose. New vulnerabilities resulting from changing societal, environmental, demographic and technological patterns threaten to undo the dramatic gains in wellness and prosperity that health systems have supported over the last century. Non-communicable diseases— such as cardiovascular diseases

and mental illness—have replaced infectious diseases as the leading cause of death, while increases in longevity and the economic and societal costs of managing chronic diseases have put healthcare systems in many countries under stress. Progress against pandemics is also being undermined by vaccine hesitancy and drug resistance, making it increasingly difficult to land the final blow against some of humanity's biggest killers. As existing health risks resurge and new ones emerge, humanity's past successes in overcoming health challenges are no guarantee of future results.

2.5 In terms of DHCW's Corporate Risk Register, there are currently 18 risks on the Corporate Risk Register, of which 15 are for the consideration of this Committee. Four risks are classified as private due to their sensitivity and will be received in the private session of the Committee. It should be noted that the Audit and Assurance Committee on the 6th July requested a deep dive review of the four private risks by the Digital Government and Safety Committee.

2.6 Committee members are asked to note the following changes to the Corporate Risk Register (new risks, risks removed and changes in risk scores) for the period ending 30th June:

NEW RISKS – 1 RISK

- DHCW0204 – Canisc System was e-escalated risk following a review of all Canisc risks with consolidation into one risk:

REMOVED – 1 RISK

- DHCW0266 – VPN Capacity was removed as a result of de-escalation. Mitigating actions were undertaken to implement split tunnelling on the VPN service for Office 365 traffic, this resulted in a reduction in demand on the service.

DECREASED SCORE – 2 RISKS

- DHCW0205 DMZ/Internet Failure risk score has decreased from 16 to 8 (a critical to a significant risk), following implementation of mitigating actions which included the completion of the planned service migration to the cloud and increased resilience in the datacentre.
- DHCW0228 Fault Domains risk score has decreased from 16 to 12 (a critical to a significant risk), following implementation of actions to mitigate the risk which included deployment of new equipment to increase the fault domains for some services.

2.7 The Committee are asked to consider the DHCW Corporate Risk Register Heatmap showing a summary of the DHCW risk profile which includes the 10 Significant and 5 Critical risks assigned to the Committee. The key indicates movement since the last risk report.

NB all Critical risks currently on the Corporate Risk Register are assigned to the Digital Governance and Safety Committee.

CONSEQUENCES	LIKELIHOOD				
	RARE (1)	UNLIKELY (2)	POSSIBLE (3)	LIKELY (4)	ALMOST CERTAIN (5)
CATASTROPHIC (5)			**DHCW0257 ⟷ **DHCW0261 ⟷	DHCW0204: **Canisc System** ⟷	
MAJOR (4)		DHCW0205: **DMZ/Internet Failures at Data Centre** ⬇ **DHCW0218 ⟷	DHCW0260: **Shielded Patient List** ⟷ DHCW0263: **DHCW Functions** ⟷ DHCW0264: **Data Promise** ⟷ DHCW0228: **Fault Domains** ⬇ DHCW0201: **Infrastructure Investment** ⟷ DHCW0268: **Data Centre Transition** ⟷	DHCW0269: **Switching Service** ⟷ DHCW0237: **Covid-19 Resource Impact** ⟷	
MODERATE (3)				DHCW0267: **Host Failures** ⟷ **DHCW0229 ⟷	
MINOR (2)					
NEGLIGIBLE (1)					

**Private Risks

★ New Risk ⟷ Non-Mover ⬇ Reduced ⬆ Increased

2.8 The overall status of the current 15 Corporate risks assigned to the Committee in relation to their initial score is as below.

Status	Risk References Significant	Risk References Critical
Increase from initial		DHCW0269, DHCW0204
Decrease from initial	DHCW0205, DHCW0228, DHCW0218	DHCW0257
Same as Initial	DHCW0268, DHCW0260, DHCW0263, DHCW0264, DHCW0201, DHCW0229	DHCW0261, DHCW0237, DHCW0267

2.9 Committee members are asked to consider the Deep Dive Risk Report template (Appendix B) for use where the Committee wants to focus on particular risks. Key areas of the report will be used to review all risks assigned to the DG&S Committee with a focus on the current risk score, the target risk score, the mitigating action taken to date and the additional action required to achieve the target risk score and associated timeframes for doing so.

