Enw y Grŵp/Is-Bwyllgor: Name of Group:	**Information Governance Sub-Committee (IGSC)**
Cadeirydd y Grŵp/Is-Bwyllgor: Chair of Group:	**Huw Thomas, Director of Finance**
Cyfnod Adrodd: Reporting Period:	**30th November 2022**

Y Penderfyniadau a'r Materion a Ystyriodd y Grŵp/Is-Bwyllgor:
Key Decisions and Matters Considered by the Group:

Information Governance Sub-Committee – Terms of Reference
A revised set of terms of reference (ToR) was considered by the Sub-Committee. Members requested minor amendments, which were actioned and are attached for Committee approval at Appendix 1.

Policies and Procedures:
The Sub-Committee received the following policy for approval.

- 250 -Information Assurance Policy – attached at Appendix 2 for Committee approval.

The Sub-Committee agreed a number of extensions for policies, which will be staggered and submitted to forthcoming Sub-Committee meetings. The Committee is requested to approve the extension of the policies, attached at Appendix 3, whilst they are under review:

Clinical Coding Update
The Sub-Committee received a paper outlining the potential use of clinical coding within the Health Board. The Sub-Committee commended the Clinical Coding team for the uses of coding data and noted that the team is still achieving the coding completeness targets.

Information Quality Assurance (IQA) Data Quality
The Sub-Committee received an update on data quality within the Health Board. Members were introduced to a scoring approach of 1 to 5 (1 being very poor and 5 being excellent) that will be applied across systems, data types and data quality dimensions. This scoring will be pre-defined for the accuracy and completeness data quality dimensions however, the timeliness dimension will be dependent on the data being collected. Members welcomed the approach to make this meaningful to allow further comparison across systems, modules and datasets, with the intended approach to provide a summary of the output to key groups. This will provide the Health Board with the assurances, or kite mark, for the quality of the data included within systems. The Sub-Committee requested that updates are to be brought back to future meetings.

Workforce Privacy Notice
The Sub-Committee was requested to approve amendments to the Workforce Privacy Notice. The Notice is designed to help staff understand how personal information is collected, used, processed and shared, and to help them understand and exercise their privacy rights. The Privacy Notice has been updated to the same format as the main Patient Privacy Notice, with additional information added in terms of what information is used for and who it is shared with. This additional information covers systems where Data Protection Impact Assessments (DPIAs)

have been completed and reference the type of processing or the system in use. The Privacy Notice also now contains information about sharing information for the National Fraud Initiative

IG Toolkit Submission
The Sub-Committee was notified of the areas that require improvement, which will assist in informing the Health Board on the intended actions for Information Governance (IG) improvement. It will also provide re-assurance to staff and patients that their information is processed securely and appropriately, and equally assure other organisations where sharing is made that appropriate IG arrangements are in place. The specific areas that require further work are as follows:

- Section 2.7 Privacy Electronic Communications Regulations (PECR)
- Section 6.1 Physical Security Measures
- Section 6.6 Surveillance Systems

Members were assured that work is underway in all of these areas, and these areas will be improved by the submission date of 31st January 2023. The Chair also requested that the reporting officers attend the next meeting to provide assurances that progress is being made.

Caldicott: Principles into Practice (CPiP) Out-turn Report 2021 – 2022
Members received the latest CPiP report. The IG team has also developed an improvement plan, which will run concurrently with the IG toolkit work plan but will draw on those elements where there is an equivalence within the toolkit. The assessment shows an increased compliance with the previous year's assessment, having 36 standards being fully compliant and 5 being partially compliant. The table below highlights the improvements:

Year of submission	Full Compliance	Partial Compliance	Non-Compliance	Percentage of compliance
2021 – 2022	36	5	0	93%
2020 – 2021	29	12	0	86%
2019 – 2020	29	12	0	86%
2018 – 2019	28	9	4	76%

Microsoft Office 365 – Legal Hold
The Sub-Committee was asked to agree on the Health Board's position in relation to litigation hold. The decision will then need to be communicated to national team in Digital Health and Care Wales (DHCW). Members were taken through the history behind the decisions and noted the complexity and impact upon NHS Wales, given that NHS Wales is covered under one Microsoft tenancy. The Sub-Committee approved the following:

- Remove the routine application of litigation hold for all users
- Continue the approach of only applying the litigation hold for users on a designed list .

Information Commissioner Office (ICO) Notifications
Since April 2022, there have been 4 occurrences when a notification to the ICO has been required. The following table highlights the current notifications:

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Open	1	0	2	0	1	0	0	-	-	-	-	-	4
Closed	-	-	-	-	-	-	-	-	-	-	-	-	0
Total	1	0	2	0	1	0	0	0	0	0	0	0	4

Unauthorised Access to Patients Records – Poster Campaign
The Sub-Committee received a report on an Information Governance Poster campaign to raise awareness of staff obligations around patient confidentiality. The Health Board has seen an increase in personal data breaches that have required reporting to the Information Commissioners Office. These breaches relate to Inappropriate Access to Patient Records. The IG Team will continue to raise awareness in the hope that staff realise the consequences that may occur if they do not use patient systems correctly. Posters have been distributed to all acute sites, with the community sites following in the new year. A video has also been produced, which will enforce the message and raise awareness of the campaign. These actions help to demonstrate the Health Board's commitment to the Accountability Principle under Data Protection legislation.

Cyber Security and Network and Information Systems (NIS) Directive Update
A separate report has been prepared for presentation to the In-Committee meeting of the Sustainable Resources Committee to provide an update on progress of Cyber Security.

