Bundle Quality, Safety and Improvement Committee 15 January 2019

1 13:30 - Preliminary Committee Business

Kate Eden, Chair

1.1 Welcome, Introductions and Apologies for Absence

Kate Eden, Chair

1.2 Declarations of Interest

Kate Eden, Chair

1.3 Minutes from the Meeting Held 04.10.18

Kate Eden, Chair
For approval

1.3.QSIC.150119 - Unconfirmed QSIC Minutes 04.10.18 v 1.0.docx

1.4 Action Log

Kate Eden, Chair
For approval

1.4.QSIC.150119 - Updated Action Log.pdf

1.5 Matters Arising

Kate Eden, Chair

1.6 Any other items of urgent business for discussion at the end of the meeting

Kate Eden, Chair

2 13:40 - Risk Assurance Framework

2.1 Board Assurance Framework

Eleanor Higgins, Corporate Governance Manager / John Lawson, Chief Risk Officer
Report for consideration

2.1.QSIC.150119 - Board Assurance Framework Cover Paper.docx

2.1.QSIC.150119 - App 1 Board Assurance Framework v211118.pdf

2.2 Corporate Risk Register

John Lawson, Chief Risk
Report for assurance

2.2.QSIC.150119 - Dec 2018 Corporate Risk Register (QSIC).docx

2.2.QSIC.150119 - Corporate Risk Register - December 2018.pdf

3 Service User Experience Story

3.1 13:50 - Service User Experience Story linked to Breast Test Wales

Junaid Iqbal, Lead for Service User Experience

4 Quality and Safety

4.1 14:05 - Breast Test Wales Deep Dive

Sharon Hillier, Director, Screening Division
For assurance

4.1.1.QSIC.150119 - BTW Deep Dive Cover Paper.docx

4.1.2.QSIC.150119 - BTW Position Statement v11.docx

4.2 14:40 - Serious Incidents: new / update

4.3.1 14:45 - Quality and Impact Framework Implementation Plan 6 month update

Sian Bolton, Acting Executive Director of Quality, Nursing and Allied Health Professionals
For assurance

4.3.1.QSIC.150119 - Quailty and Impact Framework Implementation plan 6 month update.docx

4.3.2 Evaulation Appraisal Summary Report

Genevieve Riley, Senior Researcher, Impact and Evaluation
Presentation-

4.3.2.QSIC.150119 - Evaluation appraisal summary report.docx

4.3.2.QSIC.150119 - Evaluation Jan 2019 QSI.pptx

5 Policies and Procedures

5.1 15:00 - Update on Policies and Procedures

Eleanor Higgins, Corporate Governance Manager
Report for assurance

5.1.QSIC.150119 - Policy Update Quarter 3.docx

5.1.QSIC.150119- QSIC Policy extract quarter 3.pdf

5.2 15:05 - Policies for approval

5.2.1 Alerts, Safety Notices and NICE Guidelines Policy and Procedure

Sian Bolton, Acting Executive Director of Quality, Nursing and Allied Health Professionals
For approval

5.2.1.a.QSIC.150119 - Alerts policy cover paper.docx

5.2.1.b.QSIC.150119 - Alerts Policy v1 (Draft).doc

5.2.1c.QSIC.150119 - Alerts Procedure v1 (Draft).doc

5.2.1.d.QSIC.150119 - EHIA - Alerts Policy and Procedure.docx

5.2.2 All Wales IT policies

John Lawson, Chief Risk Officer
For adoption

5.2.2.QSIC.150119 - All Wales IG Policies front sheet.docx

5.2.2.b.QSIC.150119 - Draft All Wales adopted Information Governance policy.docx

5.2.2.c.QSIC.150119 - EHIA - All Wales IG Policy.docx

5.2.2.d.QSIC.150119 - Draft All Wales adopted Information security policy.docx

5.2.2.e.QSIC.150119 - EHIA - All Wales IS Policy.docx

5.2.2.f.QSIC.150119 - Draft All Wales adopted Internet use policy.docx

5.2.2.g.QSIC.150119 - EHIA - All Wales Internet use Policy.docx

5.2.2.h.QSIC.150119 - Draft All Wales adopted PHW Email use policy.docx

5.2.2.i.QSIC.150119 - EHIA - All Wales Email Policy.docx

5.3 15:10 - Break 5 minutes

6 Governance

6.1 Clinical Governance

6.1.1 15:15 - Interim Report of Annual Quality and Clinical Audit 2018/19

Sian Bolton, Acting Executive Director of Quality, Nursing and Allied Health Professionals
Report for assurance

6.1.1.QSIC.150119 - Interim Quality and Audit Plan Update V3.docx

6.1.2 15:20 - Putting Things Right Report: Quarter 2

Sian Bolton, Acting Executive Director of Quality, Nursing and Allied Health Professionals
Report for assurance

6.1.2.PTR Q2 Report cover sheet v2.0.docx

6.1.2.Putting Things Right Q2 Report V0b.docx

6.2 Information Governance

6.2.1 15:25 - Information Governance Performance Report

John Lawson, Chief Risk Officer
Report for approval and assurance

6.2.1.QSIC.150119 - IG Performance Report Dec 18.docx

6.2.1.QSIC.150119 - IGPR final.docx

7 15:35 - -

8 Improvement

8.1 15:35 - Service User Experience Summary Report

Sian Bolton, Acting Executive Director of Quality, Nursing and Allied Health Professionals
For assurance

8.1.QSIC.150119 - Service User Experience Summary report v1.docx

8.1.QSIC.150119 - FINAL Feedback from users of our services 2017-2018.pdf

9 Knowledge, Research and Innovation

9.1 15:45 - Official Statistics Group

Linda Bailey, Consultant in Public Health
For approval

9.1.QSIC.150119 - Official Statistics Committee Jan 19.docx

9.1.QSIC.150119 - Appendix 1 OS TOR V2.docx

10 Committee Governance

10.1 15:50 - Annual Review of Committee Effectiveness

Eleanor Higgins, Corporate Governance Manager
For consideration

10.1.QSIC.150119 - Quality, Safety and Improvement Committee self assessment 0.3.docx

10.1.QSIC.150119 - App1 QSIC self assessment.pdf

10.2 Ratification of Chairs Action

Approval of the Medical Devices and Equipment Management Policy and procedure

10.2.QSIC.150119 - Ratification of Chairs Action cover paper.docx

10.2.a.QSIC.150119 - Medical Devices and Equipment Management Policy and Procedures - cover report.docx

10.2.b.QSIC.150119 - PHW 69 Medical Devices and Equipment Management Policy.pdf

10.2.c.QSIC.150119 - PHW 69 TP01 Medical Devices and Equipment Management Procedure.pdf

10.2.d.QSIC.150119 - PHW 69 Medical Devices and Equipment Management EHIA.pdf

11 Date of Next Meeting

16th April 2019, 13:30pm, Room 3.2, 3rd Floor Capital Quarter 2, Public Health Wales

11.1 End of Public Meeting

That representatives of the press and other members of the public will be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with [Section 1(2) Public Bodies (Admission to Meetings) Act 1960 (c.67).]

11.2 16:15 - Break

12.1 16:25 - In Private Preliminary Committee Business

12.2 Declarations of Interest

12.3 Minutes of the Private Session held 04.10.18

For approval

12.4 Action Log

For approval

12.5 Matters Arising

12.6 Any other items of urgent business for discussion at the end of the meeting

13 Quality and Safety

13.1 16:35 - Serious Incident: Diabetic Eye Screening Wales

Quentin Sandifer, Executive Director of Public Health Services and Medical Director
For assurance

13.2 Serious Incident: Microbiology

Quentin Sandifer, Executive Director of Public Health Services and Medical Director
For assurance

14 Risk Assurance

14.1 16:45 - Board Assurance Framework (Confidential Extract)

Eleanor Higgins, Corporate Governance Manager / John Lawson, Chief Risk Officer
For consideration

15 Governance

15.1 Clinical Governance

15.1.1 16:50 - Claims and Redress Report: Quarter 2

Sian Bolton, Acting Executive Director of Quality, Nursing and Allied Health Professionals
For assurance

16 Date of Next Meeting

16th April 2019, 13:30pm, Room 3.2, 3rd Floor Capital Quarter 2, Public Health Wales

Unconfirmed Minutes of the Public Health Wales Quality, Safety and Improvement Committee Meeting 04 October 2018, 13:30 to 16:35 Venue: Room 3/2, No 2 Capital Quarter, Tyndall Street, Cardiff

Present:

Kate Eden	(KE)	Committee Chair and Non-Executive Director
Shantini Paranjothy	(SP)	Non-Executive Director
Alison Ward	(AW)	Non-Executive Director

In Attendance:

Sian Bolton	(SB)	Acting Executive Director of Quality, Nursing and Allied Health Professionals
Mike Fealey	(MF)	Head of Patient Safety, 1000 Lives Improvement on behalf of John Boulton
Sharon Hillier (for item 4.1)	(SH)	Director of Screening Division, (part of meeting)
Junaid Iqbal (for Service User Experience Story)	(JI)	Lead for Service User Experience (part of meeting)
Jude Kay (for item 4.1)	(JK)	Head of Programme, Diabetic Eye Screening Wales Service (part of meeting)
John Lawson (for items 4.2, 5.2.1 and 5.4.1)	(JL)	Chief Risk Officer (part of meeting)
Claire Lewis	(CL)	Representative from Staff partnership Forum
Semele Mylona	(SM)	Healthcare Inspectorate Wales Representative
Sam Ray (for item 5.1.2)	(SR)	Lead Nurse for Infection, Prevention & Control (part of meeting)
Gill Richardson	(GRi)	Deputy Director of Policy, Research and International Development on behalf of Mark Bellis
Quentin Sandifer	(QS)	Executive Director of Public Health Services /Medical Director
Cathie Steele	(CS)	Acting Board Secretary and Head of Corporate Governance

Stephanie Wilkins	(SW)	Representative from Staff Partnership Forum
Jan Williams	(JW)	Chair

Secretariat:

Reanne Reffell	(RR)	Corporate Governance Officer

Apologies:

Mark Bellis	(MB)	Director of Policy, Research and International Development
John Boulton	(JB)	Director for NHS Quality Improvement and Patient Safety / Director 1000 Lives
Eleanor Higgins	(EH)	Corporate Governance Manager
Gay Reynolds	(GRe)	Governance and General Manager, Quality, Nursing and Allied Health Professionals
Terence Rose	(TR)	Non-Executive Director

The meeting commenced at 13:30

QSIC 68/2018 Welcome, Introductions and apologies

KE, as Chair of the Committee, opened the meeting and welcomed all present. She extended a particular welcome to SM, who had been appointed the Healthcare Inspectorate Wales liaison to Public Health Wales.

MF was in attendance on behalf of John Boulton.
GRi was in attendance on behalf of Mark Bellis.

The following attended part of the meeting:

- JI for the Diabetic Eye Screening Wales Service User Experience Story (**72/2018**).
- JK and SH for the Diabetic Eye Screening Wales Deep Dive Presentation (**73/2018**).
- JL for the Serious Incidents update (**73/2018**); Information Governance Performance Report: Quarter 1 (**75/2018**) and All Wales policies for adoption (**76/2018**).
- SR for the Infection Prevention & Control Annual Update (**74/2018**).

The Committee **noted** the apologies received.

QSIC 69/2018 Declarations of Interest

There were no declarations of interest.

