
# ANNUAL REPORT 2023 – 2024

## Information Governance Sub-committee

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

## 1. Introduction

The Information Governance Sub-Committee (IGSC) has been established under Board delegation with the Health Board approving terms of reference for the Business Planning & Performance Assurance Committee at its Board meeting on 26th January 2010. The terms of reference of the Information Governance Sub-Committee were subsequently approved at its meeting on 27th November 2010.

These terms of reference clearly detailed the Sub-Committee's purpose to provide assurance to the Business Planning & Performance Assurance Committee around the organisation's information governance framework, ensuring that there is an accurate reflection of Sub-Committee activity, work programmes, action plans, and policies and procedures to deliver against gaps in assurance.

Most recently the Information Governance Sub Committee (IGSC) Terms of Reference have been reviewed, updated and approved at Sustainable Resources Committee on 27th February 2023 to reflect the changes to the membership of the group.

In discharging this role, the Sub-Committee is required to oversee and monitor the information governance agenda for the Sustainable Resources Committee in respect of its provision of advice to the Board, and ensure the implementation of the information governance agenda against the following areas of responsibility:

- Meetings
- Governance
- Assurance
- Policies and Procedures
- IGSC's Groups

## 2. Meetings

Since 1st April 2023, Information Governance Sub-Committee meetings have been held on a bimonthly basis as follows:

- **13th April 2023** (quorate)
- **8th June 2023** (quorate)
- **8th August 2023** (quorate)
- **3rd October 2023** (quorate)
- **30th November 2023** (not quorate)
- **7th February 2024** (quorate)
- **26th March 2024** (not quorate) (Extra-Ordinary meeting)

During 2023 – 2024, the Sub-Committee met on seven occasions and was quorate for five meetings. The meetings were held virtually through the Microsoft O365 Teams.

Anthony Tracey, Digital Director is acting as the Chair of the IGSC, and he is also the Deputy SIRO for the Hywel Dda University Health Board.

## 3. Governance

IGSC has been set up to:

- Promote and develop a robust information governance and security framework within the Health Board.
- Encourage a culture of information governance and information security across the Health Board.
- In conjunction with key Committees/sub-committees/groups develop appropriate systems, policies, procedures, work plans and action plans including (but not restricted to) the following areas:
    - Information and Cyber Security (including SIRO related issues)
    - Information Sharing Protocols
    - Contracts, partnership and third party and supplier agreements
    - Confidentiality and Data Protection
    - Freedom of Information
    - Individuals' Rights
    - Records Management
    - Information Quality Assurance
    - Risk Management and Incident Management
    - Data Protection Impact Assessments
    - Patient records

### 3.1 Information Governance (IG) Workplan

The main emphasis for the workplan has been:

- The Provision of IG training to staff (Raising the compliance to over 80% for the Health Board)
- IG Intranet Update
- To promote the Cyber Security within the Health Board, ensuring that all staff are targeted to undertake the on-line cyber security programme
- Provide IG service to Managed Practices
- Review of Procedures under the All-Wales Information Governance Policy, and All Wales Information Security Policy.
- Improve compliance with Welsh IG Toolkit
- Delivering Corporate Records Management Strategy and Policy
- Continue the implementation of UK GDPR within the Health Board
- Improve the NIIAS monitoring
- Reviewing Privacy Notices available on the HDUHB's internet site
- Promoting WASPI and Information Sharing across Health Board / Setting up Information Sharing Register
- Setting up Virtual IAR with Annual Review and ongoing Risk Management (Through Teams Channels)
- The provision of specific IG Guidance as well as generic good practice:
    - Live Virtual IG Training Sessions
    - IG Training Videos
    - Short IG Awareness Movies re: specific issues, e.g., Sharing Information with Police

- Supporting the Health Board in implementing new solutions across organisation through the use of Data Protection Impact Assessments (DPIAs)

## 3.2 Cyber Security

3.2.1 **Cyber Security Team**

The dedicated Cyber Security Team continues to be adequately resourced since August 2023, with minimal turnover.

3.2.2 **Network and Information Systems Regulations (NIS-R)**

In response to the Network and Information System regulations (NIS-R) the Cyber Security Team continues to maintain an assessment against the National Cyber Security Centre (NCSC) Cyber Assessment Framework (CAF). This assesses the Health Board against the four objectives of the CAF:

- **Managing Security Risk** – this ensures the Health Board has appropriate structures, policies, and processes to manage security risks.
- **Protecting Against Cyber Attack** – to assess measures are in place to protect our networks and systems from cyber-attack.
- **Detecting Cyber Security Events** – measures within the Health Board to detect cyber security events with an effective monitoring and reporting regime.
- **Minimising the Impact of Cyber Security Incidents** – ensure the Health Board can minimise the impact of any cyber incident and restore services in an appropriate timeframe.

The Cyber Security Assurance group (CSAG, a sub-group of the IGSC) programme workplan has been progressed to address the recommendations identified through external audit by the NHS Wales Cyber Resilience Unit (CRU).

Following the most recent CRU audit in March 2024, he Cyber programme of work has been amended to reflect new items that have been identified for implementation or mitigation. The programme of work has been divided into 15 separate workstreams which align with the National Cyber Security Centre's (NCSC) Cyber Assurance Framework (CAF).

3.2.3 **Phishing Campaigns**

Phishing is one of the easiest cyber-attack vectors. Staff awareness combined with technical controls is crucial to defend against phishing attacks. The Cyber Security Team have increased the amount of simulated phishing campaigns within the organsiation to increase awareness and provide additional training to staff who click on our phishing exercise emails. This increases the organisations cyber posture by reducing the risk of cyber attack through Social Engineering.

# 4. Assurance

- Ensure the Health Board is compliant with the Data Protection Legislation (the Data Protection Act 2018 and UK GDPR (General Data Protection Regulation) - together referred to as the Data Protection Legislation).
- Ensure quality and statutory compliance in relation to all information processed by the Health Board.

- Ensure that new projects, processes and the development of systems are compliant with statutory requirements in relation to information governance.
- Ensure that there is a process of Data Protection Impact Assessment in accordance with Information Commissioner's guidance.
- Ensure that information sharing and transfer with third party organisations are compliant with statutory requirements in relation to information governance.
- Ensure that the Health Board is following the Caldicott Principles when processing patient information.
- Welsh Information Governance (IG) toolkit.
- Internal and External Audit reviews.
- Information Commissioners Officer (ICO) standards, and code of practice.
- Any other relevant National or Welsh requirements/assessments.

The IG Activity Report is presented quarterly at IGSC meetings. The purpose of this report is to provide an overview to the Information Governance Sub Committee (IGSC) of the day-to-day work that has been undertaken by the IG Team. It also includes access requests made to the Access to Health Records Team, and to Freedom of Information Requests Team, Corporate Office. The Report provides an overview of the activities of the IG Team in relation to the following areas:

## 4.1 Assurance – Advice

| Advice | Apr-23 | May-23 | Jun-23 | Jul-23 | Aug-23 | Sep-23 | Oct-23 | Nov-23 | Dec-23 | Jan-24 | Feb-24 | Mar-24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Advice (P1 - Fair & Lawful Processing) | 18 | 17 | 17 | 34 | 24 | 17 | 22 | 15 | 17 | 24 | 12 | 16 |
| Advice (P2 - Specified & Legitimate Purpose) | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 1 | 0 | 2 | 1 | 1 |
| Advice (P3 - Adequate, Relevant & Limited) | 0 | 1 | 0 | 2 | 0 | 0 | 3 | 0 | 0 | 0 | 0 | 2 |
| Advice (P4 - Accuracy) | 1 | 0 | 0 | 0 | 1 | 1 | 1 | 1 | 2 | 1 | 1 | 1 |
| Advice (P5 - Retention) | 1 | 3 | 2 | 1 | 4 | 1 | 2 | 6 | 1 | 4 | 3 | 1 |
| Advice (P6 - Security) | 24 | 29 | 30 | 30 | 32 | 29 | 41 | 33 | 23 | 30 | 37 | 22 |
| Advice (P7 - Accountability) | 2 | 0 | 0 | 1 | 0 | 0 | 2 | 1 | 1 | 1 | 1 | 1 |
| Enquiry about IG Processes | 3 | 3 | 1 | 3 | 1 | 3 | 4 | 2 | 7 | 6 | 6 | 5 |
| IG Administartion Work | 5 | 5 | 36 | 17 | 11 | 21 | 18 | 19 | 3 | 20 | 35 | 18 |
| | 54 | 58 | 86 | 88 | 73 | 74 | 93 | 78 | 54 | 88 | 96 | 67 |

**909** **Enquiries on Information Governance Framework**

The IG Team provides guidance on a variety of topics to the Health Board's employees on a daily basis. Most enquiries are about the lawfulness of processing personal data, e.g., providing Privacy Notices, retention schedules and information security. The aim is to make sure that IG guidance is clear and consistent for everyone working in the Health Board.