Materion y Mae Angen Ystyriaeth neu Gymeradwyaeth Lefel y Pwyllgor Adnoddau Cynaliadwy:
Matters Requiring Sustainable Resources Committee Level Consideration or Approval:

- Approval of the IGSC Terms of Reference, attached at Appendix 1
- Approval of the following policies:
  - 250 – Information Assurance Policy, attached at Appendix 2
- Approval of the extension of the policies, attached at Appendix 3, whilst they are under review

Risgiau Allweddol a Materion Pryder:
Key Risks and Issues / Matters of Concern:

- No risks or matters of concern to be considered

Busnes Cynlluniedig y Grŵp/Is-Bwyllgor ar Gyfer y Cyfnod Adrodd Nesaf:
Planned Group/Sub-Committee Business for the Next Reporting Period:

Adrodd yn y Dyfodol:
Future Reporting:

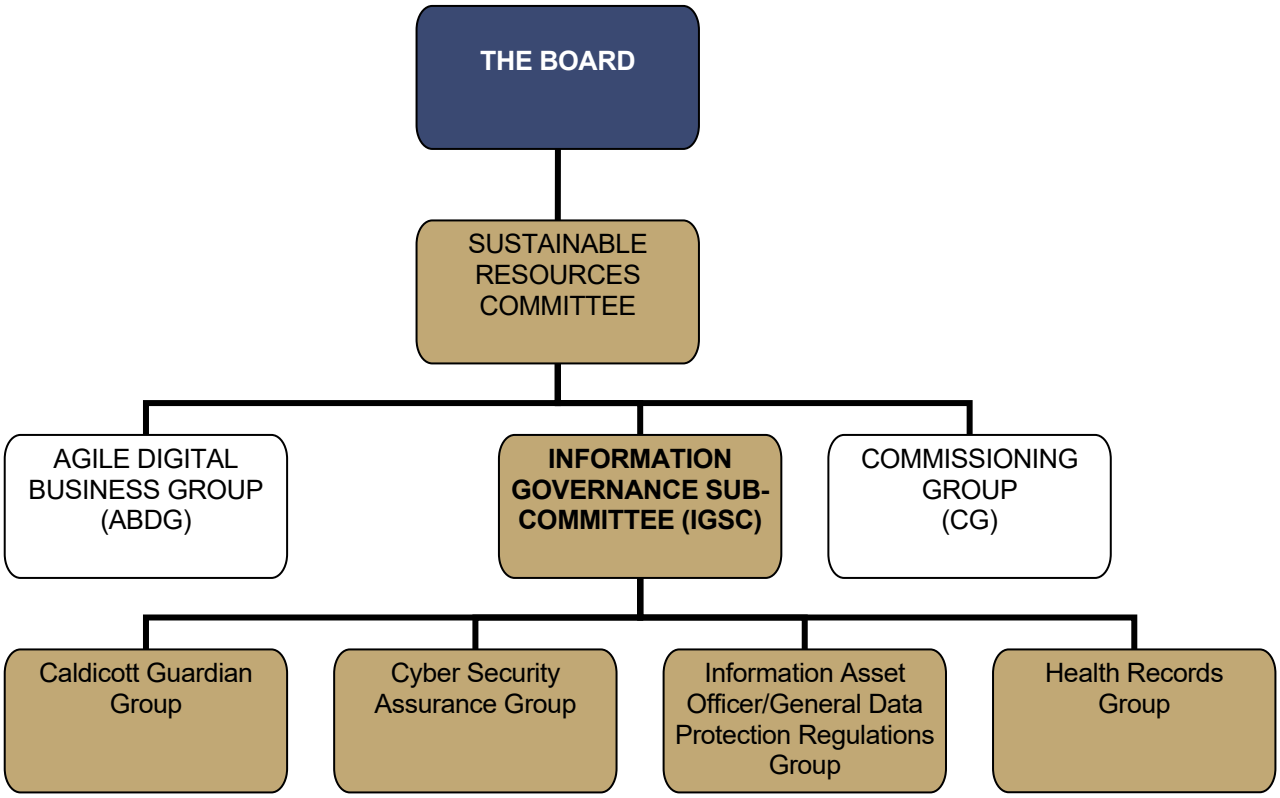
- Information Asset Owners and Information Asset Mapping Update
- Data Quality and Clinical Coding
- Information Governance Risk Register
- Information Governance Toolkit improvement plan
- Update on Cyber Security / NISR
- Caldicott Register to be returned to the IGSC meetings
- Digital / IG Policies and Procedures

Dyddiad y Cyfarfod Nesaf:
Date of Next Meeting:

31st January 2023

Appendix 3

Policy or Procedure	Action Required / Current Position
275 Secure Transfer of Personal Information Policy	To be presented at the January 2023 meeting of IGSC
172 Confidentiality Policy	To be presented at the January 2023 meeting of IGSC
238 Information Governance Framework	To be presented at the January 2023 meeting of IGSC
279 Third Party Supplier Policy	To be presented at the January 2023 meeting of IGSC
193 Retention and Destruction of Records Policy	To be presented at the January 2023 meeting of IGSC
174 Reuse of Public Sector Information Procedure	To be presented at the January 2023 meeting of IGSC
191 Health Records Management Policy	To be presented at the March 2023 meeting of IGSC
192 Health Records Management Strategy	To be presented at the March 2023 meeting of IGSC
282 Network Security Policy	To be presented at the March 2023 meeting of IGSC
319 Disposal of ICT assets Policy	To be presented at the March 2023 meeting of IGSC
320 Acceptable Use of Information and Communication Technology Policy	To be presented at the March 2023 meeting of IGSC
240 Informatics Procurement & Request Procedure	To be presented at the March 2023 meeting of IGSC
422 Consumer Device Policy	To be presented at the March 2023 meeting of IGSC



TERMS OF REFERENCE

INFORMATION GOVERNANCE SUB-COMMITTEE

Version	Issued to:	Date	Comments
V.1	Information Governance Sub Committee Integrated Governance Committee	25th November 2010 21st December 2011	Approved Approved
V.2	Information Governance Sub Committee Integrated Governance Committee	11th November 2011 20th December 2012	Approved Approved
V.3	Information Governance Sub Committee Integrated Governance Committee	14th March 2013 23rd April 2013	Approved Approved
V.4	Information Governance Sub Committee Integrated Governance Committee	14th March 2014 22nd April 2014	Approved Approved
V.5	Information Governance Sub Committee Integrated Governance Committee	13th March 2015 28th April 2015	Approved Approved
V.6	Information Governance Sub Committee	19th June 2015	Approved
V.7	Information Governance Sub Committee	27th July 2015	Approved
V.8	Business Planning & Performance Assurance Committee	25th August 2015	Approved
V.9	Information Governance Sub-Committee	27th November 2015	Approved
V.10	Business Planning & Performance Assurance Committee	22nd August 2017	Approved

V.11	Information Governance Sub-Committee	30th July 2018	Approved
V.12	Information Governance Sub-Committee Business Planning & Performance Assurance Committee	11th December 2019 17th December 2019	Approved Approved
V.13	Information Governance Sub-Committee	2nd September 2020	Approved
V.14	People Planning & Performance Assurance Committee	Via Chair's Action	Approved
V.15	Information Governance Sub-Committee Sustainable Resources Committee	12th October 2021 28th October 2021	Approved Approved
V.16	Information Governance Sub-Committee	~~Date to be inserted~~30th November 2022	To be approved outside of the meeting
V.16	Sustainable Resources Committee	20th ~~th~~ December 2022	

INFORMATION GOVERNANCESUB-COMMITTEE

1. Constitution

1.1 The Information Governance Sub-Committee (the Sub-Committee) was established as a Sub-Committee of the Sustainable Resources Committee and was constituted from 25th November 2010.