3 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 The Committee is asked to note the changes in the risk profile during the reporting period as a result of the update in the scoring of two service interruption risks and the removal of the VPN capacity risk from the corporate risk register and the addition of the overarching Canisc risk as replacement of multiple previous risks.

4 RECOMMENDATION

4.1 The Committee is being asked to:
NOTE the status of the Corporate Risk Register.
DISCUSS each of the Corporate Risks assigned to the DG&S Committee in detail, with the Risk Owner taking Committee members through the current risk position.

5 IMPACT ASSESSMENT

STRATEGIC OBJECTIVE	Delivering High Quality Digital Services

CORPORATE RISK (ref if appropriate)	All are relevant to the report

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

DHCW QUALITY STANDARDS	ISO 9001
If more than one standard applies, please list below: ISO 14001 ISO 20000 ISO 27001 BS 10008	

HEALTH CARE STANDARD	Governance, leadership and acccountability
If more than one standard applies, please list below: Safe Care Effective Care	

EQUALITY IMPACT ASSESSMENT STATEMENT	Date of submission: N/A
No, (detail included below as to reasoning)	Outcome: N/A
Statement: Risk Management and Assurance activities, equally effect all. An EQIA is not applicable.	

APPROVAL/SCRUTINY ROUTE: Person/Committee/Group who have received or considered this paper prior to this meeting		
COMMITTEE OR GROUP	DATE	OUTCOME
Risk Management Group	1st June, 5th July	Discussed and Verified
Audit and Assurance Committee	6th July	Reviewed and Discussed
Management Board	15th July 2021	Discussed
SHA Board	29th July 2021	Reviewed

IMPACT ASSESSMENT	
QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes, please see detail below
	Additional scrutiny and clear guidance as to how the organisation manages risk has a positive impact on quality and safety.
LEGAL IMPLICATIONS/IMPACT	Yes, please see detail below
	Should effective risk management not take place, there could be legal implications
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.
	The members of the Management Board will be clear on the expectations of managing risks assigned to them.
SOCIO ECONOMIC IMPLICATION/IMPACT	No. there are no specific socio-economic implications related to the activity outlined in this report

Appendix A: [World Economic Forum Long Term Global Risks Landscape (2020)]

Top 10 risks in terms of **Likelihood**

1. Extreme weather
2. Climate action failure
3. Natural disasters
4. Biodiversity loss
5. Human-made environmental disasters
6. Data fraud or theft
7. Cyberattacks
8. Water crises
9. Global governance failure
10. Asset bubbles