## 4.2 Assurance – Information Sharing

| Information Sharing | Apr-23 | May-23 | Jun-23 | Jul-23 | Aug-23 | Sep-23 | Oct-23 | Nov-23 | Dec-23 | Jan-24 | Feb-24 | Mar-24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Information Sharing Enquiries | 10 | 6 | 4 | 5 | 3 | 6 | 3 | 2 | 4 | 7 | 5 | 6 |
| Information Sharing Agreements | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 0 |
| WASPI Information Sharing Protocol (ISP) | 1 | 1 | 1 | 1 | 1 | 3 | 1 | 2 | 0 | 1 | 0 | 0 |
| WASPI Data Disclosure Agreement (DDA) | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 |
| | | | | | | | | | | | | |
| | 11 | 7 | 5 | 9 | 4 | 9 | 5 | 5 | 4 | 9 | 5 | 6 |

**79** **Enquiries on Information Sharing**

Good information sharing is essential for providing safe and effective care within the Health Board. There are other important uses of information which contribute to the overall delivery of health, social care or to serve wider public interests, for example, national registers and audits, research and service evaluation. Employee information may also be shared for Workforce related and other specified purposes.

The IG Team assist in facilitating information sharing by implementing the appropriate agreement having established that:

- the sharing is necessary and there is a clear purpose with a lawful basis,
- the information to be shared is limited to only that required to meet the intended purpose, and
- those with whom the information is being shared understand their responsibilities and obligations,
- the sharing is compliant with Data Protection legislation and any other legal requirements,
- the data subject is informed of the intended use.

| Caldicott Guardian Register and Approvals | Apr-23 | May-23 | Jun-23 | Jul-23 | Aug-23 | Sep-23 | Oct-23 | Nov-23 | Dec-23 | Jan-24 | Feb-24 | Mar-24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Caldicott Guardian Register | 18 | 18 | 14 | 13 | 14 | 21 | 37 | 16 | 9 | 11 | 27 | 21 |
| Caldicott Guardian Approvals | 8 | 10 | 6 | 8 | 8 | 11 | 14 | 8 | 2 | 3 | 11 | 4 |

219 Caldicott Guardian Register

The Caldicott Guardian's role is to ensure that procedures are in place to govern access to and the use of patient (client) identifiable information and, where appropriate, the transfer of that information to other organisations for a given purpose that is outside of direct patient care. This is to ensure that information is used legally, ethically, and appropriately, and that confidentiality is maintained. With this in mind, the Caldicot Guardian reviews and approves protocols or agreements which address the sharing of patient data between organisations, for official registers, external research projects etc., to which the Health Board is party and reviews and approves staff post graduate projects. The IG Team maintains a Caldicott Guardian Register of the above areas which is reviewed at each bi-monthly Caldicott Guardian Group meeting.

From the 219 enquiries recorded on the Caldicott Guardian register for 2023 to 2024, 93 required Caldicott Guardian approval.

## 4.3 Assurance – Personal Data Breaches

The Health Board has adopted and implemented a robust procedure for managing IG incidents across the organisation that ensures incidents are reported in line with statutory requirements and lessons are learnt to improve future practice. Where they meet the threshold, the Health Board reports to the Information Commissioner's Office (ICO) as detailed below.

| Personal Data Breaches | Apr-23 | May-23 | Jun-23 | Jul-23 | Aug-23 | Sep-23 | Oct-23 | Nov-23 | Dec-23 | Jan-24 | Feb-24 | Mar-24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Personal Data Breach (Recorded Internally) | 17 | 21 | 20 | 17 | 29 | 25 | 38 | 26 | 26 | 20 | 13 | 23 |
| Personal Data Breach (Reported to ICO) | 0 | 0 | 1 | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 1 | 0 |
| Personal Data Breach (Minor) | 24 | 23 | 45 | 43 | 48 | 28 | 29 | 37 | 25 | 25 | 31 | 21 |
| Personal Data Breach (Near Miss) | 1 | 6 | 4 | 9 | 6 | 1 | 0 | 2 | 1 | 1 | 3 | 2 |
| Personal Data Breach (Not Upheld) | 4 | 2 | 0 | 6 | 4 | 2 | 2 | 0 | 0 | 1 | 1 | 2 |
| Personal Data Breach (Not Owned by HDUHB) | 6 | 3 | 8 | 3 | 3 | 5 | 10 | 4 | 5 | 5 | 3 | 2 |
| Personal Data Breach (Withdrawn by patient) | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 |
| Incident (No IG Considerations) | 75 | 87 | 70 | 83 | 61 | 81 | 99 | 79 | 170 | 108 | 77 | 99 |
| | 127 | 142 | 148 | 162 | 152 | 144 | 178 | 148 | 227 | 160 | 129 | 149 |
| Lost in Transit | 1 | 0 | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| Lost or stolen hardware | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 0 |
| Lost or stolen paperwork | 4 | 5 | 4 | 3 | 1 | 3 | 6 | 7 | 5 | 5 | 1 | 2 |
| Disclosed in Error | 14 | 12 | 23 | 15 | 24 | 23 | 21 | 17 | 23 | 23 | 16 | 17 |
| Uploaded to website in error | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Non-secure Disposal – hardware | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Non-secure Disposal – paperwork | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 |
| Technical security failing (including hacking) | 0 | 1 | 1 | 0 | 2 | 0 | 3 | 1 | 0 | 0 | 0 | 0 |
| Corruption or inability to recover electronic data | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 |
| Unauthorised access / disclosure | 3 | 11 | 10 | 11 | 17 | 10 | 7 | 1 | 6 | 3 | 7 | 7 |
| Misfiling (Electronic) | 16 | 12 | 24 | 27 | 25 | 15 | 20 | 32 | 17 | 14 | 24 | 15 |
| Misfiling (Paper) | 2 | 0 | 0 | 3 | 5 | 1 | 3 | 2 | 2 | 3 | 3 | 4 |
| Other | 11 | 14 | 14 | 18 | 16 | 9 | 19 | 7 | 4 | 4 | 1 | 3 |

695 Personal Data Breaches

Throughout the financial year 2023-2024, the Health Board communicated with the Information Commissioner's Office (ICO) regarding 5 occurrences. This figure is consistent with the previous year, 2022-2023, where 5 instances were similarly reported to the ICO. All incidents logged through Datix and those reported directly to the Information Governance (IG) Team undergo a risk assessment to decide if they qualify as reportable personal data breaches to the ICO. The criteria for these assessments align with ICO's own guidance, with the risk scores meticulously recorded for each incident.