2. Principal Duties

2.1 The purpose of the Information Governance Sub-Committee is to provide assurance to the Sustainable Resources Committee (SRC), which is a Committee of the Board, on compliance with information governance legislation, guidance and best practice, and to:

2.1.1 Provide evidence based and timely advice to assist the University Health Board (UHB) in discharging its functions and meeting its responsibilities with regard to the quality and integrity; safety and security; and appropriate access and use of information (including patient and personal information) to support its provision of high-quality healthcare.

2.1.2 Provide assurance in relation to the Board's arrangements for creating, collecting, storing, safeguarding, disseminating, sharing, using and disposing of information in accordance with its stated objectives; legislative responsibilities, e.g., the Data Protection Act 2018, UK General Data Protection Regulations 2016, Freedom of Information Act 2000 and Network and Information Systems Regulation 2018; and any relevant requirements, standards and codes of practice.

2.1.3 Provide assurance that risks relating to information governance are being effectively managed across the whole of the UHB's activities (including for hosted and contracted services, through shared services, partnerships, independent contractors and Joint Committees as appropriate).

3. Operational Responsibilities

3.1 The Sub-Committee will, in respect of its provision of assurance/advice to the Sustainable Resources Committee:

3.1.1 Promote and develop a robust information governance and security framework within the UHB and encourage a strong information governance and security culture across the organisation.

3.1.2 Ensure that good information governance practice is integrated into service and project delivery plans and pathways across the UHB.

3.1.3 Ensure openness, security, quality and legal compliance in all information produced, utilised and reported by the UHB and its partners.

3.1.4 In conjunction with key committees / sub-committees / groups, develop appropriate systems, policies, work plans, procedures and accountability based on innovation and best practice for the effective management of information, including (but not restricted to) the areas of:

- Information and Cyber Security (Inc. Senior Information Risk Officer - SIRO related issues)
- Information Sharing Protocols
- Contracts, partnership and third party and supplier agreements
- Confidentiality and Data Protection
- Freedom of Information
- Subject Access Requests
- Records Management
- Information Quality Assurance / Data Quality
- Risk Management and Incident Management
- Data Protection Impact Assessments
- Patient records
- Clinical Coding

3.1.5 Be responsible for recommending policies and procedures relating to information governance to the Sustainable Resources Committee, for approval.

3.1.6 Monitor the UHB's compliance against relevant statutory requirements, internal and external standards and assessment criteria, via the Information Governance Toolkit, Caldicott Principles into Practice (CPIP), Cyber Assessment Framework (CAF) any other relevant requirements / assessments, and audits, inspections and reviews, including the implementation of Audit Wales, Health Inspectorate Wales and Internal Audit recommendations.

3.1.7 Provide appropriate information governance assurance in relation to any high-level projects and plans that are monitored through and reported to the Sustainable Resources Committee including the UHB's performance management framework and reporting template.

3.1.8 Develop, and performance manage action plans to achieve information governance and security objectives and direct and co-ordinate the work of the individuals and Groups involved with aspects of information governance within the UHB. Ensure that action plans and work programmes align with the UHB's Annual / Integrated Medium Term Plans (IMTP) where appropriate.

3.1.9 Inform and report the UHB's performance, action plans, and identified risks connected to information governance and information security to the Sustainable Resources Committee.

3.1.10 Provide assurance to the Sustainable Resources Committee in relation to the organisation's arrangements for managing information and cyber security incidents including emergency preparedness, resilience and response and business continuity.

3.1.11 Provide a forum for discussion and debate on any ad-hoc information governance issues. This will include receiving and enacting information governance issues arising from the implementation of national systems directed for use within the UHB.

3.1.12 Develop an annual work plan and report, for sign off by the Sustainable Resources Committee, that addresses identified risks and priorities, meets relevant statutory and good practice requirement and is consistent with the strategic direction and organisational objectives of the organisation.

3.1.13 Provide assurance to the Sustainable Resources Committee that, wherever possible, work plans are aligned with partnership plans and developed with local authorities, universities, collaboratives, alliances and other key partners.

3.1.14 Take forward any work identified by the Sustainable Resources Committee as required to feed into the UHB's planning cycle.

3.1.15 Agree issues to be escalated to the Sustainable Resources Committee with recommendations for action.

3.1.16 Consider the information governance implications for the UHB of review reports and actions arising from the work of external reviewers.

3.1.17 Ensure that there is a process of Data Protection Impact Assessment in accordance with Information Commissioner's guidance.

3.1.18 Ensure the UHB is meeting its legislative responsibilities, e.g., data protection and freedom of information legislation, as well as complying with national information governance policies and Information Commissioner's Office guidance.

3.1.19 Provide assurance on cyber security requirements, including:

3.1.19.1 The promotion of information security throughout the UHB.
3.1.19.2 The review and recommendation for the approval of all information security related policies and procedures.
3.1.19.3 The monitoring of progress in programmes to achieve compliance / certification with ISO27001.
3.1.19.4 The monitoring of progress in programmes to achieve compliance / certification with Cyber Essentials Plus.
3.1.19.5 The review and monitoring of security incidents both locally and nationally, identifying their root cause, any resolution and future prevention.
3.1.19.6 Reviewing information security risk assessments and improvement plans.
3.1.19.7 Consideration of solutions to improve security.
3.1.19.8 Monitoring and auditing compliance with standards and policies.

3.1.19.9 Receiving and reviewing information security related reports (e.g. Internal Audit).

3.1.19.10 Reviewing and commenting upon the security impact of information system development.

3.1.19.11 Reviewing, and recommending for approval, the information security elements of the annual IG toolkit submission.