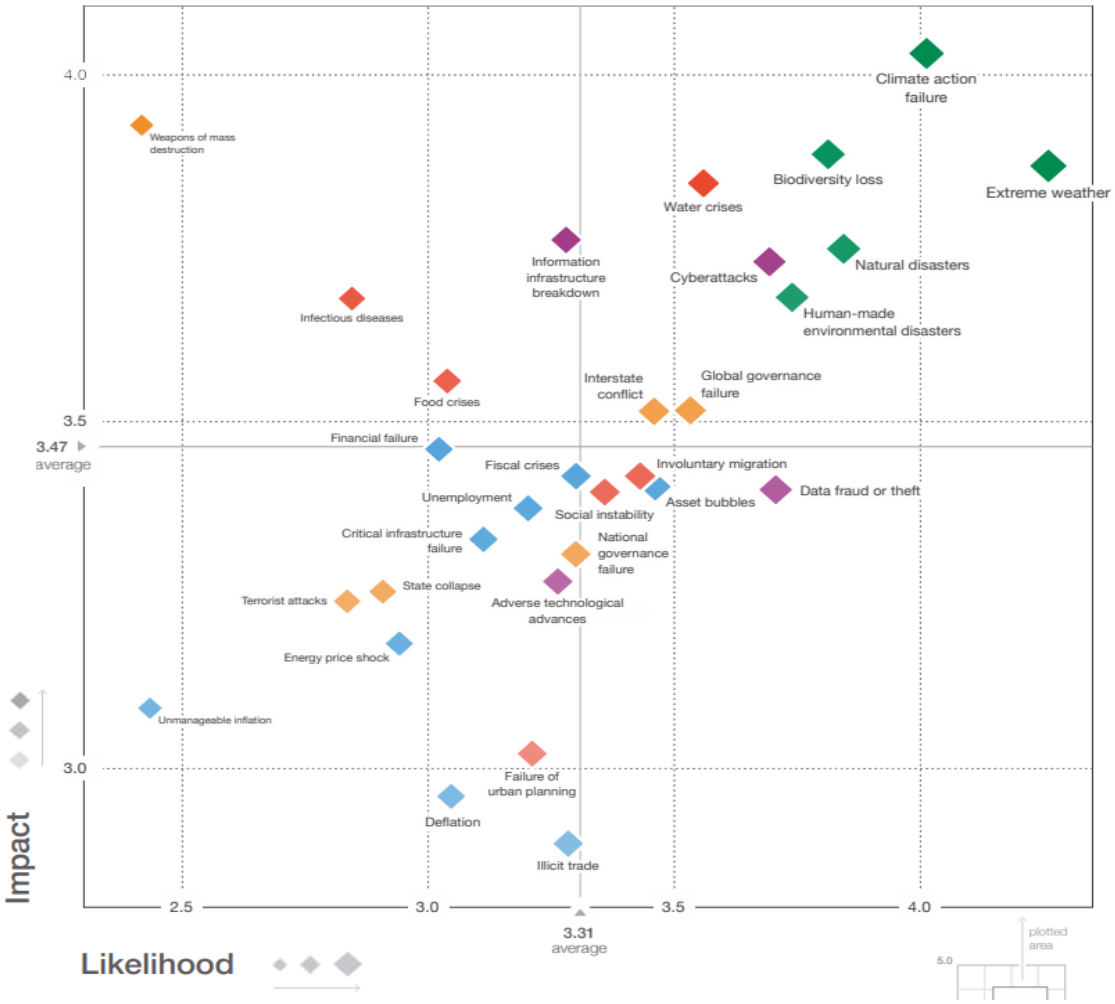
Top 10 risks in terms of **Impact**

1. Climate action failure
2. Weapons of mass destruction
3. Biodiversity loss
4. Extreme weather
5. Water crises
6. Information infrastructure breakdown
7. Natural disasters
8. Cyberattacks
9. Human-made environmental disasters
10. Infectious diseases