## 4.4 Assurance – Documents Review

| Documents Reviews | Apr-23 | May-23 | Jun-23 | Jul-23 | Aug-23 | Sep-23 | Oct-23 | Nov-23 | Dec-23 | Jan-24 | Feb-24 | Mar-24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Memorandum of Understanding | 0 | 0 | 0 | 4 | 0 | 1 | 1 | 3 | 1 | 2 | 1 | 0 |
| Contracts | 1 | 0 | 2 | 2 | 0 | 1 | 0 | 1 | 2 | 1 | 1 | 1 |
| Data Processing Agreements (DPAs) | 2 | 5 | 0 | 0 | 4 | 0 | 1 | 1 | 1 | 1 | 0 | 3 |
| Policy and Procedure Review | 2 | 8 | 1 | 4 | 4 | 0 | 3 | 3 | 0 | 2 | 0 | 2 |
| Service Level Agreements (SLA) | 1 | 2 | 2 | 4 | 0 | 2 | 3 | 0 | 0 | 2 | 5 | 1 |
| | 6 | 15 | 5 | 14 | 8 | 4 | 8 | 8 | 4 | 8 | 7 | 7 |

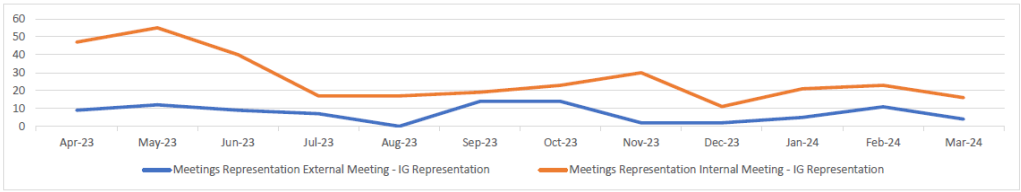
94 Documents reviewed

The Information Governance Service reviews Contracts, Terms and Conditions, Memoranda of Understandings (MOUs), Data Processing Agreements (DPAs) and Service Level Agreements (SLAs). These documents govern how the Health Board shares personal data with other organisations. It is important so that both parties understand their responsibilities and liabilities, and this is clear within the agreements. IG Service also reviews internal policies and procedures and provide relevant guidance in line with the current Data Protection Legislation.

## 4.5 Assurance – IG Meetings Representation

**Meetings Representation**

| | Apr-23 | May-23 | Jun-23 | Jul-23 | Aug-23 | Sep-23 | Oct-23 | Nov-23 | Dec-23 | Jan-24 | Feb-24 | Mar-24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| External Meeting - IG Representation | 9 | 12 | 9 | 7 | 0 | 14 | 14 | 2 | 2 | 5 | 11 | 4 |
| Internal Meeting - IG Representation | 47 | 55 | 40 | 17 | 17 | 19 | 23 | 30 | 11 | 21 | 23 | 16 |
| | 56 | 67 | 49 | 24 | 17 | 33 | 37 | 32 | 13 | 26 | 34 | 20 |




**408** **Meetings Attended**

The IG Team represents HDUHB at internal and external meetings where they can be called upon for IG advice and guidance. For instance, HDUHB's Data Protection Officer regularly attends external Information Goverance Management Advisory Group (IGMAG) meetings, where All Wales NHS Policies are developed, and national guidance is distributed. Detailed reports from the meetings were presented at every IGSC meeting in 2023-24.

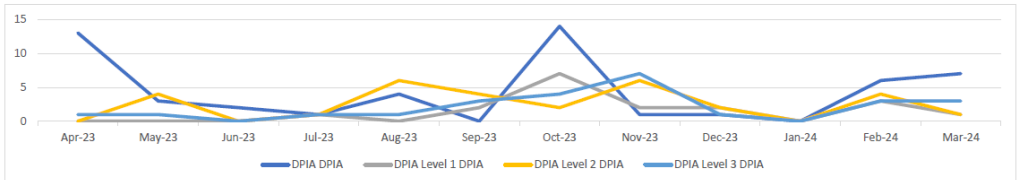
Currently reports from the following external meetings are presented to IGSC:

- IGMAG – Information Goverance Management Advisory Group
- HRMAG – Health Records Management Advisory Group
- OSSMB – Operational Security Service Management Board

## 4.6 Assurance – Data Protection Impact Assessments

**DPIA**

| | Apr-23 | May-23 | Jun-23 | Jul-23 | Aug-23 | Sep-23 | Oct-23 | Nov-23 | Dec-23 | Jan-24 | Feb-24 | Mar-24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| DPIA | 13 | 3 | 2 | 1 | 4 | 0 | 14 | 1 | 1 | 0 | 6 | 7 |
| Level 1 DPIA | 0 | 0 | 0 | 1 | 0 | 2 | 7 | 2 | 2 | 0 | 3 | 1 |
| Level 2 DPIA | 0 | 4 | 0 | 1 | 6 | 4 | 2 | 6 | 2 | 0 | 4 | 1 |
| Level 3 DPIA | 1 | 1 | 0 | 1 | 1 | 3 | 4 | 7 | 1 | 0 | 3 | 3 |
| | 14 | 8 | 2 | 4 | 11 | 9 | 27 | 16 | 6 | 0 | 16 | 12 |




**125** **Privacy Assessments**

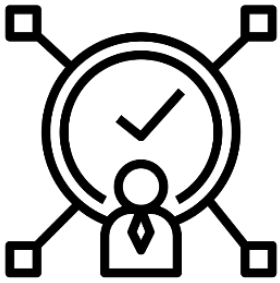
Data Protection Impact Assessments (DPIAs) are a tool to assess the risks when completing any work involving personal data. Since the pandemic, there has been a dramatic increase in the need for DPIAs due to the new ways of working and the innovative solutions that the clinical teams require to provide patient care. It has also led to an increase in sharing patient data with other organisations, all of which require careful consideration of the risks to personal data. Each DPIA involves working with the project lead in HDUHB, plus the Digital/Cyber team for the completion of Cloud Assessments and the external

service/system providers where necessary. The DPIA process can be complex and includes significant dialogue between all partners.

The IG Team record and process DPIAs within 4 classifications with the current status provided:

- DPIA: Responding to enquiries and providing details of the IG requirements and process.
  - DPIA Level 1: Review of DPIA Screening Questions or where adequate information has been provided for the IG Team to review and to make a decision as to whether a Level 2 or Level 3 DPIA is required; External DPIAs.
- DPIA Level 2: Minimal Personally Identifiable Information (PII); where a Level 3 – Mandatory / Full DPIA is not required.
- DPIA Level 3: Mandatory / Full DPIA

## 4.7 Assurance – Individual Rights



Under the Data Protection legislation, data subjects have rights with regards to their personal information, the majority of work and enquiries to the IG Team continues to be around Corporate Subject Access Requests, the volume of requests continues to make the target timescales for release difficult to achieve. The IG team have provided technical support to the Access to Health Records Team over the last 12 months, which has impacted on team's Individual Rights figures and compliance rates. Information Governance has also seen an increase in the number of requests and enquiries under a Data Subjects Right to Rectification.

| Information Rights Requests Received | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Apr** | **May** | **Jun** | **Jul** | **Aug** | **Sep** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **March** | **Total** |
| **Right of Access (Corporate)** | 2 | 4 | 3 | 2 | 4 | 7 | 8 | 8 | 5 | 7 | 2 | 4 | 56 |
| **Right to be Informed** | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 3 |
| **Right to Rectification** | 2 | 2 | 2 | 1 | 4 | 0 | 1 | 3 | 1 | 0 | 1 | 0 | 17 |
| **Right to Erasure** | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 2 |
| **Breached** | 0 | 2 | 2 | 1 | 1 | 2 | 0 | 0 | 1 | 1 | 0 | 0 | 9 |
| **Compliance** | **100%** | **72%*** | **60%** | **67%** | **88%** | **72%** | **100%** | **100%** | **84%** | **89%** | **100%** | **100%** | **89%** |

*There was a significant delay in forwarding the information to the IG team for disclosure or rectification.

**Health Records Subject Access Requests:**

The reporting mechanism for this year's IG report has altered slightly and whilst over the last 12 months we have again witnessed an increase in the number of general requests received within the Health Records Service, a total of 3,801 and an increase of 67 or 2% on last year's total, this year we will only be reporting on specific patient and third party SARs. The figures provided below will not include any

requests associated with deceased patient records, police requests or court orders. In the last year we have received a total of 2,659 requests and 2,044 of the requests were completed within the allocated timeframe. With a total of 615 breaches, it has resulted in a compliance level of 77% within the health records service. As this is the first year to be reporting in this manner, we will have to wait until next year to accurately understand the ongoing flow of requests and review if they increase or decrease over the next 12 months.