4. Membership

4.1 The membership of the Sub-Committee shall comprise:

Title
Digital Director (Deputy SIRO) (Chair)
Medical Director/Deputy CEO (Caldicott Guardian)
Associate Medical Director Professional Standards/ Deputy Caldicott Guardian (Vice Chair)
Independent Member
Head of Information Governance
Head of Information Services
Health Records Manager
Information Governance Manager(s)
Assistant Director of Workforce and OD
Deputy Digital Director
Cyber Security Senior Specialist
Mental Health Representative
Nursing Representative
Therapies & Health Sciences Representative
County/Community Representative
Primary Care Representative
Head of Digital Operations
Estates and Facilities Representative
Clinical Engineering Representative
Corporate Archivist
In Attendance
Information Governance Officer(s)
Information Asset Owners

4.2 The membership of the Sub-Committee will be reviewed on an annual basis.

5. Quorum and Attendance

5.1 A quorum shall consist of no less than 6 and must include as a minimum either the Chair (Digital Director) or the Vice Chair (Associate Medical Director Professional Standards/ Deputy Caldicott Guardian), either the Caldicott Guardian (Medical Director /Deputy CEO) or the Deputy Caldicott Guardian (AMS Leadership & Professional Standard) and the Independent Member for scrutiny.

5.2 An Independent Member shall attend the meeting in a scrutiny capacity.

5.3 Additional members may be co-opted to contribute to specialised areas of discussion.

5.4 Any senior officer of the University Health Board, or from a partner organisation may, where appropriate, be invited to attend.

5.5 Should any member be unavailable to attend, they may nominate a deputy to attend in their place, subject to the agreement of the Chair.

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

6. Agenda and Papers

6.1 The Sub-Committee Secretary is to hold an agenda setting meeting with the Chair and the Sub-Committee Lead at least 6 weeks before the meeting date.

6.2 The agenda will be based around the Sub-Committee work plan, identified risks matters arising from previous meetings, issues emerging throughout the year and requests from Sub-Committee Members. Following approval, the agenda and timetable for papers will be circulated to all Sub-Committee Members.

6.3 All papers should have relevant sign off before being submitted to the Sub-Committee Secretary.

6.4 The agenda and papers for meetings will be distributed seven calendar days in advance of the meeting.

6.5 The draft minutes and table of actions will be circulated to Members within fourteen calendar days to check the accuracy.

6.6 Members must forward amendments to the Sub-Committee Secretary within the next seven calendar days. The Sub-Committee Secretary will then forward the final version to the Sub-Committee Chair for approval.

7 Frequency of Meetings

7.1 The Sub-Committee will meet bi-monthly and shall agree an annual schedule of meetings. Additional meetings will be arranged as determined by the Chair of the Sub-Committee in discussion with the Sub-Committee Lead.

7.2 The Chair of the Sub-Committee, in discussion with the Sub-Committee Secretary, shall determine the time and the place of meetings of the Sub-Committee and procedures of such meetings.

8. Accountability, Responsibility and Authority

8.1 The Sub-Committee will be accountable to the Sustainable Resources Committee for its performance in exercising the functions set out in these terms of reference.

8.2 The Sub-Committee shall embed the University Health Board's vision, corporate standards, priorities and requirements, e.g. equality and human rights, through the conduct of its business.

8.3 The requirements for the conduct of business as set out in the University Health Board's Standing Orders are equally applicable to the operation of the Sub-Committee.

9. Reporting

9.1 The Sub-Committee, through its Chair and Members, shall work closely with the Sustainable Resources Committee's other committees, including joint /sub committees and groups to provide advice and assurance to the Board through the:

9.1.1 Joint planning and co-ordination of Board and Committee business;

9.1.2 Sharing of information.

9.2 In doing so, the Sub-Committee shall contribute to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

9.3 The Sub-Committee, may, subject to the approval of the Sustainable Resources Committee, establish groups or task and finish groups to carry out on its behalf specific aspects of Sub-Committee business. The Sub-Committee will receive updates following each meeting, detailing the business undertaken on its behalf. Groups reporting to this Sub-Committee are:

9.3.1 Caldicott Guardian Group

9.3.2 Cyber Security Assurance Group

9.3.3 Information Asset Owners/General Data Protection Regulations (IAO/GDPR) Group

9.3.4 Health Records Group

9.4 The Sub-Committee Chair, supported by the Sub-Committee Secretary, shall:

9.4.1 Report formally, regularly and on a timely basis to the Sustainable Resources Committee on the Sub-Committee's activities. This includes written updates on activity, as well as the presentation of an Annual Report within 6 weeks of the financial year.

9.4.2 Bring to the Sustainable Resources Committee's specific attention any significant matter under consideration by the Sub-Committee.

10. Secretarial Support

10.1 The Sub-Committee Secretary shall be determined by the Sub-Committee Lead.

11. Review Date

11.1 These terms of reference shall be reviewed on at least an annual basis by the Sub-Committee for approval by the Sustainable Resources Committee.

Information Assurance Policy

Policy Number:	250	Supersedes:		Classification	Corporate

Version No	Date of EqIA:	Approved by:	Date of Approval:	Date made Active:	Review Date:
V2		BPPAC	28.8.2018	13.9.2018	28.8.2020
		PPAC – approval to extend for 6m	27.8.2020	15.9.2020	27.2.2021

Brief Summary of Document:	This document is written to provide information on the Policy for ensuring Information Assurance across the Health Board
Scope:	For Use in: All Areas For use by: All Staff For use for: All Patient Information
To be read in conjunction with:	Information Security Policy Secure Transfer of Personal Information, E-mail Policy, Mobile Working Policy, IT Security Policy, Information Governance Policy

Owning Committee	Information Governance Sub Committee

Executive Director:	Huw Thomas	Job Title	Director of Finance

Reviews and updates		
Version no:	Summary of Amendments:	Date Approved:
1	New Policy	20.12.2011
2	Full review	28.8.2018

Glossary of terms

Term	Definition
IQA	Information Quality Assurance

Keywords	Data Quality, Information, Assurance, Informatics

CONTENTS

1. PURPOSE

The purpose of this document is to outline the LHBs policy for improving the quality of information within the Health Board.

2. INTRODUCTION

Good quality information underpins sound decision making at every level in the NHS and most importantly contributes to the improvement of health care. This document outlines the LHBs policy for improving the quality of information in the Health Board. Major drivers include:

- The national service frameworks
- Quality & outcomes assessment in primary care as part of the new GMS contract
- The requirements of Service Line Reporting
- Pressure from clinical communities and Ministers to produce high quality information on the quality of care;
- The inability of the LHB to properly monitor quality of service and clinical outcomes.