QSIC 70/2018 Minutes and Actions

70/2018.a Approval of Minutes of the meeting of 10 July 2018

The Committee **resolved** to approve the minutes of the meeting held on 10 July 2018 (ref 1.3.QSIC.041018) as an accurate record of the meeting.

70/2018.b Action Log

The Committee **received** the action log (ref.1.4.QSIC.100718).

Action ref **QSIC 54/2018** (10.07.18) – SW expressed concerns related to staff training on the Datix system. SB and SW agreed to discuss the Datix implementation action plan and staff training requirements outside of the meeting with the Chief Risk Officer.
Action: SB / SW/ JL

The Committee **noted** the action updates provided and **resolved** to approve the closure of the completed actions.

70/2018.c Matters Arising

There were no matters arising.

QSIC 71/2018 Risk Assurance

71/2018 a. Board Assurance Framework: QSIC Extract

The Committee **received** the updated extract of the Board Assurance Framework (BAF) (ref 2.1.QSIC.041018) from CS.

The Committee **noted:**
- That none of the risks had exceeded their "Action Due Date" at the time of the report.
- The private meeting would consider risk 4 due to the sensitive nature of the content.

71/2018 b. Risk Assurance: Items for Consideration at future meetings

The Chair noted that this would be a standing item with the intention of allowing members to highlight any issues within the BAF/risk register where members require additional information in order to gain appropriate assurance.

QSIC 72/2018 Diabetic Eye Screening Wales Service User Experience Story

The Committee **received** a service user experience video presentation from JI.

The Committee **noted**:
- Two service users' perspectives on their use of the Diabetic Eye Screening Wales Service; which included receiving the appointment letter, attending the various clinic locations and the treatment process.
- Possible service improvements from the patient perspective, which included convenient local clinic locations, clear signage and modern communication methods.
- The friendliness and professionalism of the staff members.

The Committee discussed a number of issues; which included population based screening programmes versus optometrist's visits, convenient geographical premises, service user coverage and engagement.

JI left the meeting.
JK and SH joined the meeting

QSIC 73/2018 Quality and Safety

73/2018 a. **Diabetic Eye Screening Wales Deep Dive**

The Committee **received** the Diabetic Eye Screening Wales Report (ref 4.1.QSIC.041018) and presentation from JK and SH.

The Committee **noted**:

- Mobile vans deliver the service to over 150 locations across Wales.
- The significant expertise and commitment from staff.
- Improvements / work around infrastructure, processes, performance monitoring and workforce engagement.
- The intention to future proof the service via changes to risk based screening and further advances to improve patient user experience / service.

A vigorous discussion took place regarding:

- Clarity of vision could be patient focussed not process led.
- Staff engagement.
- Modernisation of IT, increased geographical venues and premises.
- Engagement with 1000 Lives team for support.
- A system for broader routine feedback which could be learnt from.

The Committee were advised that an action plan outlining modernisation and transformation plans would go to the Business Executive Team. The Committee **resolved** to receive an update following this.
Action: QS

The Committee recommended the next steps:

- The Board would oversee the strategic vision through the Transformation Board
- Workforce implications, engagement and culture would be remitted to the People and Organisational Development Committee

Action: JR/PB

- The Quality, Safety and Improvement Committee would receive assurance on service user engagement and operational risks.

Action: KE/SB

The Chair thanked JK and SH for their comprehensive overview of the service and the challenges faced. The Chair also conveyed the Committee's thanks to the Diabetic Eye Screening Wales Service team for their commitment and contribution to the sustainability of the service.

JK and SH left the meeting
JL joined the meeting

73/2018 b. Serious Incidents Update

The Committee **received** the Serious Incidents update report (ref 4.2.QSIC.041018) from JL.

The Committee **noted** the three outstanding incidents, which were discussed further in the private meeting.

QSIC 74/2018 Clinical Governance

74/2018 a. Putting Things Right Report: Quarter 1

The Committee **received** the Putting Things Right Report: Quarter 1 (ref 5.1.1.QSIC.041018) from SB.

The Committee **noted**:

- The ratio of compliments to complaints for the year was 30:1.
- 100% of complainants were acknowledged within two working days.

The Committee received **assurance** of the effectiveness of the management of concerns (incidents, complaints and claims).

74/2018 b. Infection Prevention & Control (IP&C) Annual Update 2017/18

The Committee **received** an Infection Prevention & Control annual presentation (ref. 5.1.2.QSIC.041018) from SR.

The Committee **noted**:

- The Code of Practice Standards relevant to Public Health Wales.
- The progress against 2017/18 priorities; which were focused on audit process and flu vaccination uptake.
- Priorities for 2018/19 which built upon the codes of practice. These included the adoption of the Scottish IP&C online training manual, flu vaccinations and the provision of support to both the Diabetic Eye Screening Wales and Breast Test Wales services.
- Microbiology Services would be referred to in future updates.

The Committee were **assured** that the organisation was meeting its statutory requirements in relation to the management of infection prevention and control.

The Chair thanked SR for all of the hard work undertaken in past year.

74/2018 c. Healthcare Inspectorate Wales Annual Report 2017/18

The Committee **received** and **noted** the Healthcare Inspectorate Wales (HIW) Annual Report for 2017/18 (ref 5.1.3.QSIC.041018), and page 46 which referred specifically to Public Health Wales.

SM agreed to share with the Committee details of the Public Health Wales contact who consulted on the substance misuse section.

Action: SM/ Secretariat

The Committee also requested oversight of the matrix of evidence HIW gather in relation to Public Health Wales, which would help to inform proposed inspections for 2019/20. The Committee **resolved** to agree that this would be taken forward outside of the meeting.
Action: SM/ Secretariat

QSIC 75/2018 Information Governance

The Committee **received** the Information Governance Performance Report: Quarter 1 (ref 5.2.1.QSIC.041018) from JL.

The Committee **considered** the report and **noted:**

- Freedom of Information and Data Protection Act requests were responded to in a timely manner. JL advised that these requests were time intensive.
- An extreme risk from the Information Governance Risk Register had been escalated to the Corporate Risk Register.

The Committee **resolved** to agree that future reports would feed into the Knowledge Research and Innovation Committee.
Action: Secretariat

QSIC 76/2018 Policies and Procedures

76/2018 a. All Wales Policies: for adoption

The Committee **received** the All Wales IT Policies for adoption (ref 5.4.1.QSIC.041018) from JL.

The Committee **resolved** to agree that further assurance was required that all relevant pan Wales groups had been fully consulted during the EQIA process (completed external to Public Health Wales).

The Committee **resolved** to agree that the policies would be re-submitted for adoption once EQIA's undertaken by Public Health Wales were in place.
Action: JL

76/2018 b. Safeguarding Policy and Associated Procedures

The Committee **received** the Safeguarding Policy and associated procedures (ref 5.4.2.QSIC.041018) from SB.

The Committee **resolved** to approve the following policy and procedures:

- Safeguarding Policy
- Domestic Abuse Procedure
- Managing Allegations of Domestic Abuse Procedure

The Committee **resolved** to approve the Adults at Risk Procedure subject to amendment of the flow diagram as agreed.

Action: SB

The Committee **resolved** to approve the Children at Risk Procedure subject to clarification from the Corporate Safeguarding Lead, on the wording of one sentence. The Committee agreed that the Lead would liaise with AW to agree the wording.
Action: AW / IS

76/2018 c. Register of Policies and Written Control Documents: Bi-annual Update
The Committee **received** the register of policies and written control documents bi annual update (ref 5.4.3.QSIC.041018) from CS.

The Committee **noted**:
- That whilst the report related to quarter 1; the percentage compliance of in-date policies and procedures had increased during quarter 2.
- That the adoption of the Scottish Infection Prevention and Control (IP&C) online training manual would result in the archive of overdue IP&C procedures.

The Committee **resolved** to receive assurance on the prioritisation and progress made to review Quality, Safety and Improvement policies, procedures and other written control documents and **agreed** to receive a further update in January 2019.
Action: CS

QSIC 77/2018 Improvement

The Committee **received** the Microbiology Service: Risk Assessment and Future Operational Model for the Microbiology Service report (ref 6.1.QSIC.041018) from QS.

The Committee **considered** the update on the current risks and future requirements for microbiology and health protection and **noted**:
- The challenges faced by the service.
- The opportunity to improve service delivery through stakeholder, Welsh Government and Health Education and Improvement Wales engagement.
- Development of a skilled multidisciplinary workforce.
- The establishment of a Transformation Programme Board; chaired by the Chief Executive.
- The proposed new "National Infection Service for Wales" model.

SW requested clarification on the term "world class infection service". QS advised that the service would be benchmarked against other countries in terms of its diagnostic portfolio and the use of technologies etc.

The Committee were **assured** that appropriate governance arrangements would be put in place; and the Board would receive bi–annual updates.

The Committee **resolved** to agree to receive bi-annual updates.
Action: Secretariat

QSIC 78/2018 Knowledge, Research and Innovation

The Committee **received** the World Health Organisation (WHO) Collaborating Centre (CC) on Investment for Health and Wellbeing Update (ref. 7.1.QSIC.041018) from JR.

The Committee **noted**:

- A WHO CC Management Board would be structured to support progress and monitor governance.
- An annual report would be provided to the WHO and the Public Health Wales Board. The reporting mechanism would be via the Knowledge, Research and Innovation Committee.

The Committee were **assured** that the WHO Collaborating Centre was established and had progressed according to plan, in line with the organisational strategic priorities and objectives, as well as the national legislative and strategic context.

QSIC 79/2018 Items for noting

The Committee **noted** three items provided for information as follows:

79/2018.a Alerts Report: Quarter 1 (ref 8.1.QSIC.041018).
79/2018.b Committee Workplan 2018-19 QSIC Extract (ref 8.2.QSIC.041018). CS advised that outstanding reports would be submitted at the next Committee meeting.
79/2018.c Updated Terms of Reference (ref 8.3.QSIC.041018)

QSIC 80/2018 Any Other Items of Urgent Business

There was no other urgent business.