During the year of reporting the staff have witnessed additional complexity associated with the requests they have received and more requests requiring information from a variety of services operating across the Health Board and these factors have placed additional pressure on the staff responsible for delivering the service. The access team have encountered further challenges in regards staff absence associated with vacancies, which have been delayed due to the recruitment approval process and delays in terms of clinical approval for the release of patient information, which is currently being addressed by the Information Governance Sub-Committee. Additional staff resource has been allocated to the access team to try and support the administrative elements associated with the process, however due to the increased complexity of the requests, individuals requesting more varied information across a number of services and the delayed approval, we are still unable to attain compliance levels that we are satisfied with, and this remains an ongoing challenge and concern. These concerns will be worked through with the support of the IG team, the Digital Director and the Assistant Director of Operations.

| Right of Access (Health) | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Apr** | **May** | **Jun** | **Jul** | **Aug** | **Sep** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **March** | **Total** |
| **Received** | 178 | 215 | 236 | 232 | 243 | 224 | 251 | 219 | 159 | 245 | 238 | 219 | 2659 |
| **Breached** | 32 | 44 | 48 | 54 | 56 | 47 | 50 | 62 | 37 | 49 | 44 | 92 | 615 |
| **Compliance** | 82% | 80% | 80% | 77% | 77% | 79% | 80% | 72% | 77% | 80% | 82% | 58% | **77%** |

## 4.8 Assurance – Freedom of Information (FOI)

The 2023/24 financial year has once again seen an increase in the number of Freedom of Information requests received by 103 requests. This is a considerable increase in work for both the Freedom of Information team and colleagues across the Health Board. In addition to the increase in volume, both the size and complexity of these requests has increased, with requests including multiple questions and often requiring information from multiple teams. Despite the increase in requests, we have successfully cross-trained another member of the team; this increasing our internal resource, providing us as a team greater stability and ability to fulfil our statutory duties.

| Freedom of Information Requests | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Apr** | **May** | **Jun** | **Jul** | **Aug** | **Sep** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **March** | **Total** |
| **Received** | 43 | 49 | 49 | 59 | 54 | 48 | 53 | 65 | 54 | 91 | 63 | 41 | 669 |
| **Breached** | 4 | 2 | 3 | 2 | 8 | 7 | 5 | 4 | 3 | 2 | 8 | 2 | 50 |

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Compliance** (%) | 91 | 100 | 94 | 97 | 85 | 85 | 91 | 94 | 94 | 98 | 87 | 95 | 92.6% |
| **Internal Review** | - | 5 | 1 | - | - | - | 2 | 3 | - | - | 1 | 1 | 13 |

Our compliance levels have remained fairly consistent throughout the year, with the team successfully managing the increased number of requests during times of increased pressure on services across the Health Board. By year end, we achieved a compliance figure of 92.6%, a significant improvement on the 78% reported in last year's annual report; though it must be recognised that staffing challenges were a large contributor to last year's compliance figure.

Themes throughout the year remain consistent with previous years, with a continued interest in commercial matters, including medicines and agency staffing.

This year the team developed a training video, which has been shared on the Freedom of Information intranet page. The training video provides a high-level oversight of the Health Board's duties under the Act, along with some guidance on what to do should a Freedom of Information request be received by Health Board officers.

Thirteen internal reviews were received within the last financial year, a small increase on the previous year; however, this is in correlation with the increased number of requests received. Two cases progressed to the Information Commissioner's Office (ICO) last year. One was following a request submitted in August 2023, which progressed to the ICO following an internal review in November 2023; the ICO upheld our approach, and this matter has since been submitted to the First Tier Tribunal, where we have asked to be considered second defendant's and await further instructions. The second case received from the ICO was in respect of a case that had been handled by the Patient Support Services team as an enquiry, where the requestor had wished for it to be processed under FOI; this matter was quickly resolved and was closed once a response under FOI had been issued.

## 4.9 Assurance – Information Asset Registers

The information asset register is a list of personal and non-personal information assets held by service areas within the Health Board. It is important that we know what information we hold in order for us to protect it. We aim to capture all records and systems that contain personal and special category data, flows of data out of the UK, location of data, the retention periods for the records we hold and the legal basis for processing this data.

This year we have worked with our Managed General Practices to compile Information Asset Registers, and pick up any associated work highlighted within the register for example a new application is in development and will need a Data Protection Impact Assessment completed and or a Data Sharing Agreement.

The IG team have started a review process to check that there have not been any changes to the Information Asset Owner or Administrators for the assured Information Asset Registers. The IG Team have also compiled an overarching Information Asset Register, and are working with services to review their assured registers.

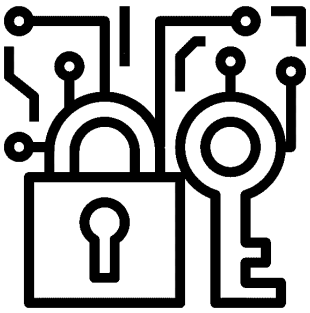
## 4.10 Assurance – Requests for Information (Third Party)

| Requests for Information (Third Party) | Apr-23 | May-23 | Jun-23 | Jul-23 | Aug-23 | Sep-23 | Oct-23 | Nov-23 | Dec-23 | Jan-24 | Feb-24 | Mar-24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Schedule 2(2)(1) - Police Request | 12 | 23 | 9 | 21 | 13 | 19 | 13 | 43 | 25 | 52 | 44 | 31 |
| Schedule 2(5)(2) - Required by Law | 14 | 20 | 23 | 16 | 10 | 28 | 32 | 32 | 12 | 20 | 24 | 10 |
| Schedule 2(5)(3) - Legal Proceedings | 5 | 12 | 4 | 19 | 11 | 14 | 7 | 14 | 11 | 7 | 17 | 14 |
| Police Request - With Patient Consent | 18 | 8 | 18 | 31 | 23 | 18 | 21 | 4 | 1 | 2 | 1 | 1 |
| Schedule 3(2)(2) - Serious Harm Test | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Access to Deceased Patient Records | 1 | 3 | 2 | 2 | 1 | 2 | 1 | 1 | 2 | 4 | 5 | 0 |
| | 50 | 66 | 56 | 89 | 58 | 81 | 74 | 94 | 51 | 85 | 91 | 56 |

| 851 | Requests from Third Parties |
|---|---|

Requests for information can be made by Third Party organisations (Police, CPS, Solicitors, Social Workers, Department of Work and Pensions (DWP), Local Authorities, the Probation Service etc). In some cases, these requests come with the patient consent however, there are instances where patient consent is not required and an exemption in the Data Protection legislation may allow for the release. The IG Team will check if the release is necessary, relevant and proportionate for the purpose of the request, and keep all documentation as evidence if a disclosure is ever challenged.

## 4.11 Assurance – Information Security



HDUHB is committed to protecting the privacy and confidentiality of its patients and staff. Therefore, it uses a special software to scan and block any emails that contain a large amount of personally identifiable information (PII). These emails are then reviewed by the Information Governance team and released if they are appropriate and necessary. If the emails are not allowed, they need to be sent through a special secure facility called Secure Shared Folder, which encrypts the data and ensures its safe delivery.

Tere was a total of 1897 logged emails over the year that were reviewed by Information Governance Team.