The starting point of this policy is the recognition that efforts to secure quality must be directed appropriately and that this should start with patient data collected for clinical and operational purposes. Whilst this policy is equally applicable to all information collected and used by the LHB, the initial focus is on information used to support clinical care. Information Quality needs

to be addressed within existing working practices and work plans, such as those required to comply with the Information Governance Toolkit rather than as a standalone initiative, though it does need to be managed in a focused way. In particular, the policy seeks to build on two key initiatives:

I. The recognition of, and the drive to reduce, 'adverse health events'
II. The modern approach to error prevention and risk management

'Data quality' is a term that has often been used in the past as if it were interchangeable with information quality, but it is actually a more limited term. Data quality relates to the building blocks of information, i.e. data items. Until data is assembled and interpreted it is not information. Considerable attention has also been focused upon readily measurable aspects of data quality, namely the validity and completeness of data items, whilst harder to measure but perhaps more important aspects in the context of overall information quality, such as accuracy, have been neglected. Data quality is an important component of information quality but there are other components that influence just how useful the information is to a particular user.

Previous centrally led initiatives to monitor and improve the quality of information have focused on a "top-down" audit / accreditation approach and largely on administrative or management information. In contrast, this policy focuses on building in quality from the bottom up – at the point that information is collected and recorded – with the clear goal of improving the quality of the information used to support clinical care.

3. AIM

The policy is intended to:

- Define the organisational structures within which data quality is managed, monitored, reported and improved
- Outline main responsibilities and accountabilities, together with the appropriate reporting mechanisms for providing feedback
- Mandate the use of validated NHS Numbers as the unique identifier on all patient records
- Confirm Health Board policies and procedures relating to data quality
- Allocate responsibility for reviewing, updating and amending such documents, with an established timetable and monitoring system, ensuring compliance with written policies and procedures
- Ensure compliance with data standards and all legal obligations
- Create a framework within which information quality issues can feed into training programmes, to address any recurrent problems
- Raise awareness of information quality issues with clinical and nursing staff, and ensure that information systems meet clinical needs.
- Compliance with Freedom of Information legislation, which substantially increases the public visibility of information quality issues.

4. SCOPE
For Use in: All Areas
For use by: All Staff
For use for: All Patient Information

All authorised staff involved in the collection of data are responsible for accurate and timely records to ensure that Health Board information is correct and available. This is required to ensure seamless care from teams within the Health Board and to enable the Health Board to accurately report activity. This Policy is intended to be a comprehensive guide to all staff involved in managing data associated with Clinical Information Systems both electronic and manual.

The purpose of this policy is to set out the strategic direction for further developing information assurance capability and effectively embedding an Information Assurance culture across the Health Board.

This policy describes the measures that all the Health Board's information systems must implement to achieve appropriate levels of quality in normal operation.

The policy supports the Health Board's Digital Response and aims to guide improvement in three broad areas:
availability, integrity and confidentiality.

Information Assurance		
Confidentiality: We protect information from unauthorised disclosure and ensure that we only hold information that we need and have a right to retain	**Integrity:** We ensure that the data we hold is correct, current, & can only be modified by authorised users with clear audit trails	**Availability:** We ensure that the data needed is there when its needed
Board Governance of IA Clear lines of accountability & roles and responsibilities Awareness & Education of all employees Codes of Practice: confidentiality , Health records management, HR, IG & acceptable use policies Information sharing protocols	Development & implementation of Clinical & Administrative systems & workflows Data Quality Classification of Information & application of applicable security controls System Audit & monitoring	Development & implementation of Clinical & Administrative systems & workflows Risk Management Business continuity Incident reporting & response procedures

Fair processing Privacy impact assessment Identity & access management	Software & hardware-based solutions to protect information systems Corporate records management	Service & operational level agreements. DR plans and wider IA activity are clearly articulated Technical system performance. IT operational environment maintenance

This Information Quality Assurance policy sets out a coherent approach to managing information by making it an integral and effective part of normal business processes.

5. WHY DOES THE QUALITY OF INFORMATION MATTER?

High quality information is vital to safe and effective patient care and for this purpose 100% accuracy 100% of the time must be the goal. The model of care is changing and broadening to rely upon inter-disciplinary care pathways and clinical networks that transcend organisational boundaries. Information is increasingly used in new and different ways, in a range of different settings, underpinning the continuity and quality of care. These developments create pressure to improve the quality and standardisation of existing information collections, but also lead to new and greater demands for information to be made available to different users.

Poor quality information impacts directly upon each and every use made of that information. For example:

- In clinical care, poor quality information may:
  - result in patients being harmed or distressed
  - undermine the Health Board clinicians place in recorded information
- In disease surveillance, poor quality information may:
  - undermine the validity of conclusions drawn
  - obscure facts and put the public at risk
- In medical research, poor quality information may:
  - undermine the credibility of evidence basedcare
  - cause the validity of findings to be questioned
- In health service management, poor quality information may:
  - prevent understanding of best clinical practice
  - result in resources being poorly targeted

Clinical audit and governance processes require that clinical practice be monitored and reviewed and the performance management of clinicians is receiving increased attention. All this activity is dependent upon the availability of high quality information. High quality information should be produced as part of the routine daily activity within a healthcare setting.

6. CAUSES OF POOR INFORMATION QUALITY

Poor information quality may be due to errors in systems design; adequacy of training, guidance and support; the way the information is processed or interpreted or a combination of all 3. Whilst error is not the sole cause of poor information quality it is by far the most significant. The prevention, detection and correction of error, is a key goal of the Information Quality Assurance Policy.

This policy therefore needs to be set within a programme of work that seeks to improve organisational performance across a wide range of traditionally distinct disciplines.

7. A POLICY FOR INFORMATION QUALITY ASSURANCE

This policy provides a framework for Information Quality Assurance (IQA). It also outlines the roles and responsibilities of key roles within the organisation to ensure that the information quality policy is realised.

The tools, techniques and interventions that can lead to improved information quality, the options for their deployment and the process of learning from outcomes, are the elements of the IQA framework. The key application of the framework is the development of IQA templates to support specific work areas and/or information flows. The framework will evolve as our understanding improves, both centrally and locally, but the work needs to begin now.

The policy reinforces basic principles, namely that:

- High quality clinical information underpins high quality clinical care;
- Information should be captured once only;
- Information should be accurate and complete the first time it is recorded;
- Information for management purposes should be, wherever practicable, derived from the information collected to support care.

8. ELECTRONIC RECORDS AND INFORMATION QUALITY

Over recent years attempts have been made to introduce universal electronic medical records. Through the Digital response of Hywel Dda UHB there is now a drive towards an electronic record for every patient, and elements of that record being directly available to the patient themselves to further support the care they receive.