Date of the Next Meeting:
15 January 2019, 13:30hours, Room 3/2 (Boardroom) - Public Health Wales, No 2 Capital Quarter, Tyndall Street, Cardiff, CF10 4 BZ

The Public Session closed at 16:15

RAG Rating Guide

- Red - Action date passed - action not complete
- Orange - Action not on target for completion by agreed/revised date
- Yellow - Action on target to be completed by agreed/revised date
- Green- Action complete
- Blue - Action to be removed and replaced by subsequent action

Meeting	Action Ref/Date Raised	Action	Update	Original Target Date	Revised Target Date	RAG Rating	Lead	Status (Open or Complete)
Open Action								
QS&I Committee	74/2018 c (04.10.18)	Healthcare Inspectorate Wales Annual Report 2017/18 - The Committee requested oversight of the matrix of evidence HIW gather in relation to Public Health wales outside of the meeting.	Update 10.01.19: A meeting will be arranged between the Chair of PHW and HIW colleagues to address the request for information.	QSIC 15.01.19			SM / Secretariat	Open
Completed action to be approved								
QS&I Committee	74/2018 c (04.10.18)	Healthcare Inspectorate Wales Annual Report 2017/18 - The Committee requested details of the Public Health Wales contact who consulted on the substance misuse section.	Update 10.01.19 : Erica Emes, project lead for thematic review of substance misuse services across Wales has confirmed that the PHW contact who liaised on the review into Substance Misuse was the PHW National Lead for Substance Misuse (Harm Reduction) and Research Scientist.	QSIC 15.01.19			SM / Secretariat	Complete
QS&I Committee	77/2018 (04.10.18)	The Committee would be presented with bi-annual updates to the Microbiology Service.	Added to the Committee workplan	QSIC 15.01.19			QS	Complete
QS&I Committee	76/2018 c (04.10.18)	Progress update to the register of Policies and Written Control Documents to be provided at the next Committee.	Added to the Committee workplan	QSIC 15.01.19			CS	Complete
QS&I Committee	76/2018 b (04.10.18)	The Children at Risk Procedure would be subject to clarification from the Safeguarding Lead. The Committee agreed that the Safeguarding Lead would liaise with AW to agree the wording of one sentance.	Procedure amended as required and published.	QSIC 15.01.19			SB	Complete
QS&I Committee	76/2018 b (04.10.18)	The Adults at Risk Procedure flow diagram would be amended as agreed.	Procedure amended as required and published.	QSIC 15.01.19			SB	Complete
QS&I Committee	76/2018 a (04.10.18)	All Wales IT policies are to be re-submitted for adoption following the undertaking of internal EHIA's.	Added to the 15.01.19 Committee agenda	QSIC 15.01.19			JL	Complete
QS&I Committee	75/2018 (04.10.18)	The Committee agreed to remit oversight of the Information Governance Performance reports to the Knowledge Research and Innovation Committee	Added to the Knowledge, Research and Innovation Committee workplan from Apri 2019.	QSIC 15.01.19			Secretariat	Complete
QS&I Committee	74/2018 c (04.10.18)	Healthcare Inspectorate Wales Annual Report 2017/18 - The Committee requested oversight of the matrix of evidence HIW gather in relation to Public Health wales outside of the meeting.	The HIW representative has provided information to the Chair of Public Health Wales.	QSIC 15.01.19			SM / Secretariat	Complete
QS&I Committee	73/2018 a. (04.10.18)	The Committee requested assurance on the service user engagement and operational risks for the Diabetic Eye Screening Wales Service.	Added to the Committee workplan	QSIC 15.01.19			Secretariat	Complete

QS&I Committee	73/2018 a.(04.10.18)	The Committee agreed to remit oversight of the Diabetic Eye Screening Wales workforce implications, engagement and culture to the People and Organisational Development Committee	Added to the People and Organisational Committee workplan	QSIC 15.01.19			Secretariat	Complete
QS&I Committee	73/2018 a (04.10.18)	The Diabetic Eye Screening Wales action plan outlining modernisation and transformation plans would be presented to the Committee following its update at BET.	Added to the Committee workplan	QSIC 15.01.19			QS	Complete
QS&I Committee	54/2018 (10.07.18)	SB and SW agreed to liaise with the Chief Risk Officer to discuss the Datix implementation action plan and staff training requirements outside of the Committee.	Meeting arranged to disucss this issue with SW/ Chief Risk Officer.	QSIC 15.01.19			SB	Complete
Completed actions (approved)								
QS&I Committee	54/2018 (10.07.18)	Corporate Safegaurding Annual Report - The Committee requested calrification on the extent to which staff undertstand the Datix system	Update 24.09.18: Datix is currently being reconfigured and when this work has been completed it will be followed up with training, with a particular emphasis on reviewer and approver training.	QSIC 4.10.18			SB	Complete
QS&I Committee	55/2018 (10.07.18)	Quality & Clinical Audit Plan 2017/18: Outcomes Report: - The Committee requested a completed audit be presented in Oct 18 with a fuller explanation of examples of clinical audit.	Update 24.09.18: The 'deep dive' reviews will incorporate audits undertaken by programmes, functions and services.	QSIC 4.10.18			QS / SB	Complete
QS&I Committee	55/2018 (10.07.18)	Quality & Clinical Audit Plan 2017/18: Outcomes Report - The Committee requested that the presentation of information in future reports be reviewed, ensuring a clearer explanatory narrative, a greater focus on exception reporting and further updates on the progress of individual audits.	Update 24.09.18: The format of the next audit plan has been amended to incorporate suggested changes.	QSIC 4.10.18			SB	Complete
QS&I Committee	57/2018 (10.07.18)	A further update on the refresh of the organisational website (to include a single easily identifiable 'button' for complaints/ concerns/ complements etc.) would be provided at the next meeting.	Update: 26.09.18 The All Wales approach for feedback is being adopted to ensure consistency across the NHS web estate. In addition the PHW homepage will include a 'contact us' plugin, which will be in the form of a drop down enquiry list for users where they will be able to select from a range of issues, and will include raising concerns.	QSIC 4.10.18			GR	
QS&I Committee	57/2018 (10.07.18)	The revised Putting Things Rights Policy and Procedure would be approved at the earliest opportunity through the provision of Chair's Action.	Update 24.09.18: The Policy and Procedure have been forwarded to the September Board meeting for approval.	QSIC 4.10.18			KE	Complete
QS&I Committee	29/2018a (10.04.18)	The Draft Annual Quality Statement 2017/18 to be circulated to the Committee outside of the meeting.	Update 28.06.18 Draft Annual Quality Statement for 2017/18 circulated prior to the July meeting to enable comments Agenda item	QSIC 10-Jul-18			SB	Complete
QS&I Committee	29/2018b (10.04.18)	The final Annual Quality Statement 2017/18 to be circulated to the Committee outside of the meeting.	Added to the Committee Woprkplan for the 10 July 2018 meeting of the Committee.	QSIC 10-Jul-18			SB	Complete
QS&I Committee	30/2018b (10.04.18)	Health and Care Standards Self-Assessment - Delivery against the improvement actions identified by the Directorates were measured on a quarterly basis through the performance reporting process. The Committee agreed to discuss this further outside of the meeting.	Update 03.07.18 Public Health Wales Chair, Chair of the Committee and Executive Lead met and discussed the Health and Care Standards. Dialogue with Welsh Government has also been initiated in relation to any potential changes to the Standards in the future to make them more relevant to Public Health Wales.	QSIC 10-Jul-18			SB/JW	Complete

QS&I Committee	30/2018a (10.04.18)	Health and Care Standards Self-Assessment - low overall compliance score for the NHS Wales Health Collaborative ("the Collaborative") reflected the fact that this was the first year the Collaborative had undertaken the review. The Committee requested further clarity on how the Collaborative will address any issues raised in the review.	Update 03.07.18 Confirmation received from Director, Clinical Networks (Collaborative) confirming that the Collaborative Management Team is overseeing the monitoring of progress	QSIC 10-Jul-18			SB	Complete
QS&I Committee	31/2018a (10.04.18)	Microbiology Service: Risk Assessment and Future Operational Model Report - QS advised the Committee that the draft stabilisation plan could be shared with the Committee members after it had been considered at the first scrutiny meeting to be held on the 13 April 2018.	Agenda item for meeting 10.07.18	QSIC 10-Jul-18			QS	Complete
QS&I Committee	31/2018b (10.04.18)	Microbiology Service: Risk Assessment and Future Operational Model Report - The Committee agreed that the outline action plan and options analysis would be provided to the Committee in a separate meeting by the end of May 2018.	Agenda item for meeting 10.07.18	QSIC 10-Jul-18			QS	Complete
QS&I Committee	33/2018 (10.04.18)	Information Governance Consolidated Performance Report - Due to the timeliness of the data available, the Committee did not receive the report. The Committee agreed that the report would be presented at the next Committee meeting on 10 July 2018.	Added to the Committee Woprkplan for the 10 July 2018 meeting of the Committee.	QSIC 10-Jul-18			JL	Complete
QS&I Committee	34/2018 (10.04.18)	Quality, Safety and Improvement Committee Annual Report 2017/18 - amend the report as per the Committee's comments at its meeting on 10 April 2018. The Committee agreed that the Committee's Terms of Reference would be reviewed in light of these comments.	Reporta mended and agreed by Committee Chair. Final report was presented to the Board at its meeting on 31 May 2018.				AR/SB	Complete
QS&I Committee	8/2018 (27.2.18)	Clarification to be provided as to whether the two radiation incidents reported in the Putting Things Right Report (Quarter 3, 2017-18) were reportable under the Ionising Radiation (Medical Exposure) Regulations (IRMER), together with a rationale explaining the outcome.	The Head of Medical Physics, Breast Test Wales, and the Acting Director of Screening, are able to clarify that the two radiation incidents referred to in the Putting Things Right Report (Quarter 3, 2017-18) were not reportable under IRMER or RIDDOR. With regard to the two incidents, the risk from the extra dose was very low. The total dose received would still be within the "normal range" for a mammogram. Staff are encouraged to report such incidents on Datix so lessons can be learned from them, but there are no health implications for the individual patients. A summary of radiation incidents from Datix at Public Health Wales' Radiation Protection Group meeting in March 2018. Update 02.07.18 The investigation reports on Datix have been reviewed and confirm that there were no consequences for either individuals and no special reporting was required. For internal purposes, BTW's Radiation Safety Procedures define a radiation incident as one in which the dose is more than 3 times the intended amount. This incident does not fall into that category.	QSIC 10-Apr-18			SH/SB/GR	Complete

QS&I Committee	6/2018 (27.2.18)	Screening for the Future Strategic Review Progress Report - organisational development and quality improvement issues had been identified. The Committee recommended that appropriate performance metrics, on which the Quality, Safety and Improvement Committee and the People and Organisational Development Committee could monitor and receive assurance, be developed. Once developed, these would be agreed with the respective committee Chairs.	Following the committee meeting in February 2018, work has been undertaken on the Screening for the Future programme to map out the products, dependencies and timescales in the format that was required for the IMTP. A programme board has been established to lead this work. This is chaired by the Executive Director of Public Health Services/Medical Director to monitor progress. The chairs of the Quality, Safety and Improvement Committee and the People and Organisational Development Committee will meet to discuss scrutiny and reporting arrangements once these performance metrics have been developed. Update 28.06.18 Performance metrics and products have been identified and these are included and will be monitored as part of the annual IMTP plan. Therefore scrutinty will be through the operational plan monitoring		30.04.18		TR/KE/SH	Complete

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales	**Name of Meeting** Quality, Safety and Improvement Committee **Date of Meeting** 15 January 2019 **Agenda item:** 2.1.PODC.150119

Board Assurance Framework

Executive lead:	Tracey Cooper, Chief Executive
Author:	Eleanor Higgins, Corporate Governance Manager (cover paper) John Lawson, Chief Risk Officer (Board Assurance Framework)

Approval/Scrutiny route:	Business Executive Team – 19 November 2018 Board – 29 November 2018

Purpose

The purpose of this report is to provide the Committee with an update regarding any significant changes to the strategic risks contained in the Board Assurance Framework (BAF) assigned to the Committee (that could prevent the delivery of one or more strategic priorities) and action being taken to manage those risks.

Recommendation:

APPROVE	CONSIDER	RECOMMEND	ADOPT	ASSURANCE
☐	☒	☐	☐	☐

The Committee is asked to:

- **Consider** the Board Assurance Framework (BAF) and note the updates provided.

Link to Public Health Wales Strategic Plan Public Health Wales has an agreed strategic plan, which has identified seven strategic priorities. **This report contributes to all of the Strategic Priorities**

Summary impact analysis	
Equality and Health Impact Assessment	No decision is required
Risk and Assurance	This is the Board Assurance Framework
Health and Care Standards	This report supports and/or takes into account the Health and Care Standards for NHS Wales Quality Themes Governance, Leadership and Accountability
Financial implications	No financial implications
People implications	No people implications

1. Purpose / situation

The purpose of this report is to provide the Committee with an update regarding any significant changes to the strategic risks contained in the Board Assurance Framework (BAF) assigned to the Committee (that could prevent the delivery of one or more strategic priorities) and action being taken to manage those risks. The BAF is attached at **Appendix 1**.