## 4.12 Training Compliance

| Training Compliance | Apr-23 | May-23 | Jun-23 | Jul-23 | Aug-23 | Sep-23 | Oct-23 | Nov-23 | Dec-23 | Jan-24 | Feb-24 | Mar-24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Cyber Security E-Learning Compliance | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | n/a | n/a | n/a |
| | | | | | | | | | | | | |
| Information Governance E-Learning Compliance | 80.96% | 79.94% | 79.87% | 79.21% | 78.63% | 77.27% | 77.31% | 77.58% | 77.59% | 77.87% | 78.13% | 77.96% |
| Level 1 Training | 4 | 4 | 3 | 1 | 3 | 2 | 5 | 3 | 2 | 0 | 0 | 0 |
| Level 1 Staff Trained | 29 | 54 | 30 | 52 | 53 | 46 | 77 | 95 | 56 | 0 | 0 | 0 |
| Level 2 Training | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Level 2 Staff Trained | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Training Enquiry | 1 | 6 | 0 | 2 | 4 | 4 | 4 | 3 | 3 | 0 | 0 | 0 |
| Training (Informal) | 3 | 1 | 1 | 0 | 0 | 0 | 2 | 3 | 0 | 0 | 0 | 0 |
| | 8 | 11 | 4 | 3 | 7 | 6 | 11 | 9 | 5 | 0 | 0 | 0 |

| | |
|---|---|
| 27 | Training Sessions Delivered |
| 492 | Employees Trained |

Information Governance training and guidance is designed to be clear, concise and engaging so we enable staff to understand and confidently discharge their data protection responsibilities. Data Protection Legislation requires individuals who process personal information to undertake regular data protection training. In NHS Wales refresher training in data protection is included in the Information Governance (IG) and is mandated for ALL staff to complete every two years as a minimum.

Information governance compliance within HDUHB has decreased from 80.96% in April 2023 to 77.96% in March 2024. The average percentage for training compliance for the period 2023 to 2024 is 78.52%. Areas identified with lower levels of training compliance have been targeted to complete their Information Governance training. The IG Team aims to improve this training compliance figure in 2024-25 by working with the sectors with the lowest compliance to encourage staff through the training programme.

A paper-based Information Governance Training workbook has been developed to target those staff without a pc or access to on-line learning to be able to undertake IG training.

An Information Governance Training Plan has also been developed to log IG training and awareness raising across the Health Board. This includes utilising global email messages, Medical Director's Newsletters, as well as bespoke IG training, awareness raising as part of IG audit visits and issuing IG posters.

## 4.13 Assurance – NIIAS Monitoring

| NIIAS Monitoring | Apr-23 | May-23 | Jun-23 | Jul-23 | Aug-23 | Sep-23 | Oct-23 | Nov-23 | Dec-23 | Jan-24 | Feb-24 | Mar-24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Own Records | 13 | 7 | 7 | 6 | 8 | 7 | 5 | 6 | 4 | 3 | 5 | 5 |
| Family Records | 8 | 5 | 4 | 5 | 7 | 7 | 4 | 7 | 12 | 11 | 8 | 3 |
| Person of Interest | 0 | 0 | 11 | 12 | 0 | 2 | 0 | 0 | 0 | 25 | 0 | 8 |
| **Choose Pharmacy** | | | | | | | | | | | | |
| Own Records | 0 | 0 | 1 | 0 | 1 | 1 | 2 | 0 | 0 | 1 | 1 | 1 |
| Family Records | 0 | 0 | 3 | 1 | 0 | 1 | 3 | 0 | 0 | 0 | 0 | 1 |

| |
|---|
| NIIAS Notifications |

The National Intelligent Integrated Audit Solution (NIIAS) audits staff access to patient records, it has now been fully implemented within the Health Board with procedures for managing any inappropriate access to records. There are regular staff communications, Newsletters, Information Governance Videos, Posters, leaflets, that have all been used to disseminate information to staff around the

importance of confidentiality, appropriate access to patient records and ensuring information is shared in an appropriate way.

There have been no NIIAS Management Board meetings held with DHCW and other Health Boards and Trusts during 2023/2024. DHCW continues to integrate new systems with NIIAS.
All confirmed personal data breaches caused by inappropriate access to patient records are reported to the Data Protection Officer, Deputy Caldicott Guardian and Deputy SIRO, and where necessary reported to the Information Commissioners office. Workforce Department is also notified and internal disciplinary investigations take place if required.

## 4.14 Assurance – IG Compliance

| Information Governanace Compliance | Apr-23 | May-23 | Jun-23 | Jul-23 | Aug-23 | Sep-23 | Oct-23 | Nov-23 | Dec-23 | Jan-24 | Feb-24 | Mar-24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| IG Toolkit Compliance | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 1 | 2 |
| IG Audit Compliance | 0 | 1 | 2 | 7 | 0 | 1 | 0 | 1 | 1 | 1 | 6 | 1 |
| NIIAS Reports | 0 | 2 | 3 | 0 | 0 | 1 | 2 | 0 | 0 | 0 | 2 | 5 |
| Risk Register IG owned | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Risk Register IG Theme | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| IG Compliance Report | 4 | 3 | 1 | 2 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 |

| 53 | IG Enquiries |
|---|---|

The IG Team completed 26 Information Governance audits over the period June 2023 to March 2024 across the four main hospital sites. The purpose of the audit is to identify any Information Governance and Information Security risks and seeks assurance that the relevant procedures and protocols in relation to Information Governance are adhered to. The IG audit covers 12 themes to ascertain the strength of controls in place, the risk level identified and the resulting impact of any risks found.

Those audited are provided with an Audit Summary report which includes recommendations for follow up as well as supporting guidance, information, and tools to achieve the recommendations.

## 4.15 Compliance with the Data Protection Legislation

The General Data Protection Regulation (GDPR) came into force on 25th May 2018. It is now commonly referred to as the UK-GDPR, as a result of the UK leaving the EU. The UK GDPR and Data Protection Act 2018 both update and strengthen current data protection legislation with more emphasis on accountability and the individuals' information rights. In addition to the risk to the organisation of increased fines for non-compliance, because of the highly sensitive nature of the information Health Board hold about individuals, the organisation has an ethical and moral duty to protect the information it is responsible for. An invasion of a person's privacy whether by an accidental loss of their data, a security attack on our systems or by the dishonest actions of a staff member will all have a major impact upon our patients and the trust they put in the organisation to deliver safe and effective care.

The IG Team produces a report which is submitted to every bi-monthly IGSC meeting on the progress in meeting key areas of the UK GDPR requirements to improve systems and processes to better safeguard personal data within the Health Board. This includes regularly reviewing our patient and workforce Privacy Notice's, updating our Information Rights request forms and third-party request for information forms. The IG team have worked with our Digital Service to develop an IG Work Tracker, where work and

queries that are received by the team are recorded, the tracker enables the IG team to log any ICO recommendations that may have been given to the Health Board, and our progress in achieving compliance.

## 4.16 Assurance – Data Quality and Clinical Coding Update

**Clinical Coding Update**

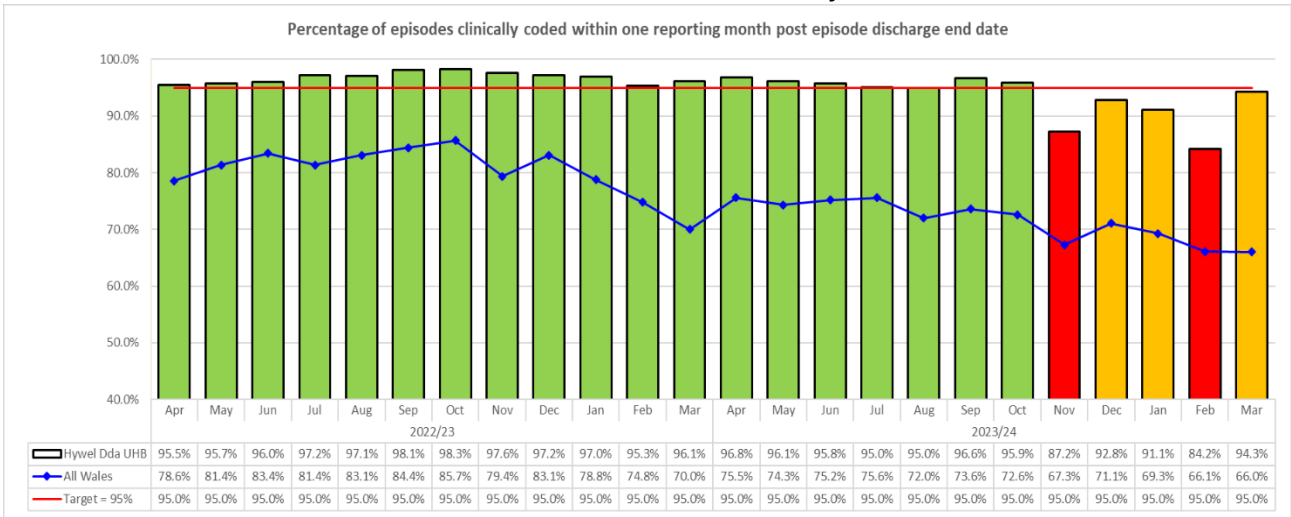
Clinical coding is the process whereby information recorded in the patient notes or record which describes a patient's symptoms, diagnosis and treatment is translated into internationally and nationally recognised coded data and entered onto hospital information systems which can then be used for statistical and clinical purposes. Coding usually occurs after the patient has been discharged from hospital and must be completed to strict deadlines and rules in order for hospitals to understand their activity both locally, nationally and internationally. Hospital coded data on inpatient activity is important, being used for many purposes including NHS financial planning, performance management, epidemiology, clinical governance as well as monitoring of health provision and clinical audit.