Amongst the benefits electronic records bring is the potential for a fundamental improvement in information quality. However, without agreed standards for recording and exchanging health data, computerisation can significantly increase the risk of poor quality data leading to misinterpretation and adverse events. Equally, the skills to effectively capture information, manipulate data, present data meaningfully and realise the benefit from improved information quality must be developed and effectively supported.

9. INFORMATION QUALITY ASSURANCE THROUGH INFORMATION GOVERNANCE

It has become clear that whilst data, information, quality, information quality and data quality are all frequently used terms, there is no general agreement on definitions.

Whilst this policy is unlikely to resolve this, in order to avoid confusion and unhelpful debate it is necessary to clarify the way that these terms are used here and to set them within the, perhaps less familiar, concepts of information governance and information quality assurance.

Term	Definition
Data	Facts, readings, measurements – items that are essentially 'value free'
Information	Data that has been interpreted or to which commentary has been added by a user for a purpose, making it 'value-laden'.
Quality	Has two aspects: i. The characteristics that meet user needs and thereby provide user satisfaction ii. The absence of deficiencies that result in user dissatisfaction

9.1. Definition of Data Quality

According to J.M. Juran (1951), data is of high quality "if they are fit for their intended uses in operations, decision making and planning." Alternatively, data is deemed of high quality if it correctly represents the real-world construct to which it refers. Within an organisation, acceptable data quality is crucial to operational and transactional processes and to the reliability of business analytics / business intelligence reporting. Data quality is affected by the way the data is entered, stored, analysed, managed and reported.

Consideration of information and data quality are made more complex by the general agreement that there are a number of different aspects to information/data quality but no clear agreement as to what these are. When assessing data within any dataset, it is important to acknowledge that there are several dimensions to its quality, all of which impact on the usability of the information it represents. These can be summarised as follows:

9.2. The Six Dimensions of Data Quality

Data quality in essence is the foundations of information. The six dimensions of data quality are defined as:

- **Timeliness**: Data must be available quickly and frequently enough to support information needs and to influence the appropriate level of service or management decisions.

- **Completeness**: Data requirements will be clearly specified and based upon the information needs of the organisation and data collection processes matched to these requirements.

- **Accuracy**: Data should be sufficiently accurate for its intended purposes and captured as close to the point of activity as possible.

- **Consistency**: Data will reflect stable and consistent data collection processes across collection points and over time. Managers and stakeholders should be confident that progress toward performance targets reflects real changes rather than variations in data collection methods.

- **Precision**: Data captured will be relevant to the purposes for which it is used, capable of evolving to reflect changing needs. Quality assurance and feedback processes are needed to ensure the quality of such data.

- **Validity**: Data will be recorded and used in compliance with relevant requirements, including the correct application of any rules or definitions.

When addressing the issue of data quality, it is common for only one or two of these dimensions to be taken into account. However, to gain a full understanding of the quality of data, all of the above dimensions need to be considered as a whole, even if this is not always done at the same time.

The dimensions arguably increase in complexity and detail as one moves from examining the basic dimensions focussed on whether the data is valid and submitted on time, to whether the data actually paints an accurate and consistent picture of the activity it represents.

As it is not always possible, for a variety of reasons, to adhere to all the principles in every case, a judgement must be made by each information Asset Owner to the relative importance of individual data items. This will depend on the intrinsic nature of the data, as well as the use to which the application is put. High priority items could include important clinical details such as allergies, chronic disease factors or current medication. Other examples might include identification data, financial transactions, etc. However, lower priority items should not be considered as optional for data collection (unless defined as such), merely that the consequences of being unable to collect the data are less serious.

The Information Governance Toolkit introduced to the Health Board will allow focused work to be undertaken in order to deliver the necessary assurance for the Health Board.

10. WHAT IS INFORMATION QUALITY ASSURANCE (IQA)

Information quality assurance is a cycle process that aims to assess performance and deliver improvement. Improvements relate both to the quality of the information but also, a means of developing and reinforcing an information quality culture, to improve compliance with information quality standards. In line with the approach adopted for broader information governance, these standards relate to:

a) The management of Information Quality
b) The requirements for systems that process information
c) Organisational processes and working practices
d) The training and guidance that should be provided to staff

IQA requires the assessment of compliance with information quality standards and an assessment of outcomes in terms of improved information quality. A generic model of information quality with standards, guidelines and measurement tools is necessary. Whilst the assessment of compliance against information quality standards is relatively straightforward – attainment levels are either achieved or they are not –the measurement of information quality is more complicated. On the one hand information quality can be measured with subjective perceptions (qualitative) from information users. On the other hand there are approaches developed on the basis of quantitative characteristics such as completeness and accuracy.

IQA proposes a measuring system for information quality that assesses both qualitative and quantitative aspects in the context of key information pathways.

11. MANAGEMENT STRUCTURES, POLICIES & LEADERSHIP INCLUDING RESPONSIBILITIES

The organisational commitment to data quality is fundamental if the Health Board is to ensure appropriate management structures and processes are in place to enable them to resolve local data quality issues.

In view of this the Health Board must have appropriate management structures for ensuring that information quality is systematically and rigorously addressed. The table outlines the proposed responsibilities;

Role	Responsibilities
Chief Executive	The Chief Executive has overall responsibility for data quality management within the Health Board. As the accountable officer they are responsible for the management of the organisation and for ensuring appropriate mechanisms are in place to support service delivery and continuity. Records management is vital to this in order to ensure appropriate, accurate information is available as required. The Chief Executive is responsible for all submitted data and information reporting.
Director of Finance	Formal responsibility for Data Quality lies with the Executive Director of Planning, Performance, Informatics & Commissioning who is responsible for reporting on data quality to the Board.
Caldicott Guardian	The Health Board's Caldicott Guardian has a responsibility for reflecting service users' interests regarding the use of patient identifiable information and is responsible for ensuring patient identifiable information is shared in an appropriate and secure manner.
Senior Information Risk Officer	The accountable director for the policy is the Senior Information Risk Officer (SIRO). The SIRO take ownership of the Health Board's information risk policy and acts as an advocate for information risk on the Board. The SIRO works closely with Information Asset Owners to ensure Health Board information systems are fit for purpose.
Information Governance Manager	The Information Governance Manager is responsible for ensuring that the Health Board is working within the legal framework of GDPR, Freedom of Information Act, NHS Code of Practice for Confidentiality and Information Governance Standards etc. They are responsible for the co-ordination and management of Information Governance including the completion of the Information Governance Toolkit.