2. Background

The Board Assurance Framework (BAF) describes how Public Health Wales is provided with assurances on the delivery of its core purpose of "working to achieve a healthier future for Wales" supported by its seven strategic priorities outlined within the Integrated Medium Plan 2018/19 – 2020/21, and through robust risk management processes. The organisation's seven strategic priorities are:

Number	Strategic Priority
1	Influencing the wider determinants of health
2	Improving mental wellbeing and building resilience
3	Promoting healthy behaviours
4	Securing a healthy future for the next generation through a focus on early years
5	Protecting the public from infection and environmental threats to health
6	Supporting the development of a sustainable health and care system focused on prevention and early intervention
7	Building and mobilising knowledge and skills to improve health and wellbeing across Wales

The BAF supports the Annual Accountability Report, which includes the Annual Governance Statement (AGS). The term "BAF" has been used with in NHS settings for a number of years. For the purpose of clarity, this document provides the overall narrative description of the system of assurance operating within the Trust.

The BAF is designed to support the Board in the delivery of its Strategy as outlined with its 3 year Integrated Medium Term Plan (IMTP). The IMTP is underpinned by an annual Operational Plan, which provides more detail on the strategic objectives for the year. The BAF also serves to inform the Board of the strategic risks threatening the delivery of the organisations' objectives. The BAF aligns strategic risks, key controls, the risk appetite and assurance on controls alongside each priority. Gaps are identified where key controls are insufficient to mitigate the risk of non-delivery of

objectives. This enables the Board to develop and monitor action plans intended to close the gap.

The concept of a BAF is not new to the Board and arrangements have been in place during 2016/17 and 2017/18 with reports presented at Board and Committee meetings. The development of the new IMTP and the activity required to deliver against the strategic priorities provides a timely opportunity to further implement and sustain the Board Assurance Framework with a focus on assurance mapping. This will form part of the organisation's Good Governance Framework, which is currently under development.

3. Description/Assessment

The BAF attached to this report (Appendix 1) incorporates all updates provided up to and including 21 November 2018. As part of the routine Business Executive Team agenda, the Executive Team considered the risks and significant issues at their meeting on 19 November 2018. The Board considered the BAF at the meeting on 21 November 2018.

The following risks are assigned to the Quality, Safety and Improvement Committee:

Risk Description	Update
Risk 2 There is a risk that Public Health Wales will cause significant harm to a patient, service user or staff member. This will be caused by misdiagnoses or incorrect identification of serious health conditions, the provision of inappropriate clinical advice or the failure of staff to follow correct procedures.	All actions are on target for completion.
Risk 3 There is a risk that Public Health Wales will fail to deliver a sustainable, high quality and effective infection and screening services. This will be caused by a lack of sufficient workforce capacity; over-reliance on existing systems/procedures, lack of sufficient change capacity and an estate and infrastructure, which is not fit for purpose.	The Board revised the "due date" for action 3.1 to January 2019.
Risk 4 There is a risk that Public Health Wales will suffer a major IT security breach resulting in a failure in service delivery and/or loss of personal data. This will be caused by a cyber-attack made with malicious intent either directly against Public	A confidential addendum has been provided to Members

Health Wales or if we suffer collateral damage from a wider ranging cyber-attack.	

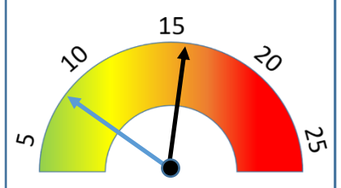
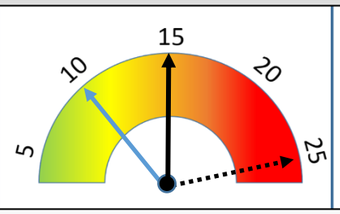
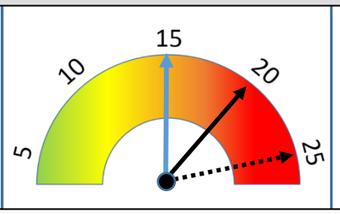
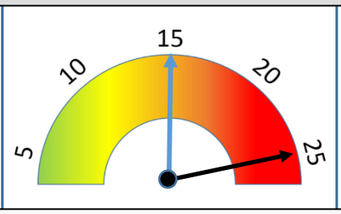
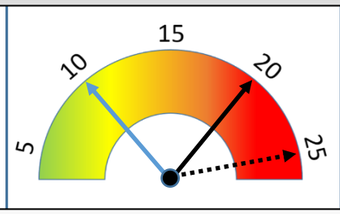
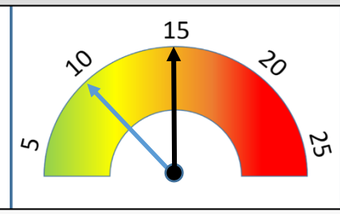
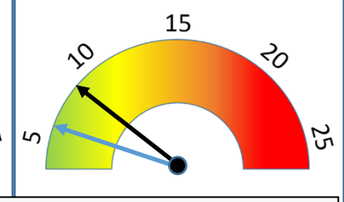
4. Recommendation

The Committee is asked to:

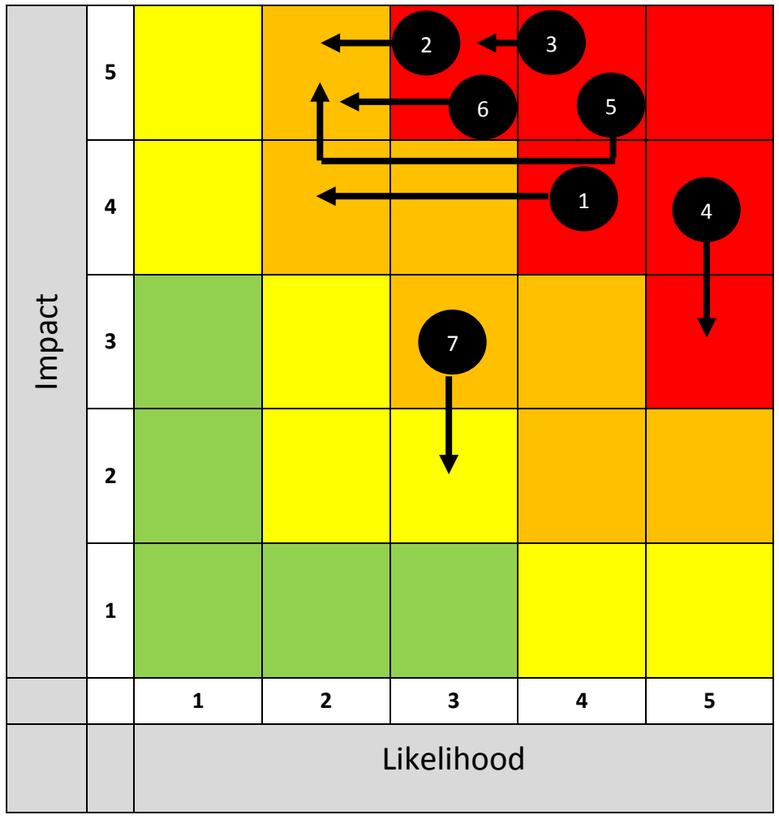
- **Consider** the Board Assurance Framework (BAF) and note the updates provided.

Public Health Wales – Board Assurance Framework Strategic Risk Dashboard November 2018

There is a risk that Public Health Wales will…

1. Find itself without the workforce it requires to deliver on its strategic objectives	2. Cause significant harm to a patient, service user or staff member	3. Fail to deliver sustainable, high quality and effective infection and screening services	4. Suffer a major IT security breach resulting in a failure in service delivery and/or loss of personal data	5. Fail to effectively influence stakeholders and support others to deliver the population health gains required to achieve its purpose	6. Fail to secure and align resources to deliver on its strategic priorities	7. Fail to sufficiently consider, exploit and adopt new and existing technologies
Individual Risk Severity Scores – Inherent ⋯▸ Residual ⟶ Target ⟶ (**NOTE** - For clarity where inherent and residual risk scores are the same, only the residual is shown)						
						
Outstanding actions						
3 / 0 / 1	7 / 0 / 0	7 / 0 / 1	See Risk Report for details	11 / 0 / 0	5 / 0 / 2	4 / 0 / 1

Residual Risk Severity Map
(showing direction of travel to target)



Strategic Priorities and Risk Appetite 2018 - 2019

Strategic Priority	Risk Appetite Level
Influencing the wider determinants of health	3 – Accepting
Improving mental well-being and building resilience	4 – Willing
Promoting healthy behaviours	3 – Accepting
Securing a healthy future for the next generation through a focus on early years	4 – Willing
Protecting the public from infection and environmental threats to health	2 – Cautious
Supporting the development of a sustainable health and care system focused on prevention and early intervention	3 – Accepting
Building and mobilising knowledge and skills to improve health and well-being across Wales	4 – Willing

Strategic Risk Impact Statement

The consequences of any of the strategic risks being realised would include potential of harm to patients, impacts on the welfare of staff, poor quality service, failure to achieve population health gains, potential litigation at both a corporate and personal level with financial and/or penal sanctions and/or significant reputational damage which could threaten the future of the organisation.

Board Assurance Framework

Risk 1

There is a risk that Public Health Wales will find itself without the workforce it requires to deliver on its strategic objectives. This would be caused by a lack of staff with the relevant skills and / or cultural fit in the external market / education system, internally due to a lack of staff skills and behaviour development, career mobility and succession planning and talent management, or due to undesirable employee attrition.

Applicable Strategic Priorities	
Influencing the wider determinants of health	X
Improving mental well-being and building resilience	X
Promoting healthy behaviours	X
Securing a healthy future for the next generation through a focus on early years	X
Protecting the public from infection and environmental threats to health	X
Supporting the development of a sustainable health and care system focused on prevention and early intervention	X
Building and mobilising knowledge and skills to improve health and well-being across Wales	X

Risk Score

Inherent Risk			Current Risk			Target risk		
Likelihood 4	Impact 4	16	Likelihood 4	Impact 4	16	Likelihood 2	Impact 4	8

Sponsor and Assurance Group

Executive Sponsor	Phil Bushby, Director of People and Organisational Development
Assuring Group	People and Organisational Development Committee

Risk Decision

Treat

GAPS IN CONTROLS	GAPS IN ASSURANCE
1. An implemented corporate approach to succession planning and talent management 2. There is no Organisational level workforce plan 3. Workforce plan in support of organisational strategy	

ACTION PLAN

Action Plan		Owner	Progress Update	Due Date
1.1	Deployment / completion of corporate approach to succession planning and talent management.	Matthew Browne	Organisational approach to Succession Planning finalised by 31 December following Exec Team discussion in October 2018 **Request to Board for revised date of 31 January 2019.**	31/10/2018 (change to 31/12/2018)
1.2	From returned workforce plans and wider discussion around ways of working to support the IMTP, an organisational level workforce plan will be created to cover the course of the IMTP	Michelle Hurley-Tyers and Tim Williams	This plan will be completed in draft by the end of the performance year drawing information from submitted workforce plans and discussions with the planning and performance team and business leads group	31/03/2019
1.3	Further to 2 above and following discussions with Executive, pull together an organisational level workforce strategy in support of the organisation's long term strategy	Tim Williams and Michelle Hurley-Tyers	This plan will be completed in draft by the end of the performance year drawing information from submitted workforce plans, 1:2:1 interviews with the executive and SLT members and discussions with the planning and performance team and business leads group	31/03/2019