The Clinical Coding Department have two Welsh Government Targets in place which normally form part of the NHS Wales Delivery Framework:

1) Percentage of episodes clinically coded within one reporting month post episode discharge end date;
2) Percentage of clinical coding accuracy attained in the DHCW national clinical coding accuracy dashboard;

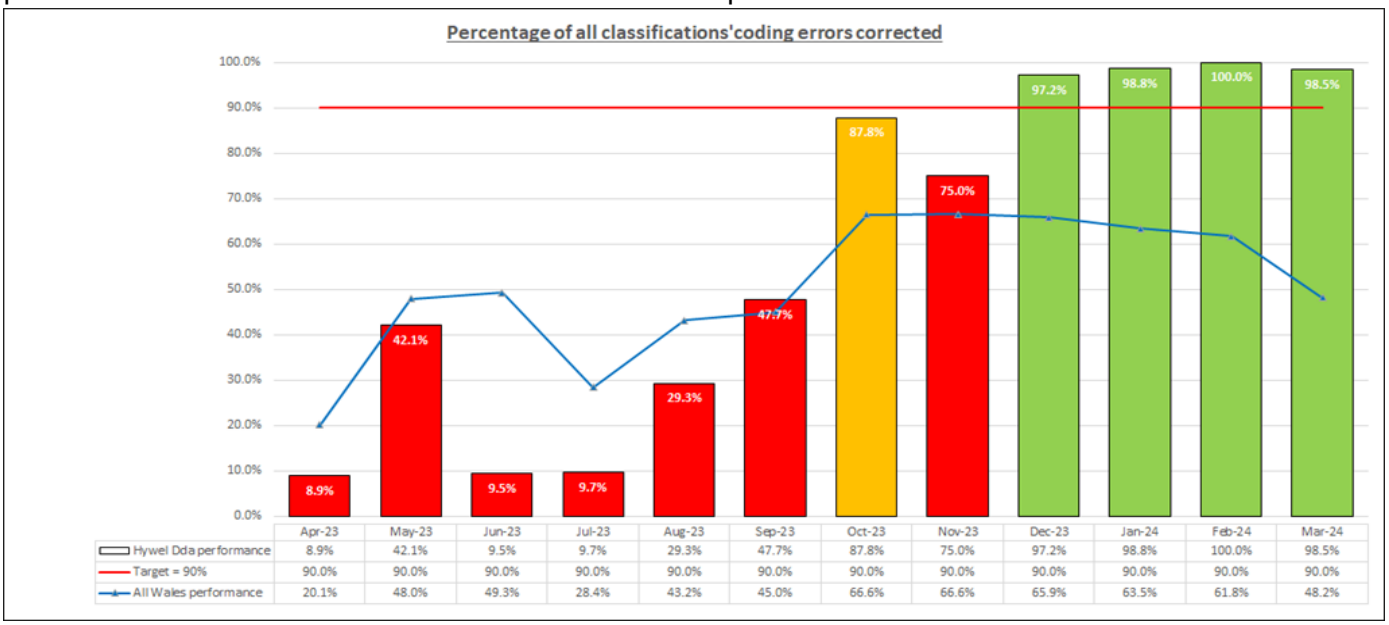
**Percentage of episodes clinically coded within one reporting month post episode discharge end date performance – 2023/24**

- The Health Board has achieved the 95% monthly completeness from April to October, the position from November onwards was down to staff turnoverThe Health Board did not meet the 98% year end completeness target for Welsh Costing Returns with the final compliance being 96.7% at year end.




- **Percentage against the Welsh Government accuracy target**
- DHCW have implemented a new way to measure accuracy during 2023/24 and this can be monitored by individual Health Boards via a national dashboard

Following initial issues with addressing and identifying the errors the team has now developed internal procedures to ensure errors are kept to an absolute minimal level




**Other work in the year**

- The functionality of clinically coding A&E activity has been implemented and the team are able to now capture comparable data for both A&E and inpatient activity. This also opens the door to other patient interactions using clinically coded data.

Work is currently underway to look at automated coding for high volume low complexity cases to further improve efficiencies within the service and the team. We are currently working with CHKS to explore possibilities for proof of concept areas where the digital data is sufficiently captured. An All-Wales Coding Improvement Programme is currently being developed via the NHS Wales Leadership Board to assess the challenges and opportunities to develop an immediate, medium and long term action plan for the clinical coding services in Wales.

**Information Quality Assurance Update**

It is important that the quality of data collected in the healthcare environment is of a high standard and be fit for purpose. High data quality leads to effective decision making which in turn results in better patient care, wellbeing and safety. It is essential in the production of management information to enable the efficient running of the Health Board and to maximise the utilisation of resources. Data quality is the foundation of information and needs to be of a high standard and fit purpose in order to enable the efficient running of the Health Board and to maximise the utilisation of resources. The six dimensions of data quality are defined as Timeliness, Completeness, Accuracy, Consistency, Precision and Validity.

**Work in the year:**

- 9 Information Quality Assurance Reports were completed and circulated for areas identified via the prioritisation process
- The identification and appropriate recording of Transgender patients is still a topic that has not been resolved on a national basis, so the local teams have developed a process to ensure that such detail is captured sufficiently until a national solution is delivered.A scoring mechanism for data quality metrics has been developed to show areas that are doing well and those in need of improvement

- Regular data quality tasks/reports continue to be sent weekly/monthly to staff across the Health Board

## 4.17 Assurance – IG Risk Register

The Information Governance Sub-Committee Terms of Reference state that it will: "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)."

The 2 risks contained in the Information Governance Sub Committee Risk Register has been extracted from Datix Risk Module based on the following criteria:

- The Information Governance Sub Committee has been selected by the risk lead as the 'Assuring Committee' on Datix Risk Module
- Risks are above the proposed tolerance level that will be discussed and agreed by the Board on 27th September 2018
- Risks that have been approved at Directorate level on Datix
- Risks have not been escalated to the Corporate Risk Register.

The risk has been scored against the following 'impact' domains': Statutory duty and inspections.

| Risk Reference and Title | Date Risk Identified | Executive Director | Current Risk Score | Update | Target Risk Score |
|---|---|---|---|---|---|
| 826 - Risk of Withybush General Hospital network failure due to being at end of life and support | 07/01/20 | Huw Thomas | **5x3=15** → (reviewed 11/09/23) | The control measure of having a maintenance contract in place on a 'best endeavours' basis reduces the likelihood of the risk but not the impact. The Likelihood will only be reduced once the new components are in place. | **5x1=5** |
| 1369 – Risk of non-compliance with data protection legislation for Corporate & Medical Records due to a lack of storage risk assessment | 04/04/22 | Huw Thomas | **5x3=15** → (reviewed 11/09/23) | Information Governance are providing regular updates to the IGSC on Records Storage. A new internal storage facility will be ready shortly and this should alleviate some of the storage pressures across the Health Board.<br><br>Impact score of 5 due to potential prosecution from patients and the change in system currently in process. Impact score will only be reduced once digital records start to replace paper records - physical storage locations will not be needed as much. Digital storage overseen by Digital team and therefore more secure and within IG compliance criteria. | **3x2=6** |

The Sub-Committee continues to monitor not only the risks outlined above, but also the wider IG themed Risk Register. The monitoring of the Risk Register is a standing agenda item for consideration by the Sub-Committee.