Digital Director	Digital Director has delegated professional responsibility for information assurance and data quality within the Health Board. They are also responsible for the Data Quality Team and their annual programme of work, clinical information systems and the reporting of management information. They act as an advocate for Data Quality and is responsible for reporting on Data Quality to the Executive Director of Finance
Head of Information Services	The Head of Information Services has delegated responsibility for the management of data quality across the Health Board. Key roles will be the promotion of data quality and include: • Providing direction and responsibility for the Clinical Coding Manager • Highlighting the importance of data quality at Management Team, Operational Services Managers meetings and other relevant committees and groups

Role	**Responsibilities**
Clinical Coding Manager via the Data Quality Improvement Manager	The Clinical Coding Manager via the Data Quality Improvement Manager is directly responsible to the Head of Information Services for the day to day management of data quality across the Health Board. • Ensuring the quality of data produced meets the requirements of the Health Board and ensuring sufficient mechanisms are in place to ensure this happens • Developing a culture where there is an appreciation of the importance of high standards of data quality across all relevant staff groups, involved in the production and collation of data • Ensures that through increased confidence in the quality of data reports and analyses of the data, they can be relied upon for use in better management and clinical decision making • Provide all relevant staff with sufficient guidance and appropriate training to ensure data is collected in a consistent and accurate manner, ensuring training is updated as required • Establish a departmental/unit data quality group to identify and address data quality issues which feeds into Health Board wide groups such as Information Asset Owners group, Transformation Working Groups, Directorate meetings etc.

Departmental Data Quality Leads	Health Board Managers have a responsibility for ensuring that staff working for them: • Record accurate and complete data in a timely manner • Are aware of their responsibilities with regard to checking and updating any inaccuracies and missing data items in service user records • Address any data quality issues as soon as possible and escalate appropriately • Ensure all local procedures are documented and updated regularly and are available to all staff • Ensure all staff are familiar with and adhere to current legislation, Health Board and local policies, procedures etc. ▪ Ensure all staff meet the Health Board's Data Quality Standards • Monitor staff competencies and training needs and ensure staff attend appropriate training including refresher as appropriate for both clinical information systems and record keeping/data quality ▪ Ensure staff deal with data in a secure and confidential way to comply with Information Governance standards.

Employees	All Health Board staff including clinicians and administrative staff, who collect and record data both manually or on the Health Board clinical information systems must: • Ensure timely, accurate and complete recording of data in service user records • Update any inaccuracies and/or missing data in service user records • Address any data quality issues as soon as possible and escalate appropriately • Be aware of and comply with legislation, Health Board and local procedures etc. • Ensure they meet the Health Board's Data Quality Standards • Monitor own competencies and access training where necessary both for clinical information systems and record keeping/data quality ▪ Ensure all data is dealt with in a secure and confidential way to comply with Information Governance standards.

Information Asset / System Owners Responsibilities	IAO's have responsibility for the quality of the data held within their systems. This will be achieved by setting data quality standards for the systems and routinely measuring performance against those standards. Where the standard is not being achieved, it is the responsibility of the Information Asset Owner to put in place an action plan to address. Where this requires Health Board wide action, the IAO will be supported by the Assistant Director of Informatics to ensure that the action plan is agreed and implemented at the appropriate level within the Health Board. For each information system in the Health Board, there is a named person who is ultimately accountable for the quality of information held in that system. This register of system responsibilities, informed by the Information Asset Register, will be monitored and updated on a routine basis. In accordance with the Policy, the named individual will be responsible for: ▪ Reviewing policies and procedures and ensuring they are kept up to date in line with system changes • Ensuring compliance with written policies and procedures – via spot check, and rolling programmes of audit • Ensuring staff receive adequate training in the use of the system • Monitoring and communicating error rates – informed via the System Administrators own localised Data Quality regime ▪ These responsibilities should be explicitly identified in the job descriptions for these posts, and should form part of the post holder's Appraisal and Development Review.
Information Governance Committee	The Information Governance Committee is responsible for monitoring the outcomes of the Data Quality Steering Group Audits, Action Plan etc.
Data Quality Steering Group	The Data Quality Steering Group will meet on a quarterly basis and is accountable to the Information Governance Committee. The group is made up of representatives that have responsibility within their division to cascade relevant information to staff and to report any data quality issues as appropriate to the attention of divisional managers or to the Data Quality Steering Group as appropriate, to implement measures to address them, ensure the Data Quality Policy is followed locally, Participate in audits etc. as requested by the Steering Group. The group has overall responsibility for the implementation of this policy and the Data Quality work plan; it will manage and monitor the Data Quality Report, audit reports and action plans

	and feedback to the Information Governance Committee. It is the responsibility of the Divisions to ensure representation and attendance at the steering Group and to participate in audits as appropriate . • The Data Quality Steering Group will oversee and monitor the progress of this policy and the annual Data Quality Action Plans
Audit Committee	The Audit Committee receives assurance in respect of data quality from Internal and External Audit.

All data collection processes whether clinical, administrative or financial, electronic or manual, should be clearly documented and regularly audited. Development of data collection processes is the individual department's responsibility in conjunction with the appropriate Information Asset Owner and must be complete, up to date and available in all work areas. When new systems are implemented it is the department and projects joint responsibility to develop appropriate data collection processes prior to implementation. Such processes must be underpinned by suitable training to ensure ownership, understanding and compliance.

Information Asset Owners must also ensure that publications such as Welsh Health Circulars and Data Standard Change Notices are also implemented within the required timeframe in conjunction with other appropriate teams across the Informatics portfolio and evidence of compliance provided where appropriate.

12. PROCEDURES

The complex nature of patient data: the volume, circulation, confidentiality requirements, legal obligations and associated administrative and management issues makes it essential that procedures are in place which will ensure that the patient and the Health Board are protected from risk. The Health Board is committed to ensuring that procedures are in place to minimise risk and provide an efficient and effective information service through access to high quality patient data.

12.1. Measurement of Data Quality

The assessment of whether data quality is of sufficiently high standard is dependent on the data in question and the purpose for which it is collected and utilised. Typical measures may include the following:

- All mandatory data collection is complete, accurate and up to date
- Manual data is readable and stored in a structured filing system
- Duplication of records is minimised
- Data is collected in accordance with documented procedures and guidelines meeting national/local standards
- Percentage of completed and valid coded data regularly monitored

- Random audits on data for accuracy, timeliness and completeness

A scoring mechanism will be used to benchmark certain systems and modules against each other in an attempt to provide information asset owners and secondary users of the data a picture of the data quality of the datasets they are using.