EXISTING CONTROLS		SOURCES OF ASSURANCE	
Control	**Owner**	**Assurance**	**Owner**
Microbiology action plan	Quentin Sandifer	Detailed Stabilisation and Transformation Action Plans and regular meetings of Public Health Services Directorate leadership Team	Quentin Sandifer
Training plan through the Deanery		Annual training placements and evaluation, trainee engagement and satisfaction survey, Deanery reports and routine meetings	Brendan Mason
Medical Job Planning (including all Public Health Consultants from backgrounds other than medicine)		Job Planning reports and meetings – all verified by Medical Director	Brendan Mason / Andrew Jones
Personal Development reviews	Phil Bushby	People and OD performance report Regular update papers (2 per year) provided to Committee by Director of People and OD	Lisa Whiteman
Detailed workforce Planning, including learning needs analysis		People and OD performance report Regular update papers (2 per year) provided to Committee by Director of People and OD	Michelle Hurley-Tyers
People and OD Management Information including People Performance Reports, detailed recruitment MI, appraisal rates and attrition rates		People and OD performance report provided monthly including key people metrics. Specific in depth have been commissioned and executed in respect of sickness absence, staff turnover / attrition and gender diversity	Tim Williams
Staff Survey results around career opportunities and levels of engagement		NHS Wales staff survey results and action plans	Peta Beynon
Learning and Development Policies and Procedures		Monitoring of requests and support offered for development through the L&D Policy and High cost learning process	Lisa Whiteman
Leadership and Management Development Programmes		Take up rates and post course evaluation / management and leadership satisfaction scores in the staff survey	Lisa Whiteman
Colleague Development Programme		Take up rates and post course evaluation	Rhys Owen
Apprenticeship and Graduate Schemes		Appraisal Guidance toolkits / Graduate Placement programme and placement take up rates and evaluations	Matthew Browne
Work placement Schemes		Take up rates and post placement evaluation	Rhys Owen
Corporate Health Standard		Achievement of standard and feedback reports from assessors / plans for higher levels of CHS	Jane Rees
Public Health Workforce Development (other than medical / consultant)		Coordination of practitioner scheme development, Welsh Audit Office report and responding actions	Tim Williams
Occupational Health provision		Reports from providers on themes / KPIs, specific case updates / management and inoculation rates (for Flu via WAST and all others for Public Health Services via relevant health Boards)	Karen Williams
Employee Assistance Programme			

Board Assurance Framework

Risk 2

There is a risk that Public Health Wales will cause significant harm to a patient, service user or staff member. This will be caused by misdiagnoses or incorrect identification of serious health conditions, the provision of inappropriate clinical advice or the failure of staff to follow correct procedures.

Applicable Strategic Priorities	
Influencing the wider determinants of health	X
Improving mental well-being and building resilience	X
Promoting healthy behaviours	
Securing a healthy future for the next generation through a focus on early years	
Protecting the public from infection and environmental threats to health	X
Supporting the development of a sustainable health and care system focused on prevention and early intervention	
Building and mobilising knowledge and skills to improve health and well-being across Wales	

Risk Score

Inherent Risk			Current Risk			Target risk		
Likelihood 5	Impact 5	25	Likelihood 3	Impact 5	15	Likelihood 2	Impact 5	10

Sponsor and Assurance Group

Executive Sponsor	Sian Bolton, Interim Executive Director Quality, Nursing and Allied Health Professionals
Assuring Group	Quality, Safety and Improvement Committee (patient and service user) People and Organisational Development Committee (staff)

Risk Decision

Treat

GAPS IN CONTROLS

- Process inconsistently applied for updating and disseminating new/ update policies
- Lack of systematic and embedded approach to reflecting and learning from incidents, serious incidents, raising concerns (whistleblowing) etc to enable Public Health Wales to be an agile learning organisation
- Lack of corporate approach to succession planning and talent management (see Risk 1)
- Gaps re effective infection and screening service (see Risk 3)

GAPS IN ASSURANCE

- No consistently applied, monitored and reported quality and impact measures
- Lack of assurance mechanism for 'Raising Concerns' (Whistleblowing)
- Lack of assurance mechanism in relation to awareness/ staff training re governance/ assurance processes

ACTION PLAN

Action Plan			Progress Update	Due Date
2.1	Development of an effective management system for updating and disseminating new and revised policies and procedures. Ensure Directorates have an effective mechanism for updating Standard Operating Procedures (SOPs) when new legislation/ guidance available	Head of Corporate Governance	A new process for the development and approval of policies, procedures and other written control documents has been developed. Once approved these are posted on the intranet. A central database of policies is now held by the Corporate Governance Team, indicating their current status. This is reported to Quality Safety and Improvement committee and Board twice a year Further work to be undertaken to ensure Directorates are informed when policies are due to be updated Audit to be undertaken to determine SOPs disseminated to staff when updated and staff aware	March 2019
2.2	Development of an effective mechanism to inform staff of new/ updated policies and procedures	Head of Corporate Governance	New policies updated onto the intranet Mechanism to be developed to inform staff when policies have been updated	March 2019
2.3	Adoption and implementation of an organisational approach to raising staff awareness of the elements that encompass good governance eg risk, quality, information governance, financial governance, research governance and corporate governance	Head of Corporate Governance Sian Bolton Huw George Mark Bellis	Training on risk and financial management available Information governance training mandatory for all staff Quality Hub to be developed (via a quality network which will involve quality/ governance champions) Process for research governance in place but staff awareness to be raised Corporate Governance Framework to be developed	March 2019

2.4	Implementation and reporting of Quality and Impact indicators across the organisation	Sian Bolton	Update 10.10.2018 – Indicators will be incorporated into the Integrated Performance Report in October. Due to the timing of Quality and Safety Improvement Committee, the information was not received at the last Committee, will now be presented in January Committee. Indicators developed and approved at Board in May 2018. Indicators to be incorporated into integrated performance report	Completed
2.5	Implement an organisational approach to disseminating and raising awareness of the 'Raising Concerns' (whistleblowing) policy	Head of Corporate Governance	Policy in place and available on the intranet Slide on 'whistleblowing' incorporated into new staff induction Training to be developed for staff	March 2019
2.6	Dissemination across the organisation of learning from incidents, serious incidents, raising concerns (whistleblowing), audits and evaluations	Sian Bolton	Lessons learnt from complaints/ concerns captured within Putting Things Right report which is report to the Quality Safety and Improvement Committee and Board quarterly 'You Said we Did' used by Screening to share learning on the intranet Service User Experience and Learning Panel captures lessons learnt quarterly Clinical and Quality Audit outcomes captured annually and shared at Quality Safety and Improvement Committee Central database for evaluations to be developed Lessons from Raising concerns (Whistle blowing) need to be captured and shared Systemic method of sharing learning to be developed	March 2019
2.7	Actions as set out in Risk 1	Phil Bushby	See Risk 1	March 2019
2.8	Actions as set out in Risk 3	Quentin Sandifer	See Risk 3	March 2019

.EXISTING CONTROLS		SOURCES OF ASSURANCE	
Control	**Owner**	**Assurance**	**Owner**
Policies and Procedures (inc. Standard Operating Procedures, Quality Assurance systems, Failsafe systems etc.) Microbiology Stabilisation Plan Screening for the Future work programme	Quentin Sandifer	Performance data – monthly to Exec and bi-monthly to Board Screening for the Future Programme Board which reports to QS&I Committee Microbiology Programme Board which reports to QS&I Committee	Huw George Quentin Sandifer
Policies and procedures in place to confirm that staff have the qualifications and experience required for roles within the organisation Statutory and Mandatory training Competency and role based training Personal Development reviews Workforce Plan People and OD Management Information including People Performance Reports and detailed recruitment MI. Staff Survey results around career opportunities and levels of engagement People and OD Policies and Procedures Leadership and Management development Programme Occupational Health provision	Phil Bushby	People and OD performance report reporting to POD Committee Regular update papers (2 per year) provided to Committee by Director of People and OD Staff Survey results reported to POD Committee and Board Reports to QS&I Committee and POD Committee	Phil Bushby
Incident Reporting procedures	Sian Bolton	PTR Report quarterly to QS&I Committee SI reporting as occurs to Board and quarterly to QS&I Committee	Sian Bolton
Clinical and Quality audit	Quentin Sandifer/ Sian Bolton	Annual Plan and Report to QS&I Committee	Sian Bolton
Health and Safety/ Estates Action Plan	Huw George	Reports to Health and Safety Group and into POD Committee	Huw George

Board Assurance Framework

Risk 3

There is a risk that Public Health Wales will fail to deliver a sustainable, high quality and effective infection and screening services. This will be caused by a lack of sufficient workforce capacity; over-reliance on existing systems/procedures, lack of sufficient change capacity and an estate and infrastructure which is not fit for purpose.

Applicable Strategic Priorities	
Influencing the wider determinants of health	
Improving mental well-being and building resilience	
Promoting healthy behaviours	
Securing a healthy future for the next generation through a focus on early years	
Protecting the public from infection and environmental threats to health	X
Supporting the development of a sustainable health and care system focused on prevention and early intervention	
Building and mobilising knowledge and skills to improve health and well-being across Wales	

Risk Score

Inherent Risk			Current Risk			Target risk		
Likelihood 5	Impact 5	25	Likelihood 4	Impact 5	20	Likelihood 3	Impact 5	15

Sponsor and Assurance Group

Executive Sponsor	Quentin Sandifer, Executive Director Public Health Services / Medical Director
Assuring Group	Quality Safety and Improvement Committee Audit and Corporate Governance Committee

Risk Decision

Treat

GAPS IN CONTROLS	GAPS IN ASSURANCE
Lack of specialist workforce capacity to deliver services Lack of capacity to drive transformation of services alongside operational delivery requirements Lack of sufficient clarity and specificity in service operating systems, e.g. 'failsafe' Lack of capacity in NHS partner workforce to deliver services, e.g. screening Some infrastructure (laboratories and premises) is old and deteriorating and in some areas is not fit for purpose	

ACTION PLAN

Action Plan		Owner	Progress Update	Due Date
3.1	Delivery of the Microbiology Stabilisation Plan	Quentin Sandifer	A stabilisation action plan has been approved and a Senior Responsible Officer identified. Weekly exception reports are provided to the Executive Director, with six weekly scrutiny from a sub group of Executive team. Stabilisation has been confirmed as the first phase of Transformation Programme and has been included in new governance arrangements going forward which will be approved by the Infection Service Transformation Board in July. Increased volatility in financial month 7 in expenditure on agency locums in microbiology (both medical and non-medical), in order to secure service delivery, means that it is too early to conclude that stabilisation has been achieved. The Stabilisation Review meetings will need to continue another three months. **Request to Board for revised date of 31 January 2019.**	October 2018 (change to 31 January 2019)
3.2	Delivery of the Infection Service Transformation Programme	Quentin Sandifer	The Transformation Programme Board held its first meeting on 29th May and established a Programme Team. The second meeting is scheduled for 24th July and will approve final Terms of Reference, Governance and reporting arrangements.	April 2021
3.3	Delivery of the Screening for the Future Programme	Quentin Sandifer	Project Board established and workstreams identified: Quality assurance, service development, workforce development and division structures. Definition of tasks and projects underway. 12 of the 20 recommendations of screening review have been addressed. Quality assurance workstream being taken forward as first priority.	August 2019
3.4	Review to ensure that our Screening and Microbiology operating systems are all 'failsafed'	Quentin Sandifer	Template complete to describe detail of offer and failsafe in place to ensure offer completed and reviewed by Screening Senior Management Team. Review work undertaken and completed for Breast Test Wales with review of database to ensure women invited 3 years before their 70th birthday. Review work in process for Bowel Screening Wales and review of failsafes in place. Request the due date be deferred until the end of December 2018. Failsafe and SOPs developed for Diabetic Eye Screening and improved governance of programme.	December 2018

3.5	Implementation of UK National Screening Committee recommended new tests (Primary Human Papilloma Virus Testing, HPV and Faecal Immunochemical Testing, FIT)	Quentin Sandifer	HPV implementation for Cervical Screening Programme working to timescales set and progressing well with implementation from October 2018 FIT implementation for Bowel Screening Wales – procurement progressing but slower than planned, still on plan to start phased implementation late Jan 2019	April 2019
3.6	Implementation of Cervical Screening Information Management System (CSIMS)	Quentin Sandifer	This is progressing but later than originally planned due to delay in obtaining demographic feed so could continue to develop system. The demographics have started to be available but timescales may still be challenging.	December 2018
3.7	Implementation of risk-based diabetic eye screening	Quentin Sandifer	Resource was identified from the investment process for project lead and this needs to go through establishment control. There have been improved review of capacity and demand as a preliminary piece of work but the project will need to be progressed when the project lead is in post.	April 2021
3.8	Delivery of Estates Action Plan and Health / Safety Action Plan	Huw George	Ongoing delivery of estate / Health and Safety action plan in relation to Microbiology Laboratory estate. Work to address HSE Improvement notice regarding the sealability of Level 3 facility at Laboratory in Llandough hospital completed /approved and Improvement Notice removed.	