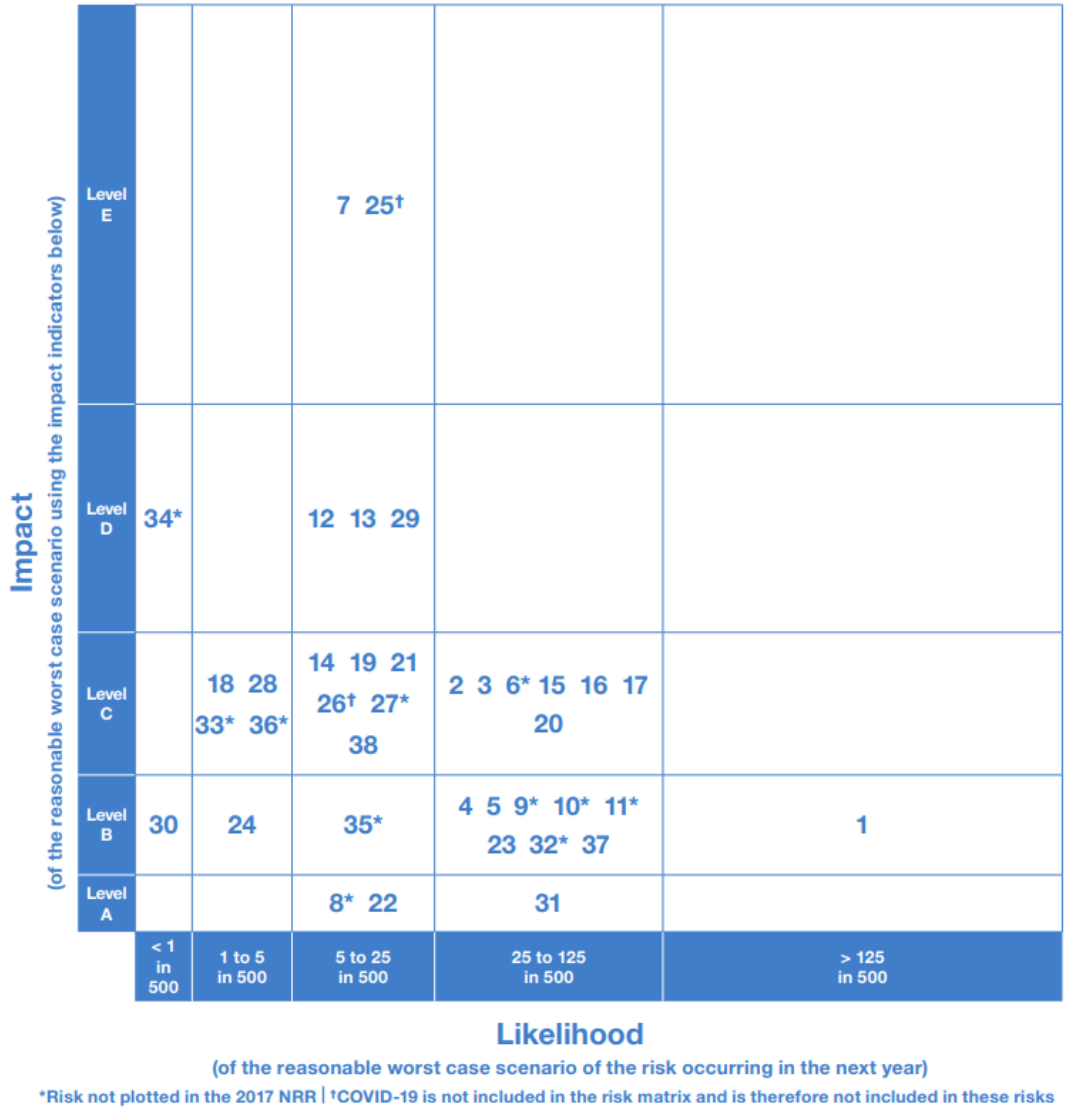
Categories

- Economic
- Environmental
- Geopolitical
- Societal
- Technological

Figure II: The Global Risks Landscape 2020



The HM Government National Risk Register (2020 edition)



Malicious Attacks
1. Attacks on publicly accessible locations
2. Attacks on infrastructure
3. Attacks on transport
4. Cyber attacks
5. Smaller scale CBRN attacks
6. Medium scale CBRN attacks
7. Larger scale CBRN attacks
8. Undermining the democratic process*

Serious and Organised Crime
9. Serious and organised crime – vulnerabilities*
10. Serious and organised crime – prosperity*
11. Serious and organised crime – commodities*

Environmental Hazards
12. Coastal flooding
13. River flooding
14. Surface water flooding
15. Storms
16. Low temperatures
17. Heatwaves
18. Droughts
19. Severe space weather
20. Volcanic eruptions
21. Poor air quality
22. Earthquakes
23. Environmental disasters overseas
24. Wildfires

Human and Animal Health
25. Pandemics†
26. High consequence infectious disease outbreaks†
27. Antimicrobial resistance*
28. Animal diseases

Major Accidents
29. Widespread electricity failures
30. Major transport accidents
31. System failures
32. Commercial failures*
33. Systematic financial crisis*
34. Industrial accidents – nuclear*
35. Industrial accidents - non nuclear*
36. Major fires*

Societal Risks
37. Industrial action
38. Widespread public disorder

Appendix B: DHCW Deep Dive Risk Report Template

DHCW RISK DEEP DIVE REPORT - To be completed by the Risk Owner			
Date of Report:			
Orginator:		Probability Rating (1-5):	
Risk Name:		Impact Rating (1-5):	
Risk Reference ID:		Initial Score:	
Target Score:		Current Score:	
Background: (a brief background history of the risk being reviewed)			
Risk Description (IF….THEN…..RESULTING IN…..) (Risk descriptions to include details of the associated impact)			
Mitigating Action Taken to Date: (Detail the actions already undertaken to mitigate the risk impact)			
Further Mitigation to Achieve Target Risk Score: (Detail the further actions required to achieve the target risk score and associated timeframes if known)			
Committee Comments/Feedback (To be included after the meeting)			