## 4.19 NHS Wales IG Toolkit

**NHS Wales IG Toolkit – Hywel Dda University Health Board**
Common to other organisations in NHS Wales, the HB completes a self-assessment of Health Board's level of maturity and competency in management information risk and compliance with data protection and Caldicott principles in NHS Wales by completing the NHS Wales IG Toolkit.

The 2022 – 2023 submission deadline has been moved to 30th June 2023 and the submission was made within the timescales. The level of compliance has been satisfactory.

This self-assessment is review by the Information Governance Team in DHCW and scores are attributed against 13 core areas:

- Leadership and Oversight
- Policies and Procedures
- Training and Awareness
- Individual's Rights
- Transparency
- Records of Processing and Lawful Basis
- Contracts and Information Sharing
- Risks and Data Protection Impact Assessments
- Records Management and Security
- Breach Response and Monitoring
- Freedom of Information (FOI) and Environmental Information (EIR)
- Information Security Measures
- Business Continuity

The aim of this breakdown enables the UHB to identify areas for improvement, and to support the prioritisation of improvement efforts.

There are 2 levels of maturity assessed by the toolkit:

- Minimum Expectations
- Expectations Exceeded

The 2023 – 2024 submission was made by 31st March 2024. Hywel Dda University Health Board were able to demonstrate 100% compliance with the Minimum Expectations level, with only Training and Awareness, Risks and Data Protection Impact Assessments, and Business Continuity Plans not achieving 100% compliance with the Exceeds Expectations level.

**NHS Wales IG Toolkit Managed General Practices**

The IG team supports the HDUHB's Managed Practices in meeting their IG and Data Protections responsibilities. There are currently six Managed Practices under Health Board's control:

- Ash Grove Medical Centre
- Meddygfa'r Sarn
- Minafon Surgery (Meddygfa Minafon)
- Neyland Health Centre
- Solva Surgery
- Tenby Surgery

The Managed Practices are required to complete the Welsh Information Governance Toolkit self-assessment tool to measure their level of compliance against national Information Governance standards and legislation. The IG Toolkit consists of simple to follow assessments across many themes, comprising of a range of rudimental questions requiring tick box answers, one-line statements and the facility to upload or link to documents as evidence.

There are two levels of compliance which are Minimum Expectations and Exceeds Expectations. With assistance from the IG Team, all six Managed Practices were able to demonstrate 100% compliance with the Minimum Expectations level, with only Training and Awareness and Business Continuity Plans not achieving 100% compliance with the Exceeds Expectations level.

The IG Team presented the submissions to an Extra-ordinary meeting of the IGSC and demonstrated a marked improvement from the 2022 to 2023 submissions across all the Managed Practices. The IG Toolkit responses were assured for submission to DHCW and were submitted by the deadline of the 31st March 2024.

The Managed Practices Improvement and Action Plans were developed by the IG Team to identify and address key areas across all the Practices which required action to ensure compliance and to improve their future IG Toolkit Submissions. The plans were reviewed ahead of the IG Toolkit submission with the majority of actions required having been completed with any outstanding actions being transferred to Improvement Action Plans for 2024 onwards.

The aim of the IG Toolkit and Improvement Plans is to demonstrate that organisations can be trusted to maintain the confidentiality and security of both personal and business information. This will provide re-assurance to staff and patients that their information is processed securely and appropriately, and assure other organisations where sharing is made that appropriate IG arrangement are in place.

## 5. Policies and Procedures

**Annual Review of Information Governance related written control documentation**

The IGSC is the 'owning' Sub-Committee identified for 29 approved corporate written control documents. The overview below provides an outline of the current status of the relevant written control documentation including review dates and details of those approved in line with the UHB's 190 - Written Control Document Policy. The overview also highlights where relevant written control documents are out of date or due for review. Due to increased work pressures faced, the Digital Services Department were unable to review all policies to meet the deadlines indicated. Assurance was provided that the documents remained fit for purpose and an extension of 12 months to the review dates of all policies / procedures was requested. As detailed in the table below, most written control documents are now either back in date or have been reviewed and approved at IGSC but require approval from Sustainable Resources Committee prior to being uploaded to the website.

| Policy or Procedure | Responsible Officer |
|---|---|
| 494 AW Email Use Policy | Head of Information Governance |
| 495 AW Internet Use Policy | Head of Information Governance |
| 836 AW Information Governance Policy | Head of Information Governance |
| 837 AW Information Security Policy | Head of Information Governance |
| 224 Information Classification Policy (ARCHIVED) | Information Governance Manager |
| 275 Secure Transfer of Personal Information Policy | Information Governance Manager |
| 172 Confidentiality Policy | Information Governance Manager |
| 238 Information Governance Framework | Information Governance Manager |
| 279 Third Party Supplier Policy | Information Governance Manager |
| 773 Unauthorised access to patient records procedure | Information Governance Manager |
| 1088 Information Rights Procedure | Information Governance Manager |
| 1160 Data Protection Impact Assessment Procedure | Information Governance Manager |
| 347 Corporate Records Management Policy | Head of Information Governance |
| 193 Retention and Destruction of Records Policy | Health Records Manager |
| 249 Access to Health Records | Health Records Manager |
| 191 Health Records Management Policy | Health Records Manager |
| 192 Health Records Management Strategy | Health Records Manager |
| 173 Freedom of Information and Environmental Information Policy | Senior Corporate Information Officer |
| 174 Reuse of Public Sector Policy | Senior Corporate Information Officer |
| 465 AW Social Media Policy | Head of Digital Operations |
| 250 Information Quality Assurance Policy | Head of Digital Operations/ Digital Director |
| 281 Mobile Working Policy | Head of Digital Operations |
| 282 Network Security Policy | Head of Digital Operations |
| 301 User Account Management Policy | Head of Digital Operations |
| 319 Disposal of Digital Assets Policy | Head of Digital Operations |
| 320 Acceptable Use of Information and Communication Technology Policy | Head of Digital Operations |
| 240 Digital Procurement and Request Procedure | Head of Digital Operations |
| 422 Consumer Device Policy | Head of Digital Operations |

# 6. INFORMATION GOVERNANCE SUB-COMMITTEE GROUPS

The Information Governance Sub-Committee Annual Report 2023-2024 is intended to outline how the Sub-Committee and its Groups have complied with the duties delegated by the SRC through the terms of reference set, and also to identify key actions that have been taken to address issues within the Sub-Committee's remit.

The Groups reporting to the Information Governance Sub-Committee during 2023-2024 were as follows:

## 6.1 Information Asset Owners (IAO) Group

The group met 6 times during the financial year to oversee the work progress made by Information Governance team:

- 19th April 2023
- 28th June 2023
- 28th September 2023

- 01 November 2023
- 1st February 2024
- 7th March 2024

Purpose:

The Group has been established to:

- Agree and oversee the UK GDPR / Data Protection Act 2018 compliance project work plan.
- Develop and oversee a programme of information asset audits and asset mapping.
- Ensure that Information Asset Owners are in place across the organisation and are fully briefed in relation to their role.
- Agree a process for identifying, recording, and mitigating any information risk identified through the information asset audit programme.
- Develop and agree a communication and engagement programme for staff around the UK GDPR and information governance, including information security.
- Progress the implementation of Data Protection Impact Assessments (DPIAs) across the Health Board.

Terms of Reference:

The terms of reference for the group were updated and approved at the IGSC in April 2024, the main changes were to staff job titles and standing items on the agenda.

Main Discussions:

The main discussion points within the group are Information Governance Audits, Medical Record Storage Audits, Information Asset Registers, IG Compliance with legislation and NIIAS monitoring over the financial year. The group are regularly asked to review the Information Asset Owners and Administrators list, so that the Information Asset Register review work is targeted to the correct staff.