EXISTING CONTROLS		**SOURCES OF ASSURANCE**	
Control	**Owner**	**Assurance**	**Owner**
Microbiology Stabilisation Plan Screening for the Future work Programme Policies and Procedures Standard Operating Procedures	Quentin Sandifer	Microbiology Stabilisation Plan Project Board established	Quentin Sandifer
Health and Safety Action Plan Estate Action Plan.	Huw George		
Incident Management System Raising Concerns Policy and Procedure	Sian Bolton		

Applicable Strategic Priorities		Board Assurance Framework **Risk 4** There is a risk that Public Health Wales will suffer a major IT security breach resulting in a failure in service delivery and/or loss of personal data. This will be caused by a cyber-attack made with malicious intent either directly against Public Health Wales or if we suffer collateral damage from a wider ranging cyber-attack.								
Influencing the wider determinants of health	X									
Improving mental well-being and building resilience	X									
Promoting healthy behaviours	X	**Risk Score**								
Securing a healthy future for the next generation through a focus on early years	X	**Inherent Risk**			**Current Risk**			**Target risk**		
		Likelihood 5	**Impact 5**	**25**	**Likelihood 5**	**Impact 4**	**25**	**Likelihood 5**	**Impact 3**	**15**
Protecting the public from infection and environmental threats to health	X	**Sponsor and Assurance Group**						**Risk Decision**		
Supporting the development of a sustainable health and care system focused on prevention and early intervention	X	**Executive Sponsor**		Huw George, Deputy Chief Executive, Executive Director Operations and Finance				**Treat**		
Building and mobilising knowledge and skills to improve health and well-being across Wales	X	**Assuring Group**		Quality, Safety and Improvement Committee pending establishment of new Committee						
GAPS IN CONTROLS				**GAPS IN ASSURANCE**						
ACTION PLAN										

Note

Due to the sensitive nature of the controls and actions and the potential susceptibility to attack this information is available separately to Board members as a confidential briefing

Applicable Strategic Priorities (Figures indicate Risk Appetite levels)		
Influencing the wider determinants of health	3	x
Improving mental well-being and building resilience	4	x
Promoting healthy behaviours	3	x
Securing a healthy future for the next generation through a focus on early years	4	x
Protecting the public from infection and environmental threats to health	2	x
Supporting the development of a sustainable health and care system focused on prevention and early intervention	3	x
Building and mobilising knowledge and skills to improve health and well-being across Wales	4	x

Board Assurance Framework

Risk 5

There is a risk that Public Health Wales will fail to effectively influence stakeholders and support others to deliver the population health gains required to achieve its purpose. This will be caused by an insufficient investment and delivery of support to our key stakeholders including to the people of Wales, Welsh Government, NHS Wales, PSBs and the Third Sector.

Risk Score

Inherent Risk			Current Risk			Target risk		
Likelihood 5	Impact 5	25	Likelihood 4	Impact 5	20	Likelihood 2	Impact 5	10

Sponsor and Assurance Group		Risk Decision
Executive Sponsor	Chrissie Pickin, Executive Director Health and Wellbeing	**Treat**
Assuring Group		

GAPS IN CONTROLS	GAPS IN ASSURANCE
1) There is a lack of a sufficiently well-resourced public information offer. 2) There is a lack of capability and capacity within PHW and its partner organisations to use the most effective behaviour change approaches for public health gain. 3) There is a need for more support for and a more agile vehicle to advise national and local policy makers including WG and PSBs on key population health issues. 4) There is a lack of a co-ordinated, coherent, data driven and evidence-based approach to prevention of long term conditions across the NHS. 5) There is insufficient capacity within PHW to support the third sector to attract resources for and deliver effective public health action.	

ACTION PLAN

Action Plan		Owner	Progress Update	Due Date
5.1	Increase investment in social marketing that utilise behaviour change approaches	Chrissie Pickin	Social marketing baseline being established being identified System-wide target for increased investment to be agreed	30/03/19
5.2	Subject to securing appropriate resources, invest in the necessary digital infrastructure for the effective delivery of timely and appropriate information to the public.	Huw George	SHIFT project has identified the need and level of likely investment required. Web development project well underway. Exploring options for new investment	31/07/19
5.3	Subject to a realignment of resources, invest in people to co-produce, maintain and evaluate content for the effective delivery of timely and appropriate information to the public.	Chrissie Pickin	Additional behavioural change specialist being recruited through HWB Investment Plan. Further i investment bid for increased resource in 2019/20 has been made. If unsuccessful another internal investment proposal will be made in 2019/20	31/03/19
5.4	Understand the extent to which behavioural change theory is currently used in programmes to change people's behaviours, and identify where knowledge and skills need developing across the public health workforce	Chrissie Pickin	Actions being progressed under IMTP SO 3.9 as follows: • Current application of behaviour change theory across public health system described (Nov 18) • Training needs analysis completed (Feb 19)	28/02/19
5.5	Increase investment in providing specialist public health data and evidence advice to existing strategic national policy initiatives e.g. Early years, Obesity Prevention, Tobacco Control	Chrissie Pickin	Internal investment bid for 2018/19 being used to expand the evidence service and to provide lead consultants in public health in Health Improvement Team. Some evidence of success in influencing new policy in early years, tobacco control and the new healthy weight strategy.	31/03/19
5.6	Utilise the WHO CC to act as a policy think tank for WG and other Public Health stakeholders. Deliver the work plan of the WHO CC.	Mark Bellis	WHO CC agreed and launched.	Ongoing

5.7	Ensure more effective Health Impact Assessments through an enhanced HIA Support Unit	Mark Bellis	Additional funding agreed with Exec and expenditure plans in place.	31/03/19
5.8	Continue the periodic meetings with Cabinet Secretaries, Ministers and their officials across Government as appropriate in order to inform them on the work of Public Health Wales and support the application of health in all polices in their respective areas.	Jan Williams/ Tracey Cooper	First round of meetings completed	Ongoing
5.9	Advocate for a co-ordinated, coherent, data driven and evidence based approach to chronic disease prevention across NHS Wales.	Chrissie Pickin	A paper was submitted to and agreed by the NHS CEOs and Chairs and thence to the Cabinet Secretary during June 18 making the case for an increase in preventative funding in support of health and well-being.	Complete
5.10	Agree and establish a process to take forward the recommendations in the Long Term Conditions – Investment in Prevention paper agreed by NHS Chief Executives and Chairs	Tracey Cooper/ Chrissie Pickin	Next steps explored at CEO/Chairs meeting 17/07/18. Advice to government on priorities for investment in prevention sent September and October 2018 and discussed at PHW Board and at Chairs and Chief Executives meeting in October. All of this has stimulated positive ongoing dialogue but, as yet, has failed to secure any additional investment in prevention. Lack of additional investment in prevention will seriously hinder our ability to influence and support others to achieve population level health gain. HWB have provided input to the new strategic plan for delivering a Healthier Wales through primary care which aligns the actions on prevention and wellbeing with our advice to government. A detailed implementation plan will be developed once agreed by CEOs.	21/12/18
5.11	Ensure CWW is able do proper analyses of complex, wicked issues and to co-design evidence based or logical national programmes of action.	Chrissie Pickin	A review of CWW has commenced. New programmes expected to be agreed. New work on “a positive adolescence” and “increasing employability of people with disabilities” being discussed at next CWW strategic leadership group.	21/12/18
5.12	Subject to identification of new resource , increase support to third sector organisations through the co-design and delivery of the PHW Communities Programme.	Chrissie Pickin	The co-design and delivery of the PHW Communities Programme is ongoing. Resource realignment being explored to identify new resource.	31/03/19

EXISTING CONTROLS		**SOURCES OF ASSURANCE**	
Control	**Owner**	**Assurance**	**Owner**

Applicable Strategic Priorities (Figures indicate Risk Appetite levels)		
Influencing the wider determinants of health	3	X
Improving mental well-being and building resilience	4	X
Promoting healthy behaviours	3	X
Securing a healthy future for the next generation through a focus on early years	4	X
Protecting the public from infection and environmental threats to health	2	X
Supporting the development of a sustainable health and care system focused on prevention and early intervention	3	X
Building and mobilising knowledge and skills to improve health and well-being across Wales	4	X

Board Assurance Framework

Risk 6

There is a risk that Public Health Wales will fail to secure and align resources to deliver on its strategic priorities. This will be caused by funding cuts or inability to make required savings, generate income or move resources within the organisation

Risk Score

Inherent Risk			Current Risk			Target risk		
Likelihood 3	Impact 5	15	Likelihood 3	Impact 5	15	Likelihood 2	Impact 5	10

Sponsor and Assurance Group

Executive Sponsor	Huw George, Deputy Chief Executive
Assuring Group	Audit and Corporate Governance Committee

Risk Decision

Treat

GAPS IN CONTROLS	GAPS IN ASSURANCE
• Governance arrangements for management of new Long Term Strategy • Performance Management Framework aligned to new Strategy and governance arrangements • Robust resource based planning • Evidence of efficiency across the organisation • Model for monitoring savings and investments	• Outcome based performance metrics