2.13i Corporate Risk Register – Risks Assigned to the Digital Governance and Safety Committee

Domain	Risk Ref	Risk Description	Risk level (Initial score)	Risk level (Current score)	Current Likelihood score	Current Impact score	Risk level (Target score)	Target Likelihood score	Target Impact score	Action Status	Last Reviewed	Next Review	Risk Owner	Trend (during reporting period)
Business & Organisational	DHCW0268	**Data Centre Transition** **IF** the dates for the data centre physical transition need to moved from Quarter 2 into Quarter 3, **THEN** there may be a resource constraint in various teams **RESULTING IN** a risk of failing to deliver some items in the annual plan and the risk of increased costs.	12	9	Possible 3	Moderate 3	4	Likely 4	Insignificant 1	Project team to liaise closely with other DHCW teams to take a holistic view to re-planning and to minimise the risk of disruption to the plan and keep costs to a minimum	15/07/21	02/08/21	Director of ICT	Non-Mover
	DHCW0269	**Switching Service** **IF** the current switching service fails **THEN** no new data will be acquired into the ISD Data Warehouse **RESULTING IN** the inability to provide updates to multiple reporting systems.	9	16	Likely 4	Major 4	6	Unlikely 2	Moderate 3	Further engagement with NDR Team to consider acceleration of the switching service replacement as part of the wider requirement for the acquisition of data into NDR.	15/07/21	02/08/21	Deputy Director of Informati on	Non-Mover
Clinical	DHCW0260	**Shielded Patient List** **IF** ISD are required to maintain the Shielded Patient List using current processes with significant manual intervention **THEN** the inherent risk of human error will persist **RESULTING IN** the possible incorrect identification of patients on the list.	12	12	Possible 3	Major 4	4	Rare 1	Major 4	ISD and NDR team are working with a third party on development of an automation process. This should remove the requirement for manual intervention and hence human error.	15/07/21	02/08/21	Deputy Director of Informati on	Non-Mover
Information Governance	DHCW0263	**DHCW Functions** **IF** directions from Welsh Government do not provide a sound legal basis for the collection, processing and dissemination of Welsh resident data **THEN** (i) partners, such as NHS Digital, may stop sharing data, (ii) DHCW may be acting unlawfully if it continues to process data **RESULTING IN** (i) DHCW being unable to fulfil its intended functions regarding the processing of data, or, in the case of	12	12	Possible 3	Major 4	4	Rare 1	Major 4	Actions set against Welsh Government to define a set of Directions that will enable DHCW to move forwards on BAU and to provide cover for important functions such as NDR	15/07/21	02/08/21	Medical Director	Non-Mover

2.13i Corporate Risk Register – Risks Assigned to the Digital Governance and Safety Committee

Domain	Risk Ref	Risk Description	Risk level (Initial score)	Risk level (Current score)	Current Likelihood score	Current Impact score	Risk level (Target score)	Target Likelihood score	Target Impact score	Action Status	Last Reviewed	Next Review	Risk Owner	Trend (during reporting period)
		continued processing, (ii) legal challenge, or (iii) the need to submit a further application to the Confidentiality Advisory Group (which may not be successful) to assess the public interest in processing confidential data without a legal basis or consent.												
	DHCW0264	**Data Promise** **IF** the national conversation regarding the use of patient data (Data Promise) is delayed **THEN** stakeholders and patients will not be assured that the proposed uses of Welsh resident data include sufficient controls to ensure data is treated responsibly, handled securely and used ethically **RESULTING IN** (i) potential challenges to proposed uses of data, and/or a loss of public/professional confidence, and (ii) a failure to realise the desired outcomes regarding 'data and collaboration' (effective and innovative uses of data, joined up services, better outcomes for individuals) set out in Welsh Government's Digital Strategy.	12	12	Possible 3	Major 4	4	Rare 1	Major 4	Specific responsibilities for implementation of the Data Promise given to the Head of Digital Strategy/Technology, Digital & Transformation, WG	15/07/21	02/08/21	Medical Director	Non-Mover
Project	DHCW0237	**Covid-19 Resource Impact** **IF** new requirements for digital solutions to deal with Covid-19 and recovery of services continue to come in, **THEN** staff may need to be moved away from other deliverables in the plan **RESULTING IN** non delivery of our objectives and ultimately a delay in benefits being realised by the service.	16	16	Likely 4	Major 4	9	Possible 3	Moderate 3	The 2021/22 DHCW Plan was approved by the DHCW Board in May subject to detailed feedback from Welsh Government. Ongoing assessment of impact of new requirements being managed by the Planning and Performance Management group and Planning team.	15/07/21	02/08/21	Chief Operating Officer	Non-Mover