## 6.2 The Health Records Group

A Health Records Group (HRG) was previously established and reported to the Information Governance Sub Committee (IGSC) as a Sub-Group from April 2018 and terms of reference and key activities for the group had been approved by the IGSC. During 2023 – 2024, the Health Records Group has again been unable to meet, however this is not a matter for concern, this is simply because of the considerable developments and progress the Health Board has made in its digital transition and the new working environment. The Health Board has a clear digital strategy and an ambition to move away from a paper-based model of patient care to a digital version and that ambition has started to come to fruition over the last year. Via agreement with the Executive Team, the Health Board has made significant strides and important decisions in terms of its transition towards a digital record and progress of its digital strategy, which as previously outlined is being overseen by the Digital Records Programme Steering Group (DRPSG). Led by the Digital Director and Assistant Director of Operations the DRPSG has ensured the Health Board has fully procured the new Cito electronic document records management system (EDRMS) and are currently in the final stages of implementation and roll out and in addition approximately 385,000 records have been distributed for digitisation and ingestion into Cito, through our scanning partners. Viewed as a “high priority” by the Executive Team, this project has been a major undertaking and the progress made to date must be credited to the DRPSG. Clearly the Health Records Group in its previous guise, was not advanced enough to move forward and support the Health Board with the digital transition and therefore it is almost certain that the DRPSG will be the lead group moving forward. Not only does it encompass all elements associated with the HRG, but it now also has the appropriate leadership, knowledge, expertise and programme management resource to successfully

progress the digital strategy over the immediate and long-term future. This alteration will need to be formally confirmed by the Executive Team and through IGSC once the initial digital transition phase has been completed. Due to the considerable progress and the benefits already being witnessed in the Health Board and the fact that the DRPSG is seen as the main driver behind the delivery of a fully implemented digital patient record, this should be a formality.

## 6.3 Caldicott Guardian Group

The group met 6 times during the financial year to oversee the work progress made by Information Governance team:

- 30th May 2023
- 2nd August 2023
- 27th September 2023
- 22nd November 2023
- 29th January 2024
- 20th March 2024

Purpose:

The Caldicott Guardian Group has been established as a subgroup of the Information Governance Sub-Committee and constituted from 25th August 2020.

The purpose of the Caldicott Group is to provide assurance to the Information Governance Sub-Committee around Caldicott Guardian functions. The Group will:

- Support Caldicott Guardian in understanding their responsibilities and those of the Health Board.
- Share good Caldicott/confidentiality and information sharing practice between the Health Board and partners.
- Supporting Caldicott Guardian in raising the profile of Caldicott / confidentiality issues and appropriate information sharing across the Health Board and partners.
- Notify the Caldicott Guardian of incidents which result in a negative clinical impact or reduced level of care to patients.

Terms of Reference:

The Terms of Reference were last reviewed in March 2024 and will be reviewed on an annual basis.

## 6.4 IGSC In-Committee (Information Governance Incidents)

The group met 6 times during the financial year to oversee the work progress made by Information Governance team:

- 13th April 2023
- 8th June 2023
- 8th August 2023
- 3rd October 2023
- 30th November 2023
- 7th February 2024

Purpose:

The group has been established to:

- Receive updates on new Information Governance and Cyber Security Incidents reported including the presentation of any Information Governance Incident Investigation Reports.

- Receive detailed updates on ongoing incidents/breachers reported to the ICO.
- Agree recommendations and actions in relation to any new Incidents reported.
- Reach agreement to close any completed Incidents.
- Agree any further recommendations/work required around managing Incidents within the Health Board.
- Review relevant policies and procedures

Terms of Reference:

The In-committee is subject to the same Terms of Reference as IGSC.

## 6.5 Cyber Security Assurance Group

The group met 3 times during the financial year to oversee the work progress made by Cyber Security team:

- 28th Jun 2023
- 13th Sep 2023
- 18th January 2024

Purpose:

The purpose of the group is to provide assurance to the Information Governance Sub-Committee regarding Cyber Security remediation and reduction of Cyber Security risk. The group also works towards compliance to both the Network and Information Systems Regulation 2018 (NISR) and the implementation of technical controls under the Data Protection Act 2018 (DPA)/ UK General Data Protection Regulation 2018 (UK GDPR).

Terms of Reference:

The Cyber Security Assurance Group (CSAG) has been established since July 2022 with TORs agreed in September 2022.

# INFORMATION GOVERNANCE SUB-COMMITTEE COMMITTEE UPDATE REPORT

**Date of last meeting**: 24 July 2024

**Quoracy**: Met

**Report by**: Anthony Tracey, Digital Director, Chair

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## KEY DISCUSSION POINTS AND MATTERS TO BE ESCALATED FROM THE DISCUSSION AT THE MEETING:

**Alert** (may require discussion)

Information Governance Sub-Committee wish to **alert** members of the Sustainable Resource Committee that:

- **Mobile Working Policy** – the Sub-Committee approved the changes to the Mobile Working Policy in line with improving the cyber security resilience within the Health Board.
- **Workforce Privacy Notice** – During the review of the Workforce Information Asset Register it was agreed that the Privacy Notice should have reference to volunteers and students. The proposed changes were subsequently approved following additional text.

**Advise** (to monitor)

Information Governance Sub-Committee wish to **advise** members of the Sustainable Resource Committee that:

- **Records Management Code of Practice** – amendments have been made to the all-Wales code of practice, included splitting the retention guidance into separate categories: GP/Primary care, Local Authorities, Secondary care, Community, Mental Health and Corporate. An additional appendix will be added to cover off any Inquires that may present in the future. Health Boards have already been through past Inquires (Goddard/IBI) and whilst current ongoing Inquires such as Thirlwall and David Fuller are not specifically related to patient records, it is likely there may be a requirement for Health Boards to act in the future. The GP section has also been updated to further emphasise the fact that the 20 year long term condition retention guidance will reside within the primary care record, as these records are retained for the life of the patient.

**Assure (to note)**

Information Governance Sub-Committee wish to **assure** members of the Sustainable Resource Committee that:

- **Data Quality Update** – The Sub-Committee received the annual data quality report undertaken by the information services team. The “deep dives” undertaken covered the following areas: Clinical Decisions Unit, A&E Activity, RTT Waiting Lists, Ward Discharges, Discharge Lounge Activity, Theatre Completeness, Transgender Patients, Daycare Activity, and Cancelled

Admissions. There were a number of general themes of data quality which the team identified, around inconsistencies across sites on recording of actions. The Team continues to undertake training with specific staff, however greater monitoring and feedback is being put in place.

- **Information Governance Audits**: The Sub-Committee received an update on the final summary audit reports have been issued to those audited between June 2023 and February 2024 with each audit receiving an overall standard of satisfaction, with associated recommendations for improvement. The top four themes, that will be incorporated into the IG training plan, are, improvements to staff knowledge in terms of information rights, the use of WhatsApp, and the use of personal devices to take photographs, the lack of information governance posters in ward areas, and the lack of CCTV posters on display notifying patients, visitors, and staff that CCTV is in operation.
- **Information Governance Training Compliance**: Compliance has marginally increased over the last quarter reaching 79% during March 24, and a similar number for quarter 1. The new mandatory IG, Records Management and Cyber Security training has been placed within the IG Intranet site, providing an alternative method for completing the training and assessment. We continue to see low compliance within Estates and Ancillary with a marginal increase (65%). The lowest compliance remains within the Medical and Dental service area however they have had a further marginal increase during Q1attaining 42%.

**Review of Risks**

The Sub-Committee reviewed the two risks which are aligned to Group. As part of its review, the Sub-Committee considered the status of each risk, and the current score was deemed in tolerance. However, the Sub-Committee did recognise the work that had been done by the Information Governance and Health Records Teams in reducing the risk of inappropriate storage facilities.

**Sharing of learning**

The Information Governance Sub-Committee had no matters to alert the Group on this occasion.

**Recommendation**

The Committee is asked to **NOTE** the report and **TAKE ASSURANCE** from the actions and oversight of the Sub-Committee.