ACTION PLAN

Action Plan		Owner	Progress Update	Due Date
6.1	Develop new priority oversight and governance arrangements to manage the new strategic priorities as part of transition year	Huw George/ Sally Attwood	**Update 20/11/18**- Complete. Leads for each priority have been agreed and priority groups have been meeting since September 2018.	Completed
6.2	Develop revised Performance Management Framework including how we track progress against our Long Term Strategy and outcome based performance metrics	Ioan Francis	**Update 20/11/18**- Progress against our Long Term Strategy and Integrated Medium Term Plan 2018-21 is monitored through our newly established priority groups. These groups over the forthcoming months will be required to look at outcome based performance metrics for their priorities and which will form part of the Performance Management Framework. As we start to identify the vision for how we want Public Health Wales to operate in the future, strengthening performance management is a key element of this work, out of which the Performance Management Framework will be taken forward. In the mean time we continue to improve the quality of our performance management arrangements and reporting systems. **Request to Board for revised date of 31 March 2019.**	December 2018 (Change to 31 March 2019)
6.3	Continue to strengthen performance management arrangements throughout the organisations	Ioan Francis	**Update 20/11/18**- Strengthening performance management has been identified as part of the scope of the transition plan that will be taken forward over the next 12 months (see update above). This is also linked to development of the Performance Management Framework and arrangements for managing the Strategy. Performance management arrangements to be strengthened including further integration of performance reporting and reporting arrangements.	Ongoing
6.4	Realise savings from organisational efficiency work streams	Huw George	**Update 20/11/18-** Work on all four workstreams continues, taking forward plans to realise savings. This links to action below on monitoring of savings and investments. As part of our Budget Setting Framework, Directorates will be required to identify 1.5% savings, 0.5% of which will be from organisational efficiency savings.	Ongoing
6.5	Scope options for disinvestment and realignment of budgets including resource mapping against priorities	Huw George/Angela Fisher	**Update 20/11/18**- On track. Initial work has been undertaken to align our current budgets to our new priorities. This work has formed part of the Budget Setting Framework, agreed by the Executive	January 2019

			Team in November 2018. As part of the development of plans and budget setting, options for disinvestment will be scoped.	
6.6	Develop improved integrated workforce planning arrangements to understand resource implications	Phil Bushby	**Update 20/11/18-** The Workforce Planning toolkit has been refreshed ready for the next iteration of the IMTP, and resources are developed to support the conversion of individual learning needs into strategic development needs. People Business Partners will discuss the toolkit and supporting resources with colleagues alongside IMTP development, to identify any medium to long term workforce issues including shortage specialities or hard to recruit positions.	Ongoing
6.7	Develop improved planning arrangements through the Senior Leadership Team and Business Leads Group	Sally Attwood/Angela Fisher	**Update 20/11/18**- Ongoing. The Planners Group has been meeting weekly since August to take forward how we will improve planning with Public Health Wales. This includes representatives from the Business Leads Group and Senior Leadership Team. A review of planning has been undertaken alongside a planning DABL to understand how Directorates plan. The recommendations of the review are currently being implemented and business managers and those identified to support the priority groups are working together to inform development of the priority plans.	Ongoing
6.8	Undertake improved monitoring of savings and investments	Huw George/Angela Fisher	**Update 20/11/18**- Ongoing. Comprehensive savings analysis presented to Executives in October 2018. This detailed the delivery of the 2017/18 directorate and organisational efficiency savings schemes. Ongoing monitoring as part of the monthly close-down process.	Ongoing
6.9	Evaluate arrangements developed as part of our transition year	Huw George	To commence in quarter 4.	Q4 2018/19

EXISTING CONTROLS		**SOURCES OF ASSURANCE**	
Control	**Owner**	**Assurance**	**Owner**
Mid and End of Year Reviews Joint Executive Team meetings and papers- biannually Chairs appraisal documentation Quality and Delivery meetings/papers- quarterly Budget setting process	Huw George	Long Term Strategy- Working to achieve a healthier future for Wales Board approved Strategic Plan 2018-21 Board approved Annual Plan 2018/19 Integrated Monthly Performance Report to Board (Service/Finance/People) Annual accounts Audits of financial systems and audit management	Huw George

Applicable Strategic Priorities	
Influencing the wider determinants of health	X
Improving mental well-being and building resilience	X
Promoting healthy behaviours	X
Securing a healthy future for the next generation through a focus on early years	X
Protecting the public from infection and environmental threats to health	X
Supporting the development of a sustainable health and care system focused on prevention and early intervention	X
Building and mobilising knowledge and skills to improve health and well-being across Wales	X

Board Assurance Framework

Risk 7

There is a risk that Public Health Wales will fail to sufficiently consider, exploit and adopt new and existing technologies. This will be caused by the inability to keep up to date with relevant new and emergent technologies, their potential application and having insufficient skills to develop the case for investment.

Risk Score

Inherent Risk			Current Risk			Target risk		
Likelihood	Impact		Likelihood	Impact		Likelihood	Impact	
3	3	9	3	3	9	3	2	6

Sponsor and Assurance Group

Executive Sponsor	Tracey Cooper
Assuring Group	

Risk Decision

Treat

GAPS IN CONTROLS	GAPS IN ASSURANCE
Lack of a corporate system for ensuring a consistent approach to innovation and the exploitation of new and emergent technology	

ACTION PLAN

Action Plan		Owner	Progress Update	Due Date
7.1	Identify a replacement Executive lead for innovation	Tracey Cooper	John Boulton has now been appointed and has taken up the role of Executive lead for Innovation	Completed
7.2	Development of a framework for embedding a culture of innovation	Tracey Cooper	Senior Leadership Team and Business Executive Team to develop Innovation Strategy for Organisation	31/01/19
7.3	National and International horizon scanning to be embedded into the strategic planning process	Huw George	For updates please refer to Action 6.7	Ongoing
7.4	Development of a formal working relationship with the Life Sciences hub	Tracey Cooper	Discussions are in progress and more formalised arrangements are being developed.	31/10/18
7.5	Establishment of a New Technology and Innovation Advisory Forum to advise the Board	Tracey Cooper	Terms of Reference are going to Board for approval in July. Forum is expected to be in place by early 2019	30/04/19
7.6	Recruitment of a dedicated Non-Executive Director for Life Sciences		Recruitment in progress	31/03/19

EXISTING CONTROLS		SOURCES OF ASSURANCE	
Control	**Owner**	**Assurance**	**Owner**

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales	**Name of Meeting** Quality, Safety and Improvement Committee **Date of Meeting** 15 January 2019 **Agenda item:** *2.2.QSIC.150119*

Public Health Wales Corporate Risk Register

Executive lead:	Sian Bolton, Acting Executive Director of Quality, Nursing and Allied Health Professionals
Author:	John Lawson, Chief Risk Officer

Approval/Scrutiny route:	Executive Team

Purpose
Receive the Corporate Risk Register for the purpose of scrutiny and challenge

Recommendation:				
APPROVE ☐	CONSIDER ☐	RECOMMEND ☐	ADOPT ☐	ASSURANCE ☒

The Committee is asked to:

- **Receive assurance** that the corporate risks of the organisation are managed appropriately.

Link to Public Health Wales Strategic Plan Public Health Wales has an agreed strategic plan, which has identified seven strategic priorities. This report contributes to all Strategic Priorities	
Strategic Priority	Choose an item.
Strategic Priority	Choose an item.

Summary impact analysis	
Equality and Health Impact Assessment	No decision is required.
Risk and Assurance	This submission is the Corporate Risk Register.
Health and Care Standards	This report supports and/or takes into account the Health and Care Standards for NHS Wales Quality Themes Governance, Leadership and Accountability
Financial implications	No financial implications.
People implications	No people implications.

1. Purpose / situation

The purpose of this paper is to introduce the Corporate Risk Register to the Quality, Safety and Improvement Committee.

2. Background

In order for the Board to discharge its responsibilities, it needs to receive assurances that the organisation is effectively managing its risks to ensure the delivery of its mission and objectives. The Board receives the Corporate Risk Register at 6 monthly intervals in accordance with Risk Management Procedure and the Quality, Safety and Improvement Committee receives it at quarterly meetings to scrutinise the risks for their areas of interest.
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3. Description/Assessment

All risks within Public Health Wales are managed through the Datix platform, and the Corporate Risk Register is the visible representation of the highest level organisational risks which are managed by the Executive Team.

The risks are discussed at every Business Executive Team meeting and the Chief Risk Officer has regular meetings with each Director or their representative to discuss progress and concerns.

In terms of severity, the risks are grouped as follows:

Extreme Risk - 3
High Risk - 6
Moderate Risk - 0
Low Risk - 0

Points of note

There is one new risk added since the Committee last received the Corporate Risk Register, which is Risk no. 935 relating to service delivery within Diabetic Eye Screening Wales. This risk is subject to a detailed action plan.

3.1 Well-being of Future Generations (Wales) Act 2015

No decision required.

4. Recommendation

The Committee is asked to:

- **Receive assurance** that the corporate risks of the organisation are managed appropriately.

Risk Identifier					Risk Description			Risk Scoring								Risk Action Plan							
								Inherent Risk				Current Risk							Target Risk				
Datix ID	Domain	Date	Lead Executive	Directorate (if applicable)	Risk Description (There is a risk that…)	Cause (This will be caused by…)	Effect (The impact will be…)	Likelihood	Impact	Risk level	Key Controls	Likelihood	Impact	Risk level	Trend	Risk Decision	Action Plan	Due date	Likelihood	Impact	Risk level	Progress	RAG Status
472	Legislative	28 May 2015	Director of People and Organisational Development	Workforce and Organisational Development Directorate Wide	PHW will fail to meet the new Welsh Language standards by the required deadlines	Insufficient resources to meet new requirements	Damage to reputation, and possible sanctions due to regulatory / legislative non compliance	4	3	12	WLO in post (management via POD Director and D&I Manager) WLG re-established	4	3	12	➔	Treat	Develop response to Draft Imposition Notice to go to Exec (Board Sept 2018)	Completed	3	2	6		
																	Submit response to Welsh Language Commission in October 2018	Completed				Final Compliance Notice received on 30/11/2018	
																	Develop WL implementation plan	31 May 2019				Plan being developed following receipt of final compliance notice.	
493	Safety / Legislative	17 Jul 2015	Director of People and Organisational Development	Workforce and Organisational Development Directorate Wide	PHW will not develop their staff in line with the strategy and aspirations of the organisation	Insufficient staff receiving proper performance appraisals	PHW will have a sub-optimal workforce, unable to deliver on its strategic priorities	4	4	16	Appraisal processes for staff, either 'My Contribution' or Consultant Job Plans ESR Records	3	3	9	➔	Treat	Promotion of the value of appraisals	31 Oct 2018	1	3	3	Comms on intranet in September 2018	
																	Redesigning the ESR process to make it as easy and transparent as possible	31 Oct 2019					
																	Target set for all Execs of 90% compliance	31 May 2019					
																	Workforce Plan/Strategy to be developed in draft in support of PHW long term strategy.	31 Mar 2019				See first risk on BAF for more detail	
906	Business Objectives	20 Sep 2018	Director of People and Organisational Development	Workforce and Organisational Development Directorate Wide	PHW will not manage the change associated with the new strategy effectively	Lack of capacity or skills within the organisation	PHW will have a sub-optimal workforce, unable to deliver on its strategic priorities	2	5	10	Executive and SLT teams sponsorship of new ways of working OD plan as part of the eight steps of the strategy transition plan Long term workforce strategy Output of Talent and Succession processes	2	5	10			Update on organisational review to Exec for decision (in respect of job families / support ratios and so on). This is phase one of a program of work to review our operational organisational design.	Completed	1	5	5	Complete	
																	Matrix working - steering group established around Substance Misuse to trial matrix working (evaluation to be completed with lessons learnt in January 2019).	31 Jan 2019					
																	Long term workforce strategy in support of long term strategy to be developed building on outputs from OD plan and workforce plans. First version to be completed by end of performance year.	31 Mar 2019					
																	First Draft OD Plan in support of new strategy to be completed by Christmas 2018	31 Dec 2018					
																	Organisational approach to Talent and Succession agreed (initial discussion at Execs to be scheduled in late 2018)	31 Dec 2018					
696	Safety / Continuity / Staffing	16 Jan 2017	Executive Director for Public Health Services	Public Health Services (Microbiology)	Public Health Services will fail to recruit and retain sufficient medical microbiologists to be able to run an optimal and safe Microbiology service, particularly in North Wales.	Extremely difficult recruiting environment, compounded by changes in the specialty training and the impact this is already having on the market for microbiologists.	In the absence of sustainable clinical oversight and input, service delivery would have to be severely restricted. This would hamper infection prevention and control activities to the host Health Board. Without medical microbiologists the microbiology service in North Wales will not be able to meet service needs to the population and attempts to maintain a service with inadequate medical staffing could impact on patient safety and quality for users of health services in the health board.	4	4	16	High priority area N Wales: Agreed actions to maintain minimum level (as per agreed stabilisation plan) of consultant medical microbiologists using agency and locum staffing. Monitoring competency of locum and agency medical microbiologists to ensure appropriate service provision. In discussion with current locum/agency to determine potential packages to make posts substantive Working with recruitment and Workforce and OD to edit adverts and other recruitment information to improve attractiveness Trust agreement to utilise agency locum staff Monthly submission to Welsh Government to monitor spend on Medical Locums Alternative provision of medical microbiology services from elsewhere within the Public Health Wales network. Action plan to address the local and agency spend issues was submitted by deadline and subsequently a progress report went to Welsh Government by deadline set. Stabilisation and Transformation Group accountable to Executive	3	4	12	➔	Treat	Delivery of the Microbiology Stabilisation Plan	30 Sep 2018	2	2	4	Many actions in the original Stabilisation Plan have been completed to satisfactory outcome. However, some of the critical actions have only resulted in the process being completed e.g. recruitment process in place, but have not yet resulted in the desired outcome e.g. staff appointment. In addition, some new actions have been identified. As a consequence an updated Stabilisation Plan with actions focused on a few critical areas will be developed. Ongoing oversight via the Stabilisation Panel will continue until end January 2019.	
																	Profiling of workforce. i.e. develop novel (Public Health Microbiology) Consultant Clinical Scientist	31 Mar 2021					