2.13i Corporate Risk Register – Risks Assigned to the Digital Governance and Safety Committee

Domain	Risk Ref	Risk Description	Risk level (Initial score)	Risk level (Current score)	Current Likelihood score	Current Impact score	Risk level (Target score)	Target Likelihood score	Target Impact score	Action Status	Last Reviewed	Next Review	Risk Owner	Trend (during reporting period)
Service Interruption	DHCW0205	**DMZ/Internet Failure at Data Centre** **IF** a failure of the DMZ network or Internet Circuit in Data centre 1 occurred **THEN** DHCW patient facing digital services would be unavailable for users **RESULTING IN** service downtime and reputational damage.	12	8	Unlikely 2	Major 4	4	Unlikely 2	Minor 2	All migrations of the planned services from Datacentre 1 DMZ to Azure have now completed. The MURA service is resilient across multiple Azure Data Centres, but other services are in a single Azure data centre. A single Azure data centre has increased resilience compared to the Datacentre 1 arrangement, so likelihood is being reduced to 'unlikely'.	15/07/21	02/08/21	Director of ICT	Reduced by 8
	DHCW0228	**Fault Domains** **IF** fault domains are not adopted across the infrastructure estate **THEN** a single failure could occur **RESULTING IN** multiple service failures.	16	12	Possible 3	Major 4	6	Unlikely 2	Moderate 3	New equipment being deployed which will increase fault domains for some services. A Cloud Strategy and Business Case is being developed with a view of using Cloud services to provide the required fault domains	15/07/21	02/08/21	Director of ICT	Reduced by 4
	DHCW0201	**Infrastructure Investment** **IF** recurrent funding is not available to support the replacement of obsolete infrastructure **THEN** the risk of failure and under performance will increase **RESULTING IN** service disruption.	12	12	Possible 3	Major 4	4	Rare 1	Major 4	A revised infrastructure Business Case and Funding Requirement needs to be developed and submitted to secure additional funding	15/07/21	02/08/21	Director of ICT	Non-Mover
	DHCW0204	**Canisc System** **IF** there is a problem with the unsupported software used within the Canisc system **THEN** the application will fail **RESULTING IN** disruption to operational service requiring workarounds.	15	20	Likely 4	Catastrophic 5	6	Unlikely 2	Moderate 3	All Canisc Programme risks have been recently reviewed. All available mitigations are now complete. Being discussed and reviewed by SMB. The Cancer Informatics Programme has been accelerated to iteratively mitigate risk of disruption to services should Canisc fail.	15/07/21	02/08/21	Medical Director	Non-Mover

2.13i Corporate Risk Register – Risks Assigned to the Digital Governance and Safety Committee

Domain	Risk Ref	Risk Description	Risk level (Initial score)	Risk level (Current score)	Current Likelihood score	Current Impact score	Risk level (Target score)	Target Likelihood score	Target Impact score	Action Status	Last Reviewed	Next Review	Risk Owner	Trend (during reporting period)
	DHCW0267	**Host Failures** **IF** a host fails on one of the virtual server environments **THEN** some guests may fail to migrate seamlessly to other hosts **RESULTING IN** some servers failing to recover.	12	12	Likely 4	Moderate 3	6	Unlikely 2	Moderate 3	The periodic crashing issue continues. Latest recommendation is to install some new hardware in the servers. This is on order and will be installed in a controlled way when they are delivered.	15/07/21	02/08/21	Director of ICT	Non-Mover