12.2. Local Data Quality Procedures

All local procedures should comply with and/or map back to national data standards and coding and will be subject to control processes within the Health Board as well as to external scrutiny.

Each information system must implement well documented and clearly understood local data quality procedures with a view to ensuring that high level of data quality is maintained at all times.

It is the responsibility of the relevant named Information Asset Owner to ensure that local data quality procedures are produced and maintained and monitored. Manual recording of data is not excluded from this process.

Procedures should assess levels of risk associated with different data items, identifying high priority data items and noting the consequences of missing data.

Procedures must specify where applicable what enforcement mechanisms are available to ensure adherence.

Data quality procedures should be reviewed on a regular basis to ensure that they still meet the business requirements of the Health Board.

Regular auditing against local internal targets to monitor data quality compliance, and clear processes on handling poor data quality outcomes to ensure improvement.

Where data errors and/or corruption of data are identified, clear processes must be in place to identify implications and immediate correction of such data.

In certain circumstances, systems may have specific resources allocated for the maintenance of data quality. Local data quality procedures must specify under what circumstances those resources should be used.

12.3. Failure to Maintain Data Quality

All instances of failure to maintain adequate data quality in Health Boards systems (for example, by entering incorrect data) will be dealt with as follows:

- First Instance – The individual responsible for the data quality failure will be contacted to inform them of the error and will be offered further training.
- Second Instance – The individual responsible for the data quality failure and their Line Manager will be contacted to inform them of the error and the individual will be notified that they will need to attend further training. A support process will be developed around the individual along with a monitoring and validating routine of the individual's data entry.
- Third Instance – The individual responsible for the data quality failure and their Line Manager will be contacted to inform them of the error. Access to the relevant information

system will be reviewed for the individual concerned until they have successfully completed further training and further adjusted working practices to minimise future errors.

- Fourth and Subsequent Instances – The individual responsible for the data quality failure and their General Manager will be contacted to inform them of the error. The Divisional Manager will be expected to consider initiating the Health Board's Capability Procedure to deal with the inability of the individual to maintain adequate data quality.

13. TRAINING

Training of staff in data quality awareness, security and confidentiality issues, and use in electronic systems is a cornerstone of promoting data quality across the Health Board.

1. Established processes will enable training needs to be linked to any issues highlighted during data validation, to ensure common errors in data recording are eliminated at both individual and group level
2. Comprehensive training records will be kept to ensure progress can be demonstrated, and to assist in recall of staff in the future, including user evaluation feedback to monitor the effectiveness of the training programmes available
3. Training documentation will include a section on security and confidentiality, and will provide guidance over relevant data definitions and the importance of validating, correctly classifying and recording activity information
4. Training in understanding and utilising information should also be provided for the Health Board's decision makers
5. All staff will be provided with appropriate and relevant training before they are issued with access to the electronic systems

14. MONITORING

The Health Board will, as a matter of routine, monitor performance by collecting and processing data according to nationally defined standards and provide appropriate feedback to all staff.

Internal data quality spot checks and local audits are undertaken by the Data Quality Improvement Manager. The Health Board will put in place mechanisms to ensure there is feedback to the individual divisions where necessary, on data quality issues and of any remedial actions that may be needed to improve the quality of the data.

As part of the monitoring of this policy Appendix 1 will form an integral element of the workplan for the Data Quality Team.

15. EQUALITY

The Health Board recognises the diversity of the local community and those in its employment. Our aim is therefore to provide a safe environment free from discrimination and a place where all individuals are treated fairly, with dignity and appropriately to their need. The Health Board recognises that equality impacts on all aspects of its day to day operations and has produced an Equality Policy Statement to reflect this. All policies and procedures are assessed in accordance with the Equality initial screening toolkit, the results for which are monitored centrally.

16. REVIEW OF POLICY

The Information Quality Assurance Policy will be reviewed at least every 2 years or as often as is necessary to ensure continued compliance with relevant legislation.

HYWEL DDA UNIVERSITY HEALTH BOARD

17. APPENDIX 1 - INFORMATION ASSURANCE POLICY PROPOSED IMPROVEMENT ACTIVITY

Area key to success	Areas identified by Boards for focused improvement activity	Proposed future improvement activity
Leadership/ Governance	Acknowledgement that strong visible leadership at Board level is essential. However, others also have a role to play such as the Caldicott Guardian custodian of patient identifiable data or Information Asset Owner (Staff with service based responsibility for information assets.)	Health Board to review local arrangements to ensure there are clearly articulated lines of responsibility and accountability for both clinical and business information. Establish an Information Asset / Owners Group
Information risk management	Greater focus needs to be placed on the approach to identification, reporting and management of risks and sharing collective learning from incidents.	Health Board to ensure robust risk management frameworks in place, which feed into service plans and the development of appropriate controls. Profile is raised to CEO and Audit Committee level.
Training, Education and Awareness	Beyond the Board it is recognised that every member of staff has a personal responsibility to adhere to their professional codes of conduct and/or practice in respect of good information management including participation in information governance training relevant to their job role. Future work should challenge 'custom and practice'. This could be achieved by NHS specific package which: • clearly articulate NHS expectations • Case study based and capable of being delivered in a range of formats. • Dovetailed with the existing mandatory learning packages for junior medical and nursing staff.	Health Boards to consider developing an online training modules As interim measure information assurance and or Data Quality should form part of the induction process.

Policy and Operations	*Policies and procedures:* The Health Board should produce clear and concise core policy independently of the implementation Policies and procedures should:	Provide clear guidelines on the roles and responsibilities of Health Board staff. Establish an IA Group who are commissioned to carry out discrete pieces of work to rationalise and harmonise Health

HYWEL DDA UNIVERSITY HEALTH BOARD

Area key to success	Areas identified by Boards for focused improvement activity	Proposed future improvement activity
	• align with professional bodies codes of practice and guidance • greater collaboration internally with appropriate groups of staff e.g. HR Acknowledgment that the ability to successfully apply sanctions against individuals depends on the robustness of Health Board polices and procedures. Robust methodology in place to assess the business impact of access to information and apply the correct protection, handling and disclosure instructions. Developments in technology and communication technologies. Acknowledgement that employees and boards need to understand and respect the power, limitations and technical controls of mobile devices.	Board level policies and procedures within a given time frame. Greater focus on simplifying, standardising and documenting working practices is required to support the shared services agenda.

Policy and Operations		Expectation that the audit procured tool will be progressively implemented in tandem with associated people management across all Health Board and National Systems