Risk Identifier					Risk Description			Risk Scoring								Risk Action Plan							
								Inherent Risk				Current Risk							Target Risk				
Datix ID	Domain	Date	Lead Executive	Directorate (if applicable)	Risk Description (There is a risk that…)	Cause (This will be caused by…)	Effect (The impact will be…)	Likelihood	Impact	Risk level	Key Controls	Likelihood	Impact	Risk level	Trend	Risk Decision	Action Plan	Due date	Likelihood	Impact	Risk level	Progress	RAG Status
																	Further develop network clinical management (e.g. single on-call for Microbiology)	31 Mar 2021					
																	Redesign the service i.e. describe and plan for a National Infection Service	31 Mar 2021					
907	Safety	28 Aug 2018	Executive Director for Public Health Services	Public Health Services (BSW Screening)	Bowel Screening Programme participants will have a delayed diagnosis of bowel cancer and increased wait for colonoscopy	Lack of colonoscopy capacity in Health boards delivered for screening despite being commissioned for the service	Patient harm including increased risk of unnecessary harm due to delay in diagnosis and potential for increased deaths, with associated reputational and financial risks	4	5	20	Continuous monitoring of waiting time standard. Escalation process as per LTA Monitoring of Health Board recovery plans Regular service review meetings Establishment of a national improvement programme for endoscopy services	4	5	20	→	Escalate	Escalation letters sent to Health Boards from the Head of Programme August 2018 to initial a second round of escalation- responses requested by the 6th September	30 Sep 2018	2	4	8	Welsh Government has now confirmed that a directed national approach to endoscopy services in Wales is to be implemented. This work will be led by an Endoscopy Implementation Group and supported by the NHS Collaborative. A national workshop is planned for December 2018 to develop revised improvement plans. The risk will be further updates based on the outcomes of this workshop. Public Health Wales is continuing to work with Health Boards to improve waiting times.	
																	Recovery plans requested for short term improvement and long term development of sustainable capacity Service review meetings planned for September and October	31 Oct 2018					
897	Business Objectives	16 Aug 2018	Executive Director of Quality, Nursing and Allied Health Professionals	Risk and Information Governance	Projects involving third party data processors may be held up or stopped	The requirement by WHC 25(2017) for data processors to be certificated to Cyber Essentials Plus and the inability to find suitably qualified suppliers	Failure of a project along with associated financial and reputational impacts	5	4	20	Privacy Impact Assessment Procedure	4	4	16	→	Escalate	Any new project involving data processors will be required to be certified as set out in the WHC 25(2017) or alternative equal acreditation if approved by Welsh Government (see action below).	31 Mar 2019	1	4	4		
																	Letter to be written to Welsh Government highlighting the issue that a number of existing contracts currently do not meet the WHC requirements and requesting clarity on alternative certifications	Completed				No response received to date from Welsh Government, chasing letter to be sent.	
734	Service Continuity	17 May 2017	Deputy Chief Executive	Operations and Finance (Information Technology)	There is a risk that PHW will suffer unacceptable IT failures	We do not have consistent SLAs with NWIS and have ineffective service management processes.	Disruption to service delivery with potential or reputational financial damage.	4	3	12	In house informatics support Plan in place to bring all IT systems under PHW support.	3	3	9	→	Escalate	All Public Health Wales staff to be transitioned to in-house IT support. This is however a long term project.	31 Oct 2020	1	3	3		
916	Business Objectives	26 Jul 2018	Tracey Cooper	Policy & Public Health Services	There is a risk that the organisation will be adversely affected by the UK leaving the European Union	This will be caused by a failure by the UK Government to secure a deal with the EU	Potential effects include disruption to essential supplies and services for example Health protection, screening, Microbiology services, other procurement and supply arrangements. External impacts on population health are subject to a health impact assessment that is currently being carried out.	3	4	12	In house Brexit Group established to assess and mitigate implications across the organisation. Member of Welsh Government Health and Social Care liaison Group Member of UK Four Nations Group focussed on Public Health Protection Bilaterial relationships with Public Health England as IHR Focal Point.	3	4	12	→	Treat	Health Impact Assessment being carried out (expected to be completed in November)	30 Nov 2018	2	2	4	A Health Impact Assessment of the public health implications of Brexit in Wales has been carried out. The work is being finalised and is due to be published in January.	
																	Internal business impact assessment underway (expected to be completed in October)	31 Oct 2018					
																	Involvement in Welsh Government discussions (various activities)	31 Mar 2019					

Risk Identifier					Risk Description			Risk Scoring								Risk Action Plan							
								Inherent Risk				Current Risk							Target Risk				
Datix ID	Domain	Date	Lead Executive	Directorate (if applicable)	Risk Description (There is a risk that…)	Cause (This will be caused by…)	Effect (The impact will be…)	Likelihood	Impact	Risk level	Key Controls	Likelihood	Impact	Risk level	Trend	Risk Decision	Action Plan	Due date	Likelihood	Impact	Risk level	Progress	RAG Status
935	Organisational Objectives	02 Nov 2018	Quentin Sandifer	Public Health Services	DESW will be unable to modernise to provide quality assured delivery within sufficient time to accommodate the increasing diabetic population of Wales.	Projected increase in diabetic population (current referral level = 1000 new patients per month). Lack of service capacity and capability to achieve service standards. Lack of service infrastructure to support resilient delivery. Resistance to changes in practice from staff within the service.	Patients will have extended waits for eye screening, potentially leading to delayed referral and contributing to irreversible sight loss. Service model becomes unsustainable, resulting in increased errors/incidents. Reputational damage for PHW. Loss of confidence in service leads to detrimental impact on uptake. Increase in complaints, claims and staff grievance. Loss of staff members, resulting in service instability.	5	4	20	Standards in place and being monitored to support service transparency. Management restructure planned to increase capacity, support staff and progress change agenda. Modernisation action plan developed, calling on support from across PHW. Capital investment progressing to replace some equipment.	4	4	16	→	Treat	Action plan developed to address multiple areas for improvement, with actions spanning Sept 2018 - June 2020. Areas for improvement identified as: Governance - standards and performance monitoring against the standards. Organisational Development Workforce Quality and Safety Stakeholder engagement. Update on progress due January 2019.	30 Jun 2020	2	4	8		

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales	**Name of Meeting** Quality, Safety and Improvement Committee **Date of Meeting** 15 Jan 2019 **Agenda item:** 4.1.1.QSIC.150119

Deep Dive into Breast Test Wales- Cover note

Executive lead:	Dr Quentin Sandifer, Executive Director Public Health Services
Author:	Dr Sharon Hillier, Director Screening Division

Approval/Scrutiny route:	n/a

Purpose

This paper is a cover note for the item on deep dive into Breast Test Wales as requested to be presented to the Quality, Safety and Improvement Committee on the 15 January 2019.

The aim of this cover note is to highlight current areas of focus for the programme. A detailed presentation will be undertaken at the meeting to provide assurance that the population screening programme is being delivered to the expected quality standards and to outline areas of focus required to ensure we are able to deliver a sustainable service.

Recommendation:

APPROVE	CONSIDER	RECOMMEND	ADOPT	ASSURANCE
☐	☐	☐	☐	☒

The Board/Committee is asked to:

- Receive assurance through the presentation to the committee on the 15 January that the breast screening programme is being delivered to the expected quality standards
- To consider the issues outlined and support the necessary work to ensure a sustainable workforce.

Link to Public Health Wales Strategic Plan Public Health Wales has an agreed strategic plan, which has identified seven strategic priorities and well-being objectives. This report contributes to the following:	
Strategic Priority/Well-being Objective	6 - Supporting the development of a sustainable health and care system focused on prevention and early intervention

Summary impact analysis	
Equality and Health Impact Assessment	
Risk and Assurance	Please explain the relevance to the Board Assurance Framework (BAF),Corporate Risk Register (CRR) and / or the Directorate Risk Register.
Health and Care Standards	This report supports and/or takes into account the Health and Care Standards for NHS Wales Quality Themes Theme 1 - Staying Healthy Theme 3 - Effective Care Theme 5 - Timely Care
Financial implications	A sustainable workforce is required as if the service had to rely on locum radiologists then this would have significant financial implications.
People implications	The service faces longstanding challenges in recruiting to vacant medical posts, in particular radiology and breast clinician positions.

1. Purpose / situation

This paper is a cover note for the item on deep dive into Breast Test Wales as requested to be presented to the Quality, Safety and Improvement Committee on the 15 January 2019.

The aim of this cover note is to highlight current areas of the programme. A detailed presentation will be undertaken at the meeting to provide assurance that the population screening programme is being delivered to the expected quality standards and to outline areas of focus required to ensure we are able to deliver a sustainable service.

2. Background

The Screening Division of Public Health Wales is responsible for managing, delivering and quality assuring the breast screening programme in Wales. The aim of the breast screening programme is to reduce mortality from breast cancer. Women aged 50 to 70 who are resident in Wales and registered with a General Practitioner are invited for a mammogram (X-ray of the breasts) every three years.

3. Description/Assessment

- **Early diagnosis of breast cancer**

The latest annual statistical report released February 2017 shows performance of the programme for period April 2016 to March 2017. The next report is due to be released on the 28th February 2019.

During this period nearly 123,000 women took up their offer of screening, a coverage of 73.6%. There were 1185 cancers detected, with 77.8% diagnosed as invasive and 49.1% of these were classified as small (less than 15mm in size).

The latest figures available in Wales from 2015 shows that 64.5 % of breast cancers are identified at stage 1 or 2. There were 2786 breast cancers diagnosed which is 30.1% of all cancer diagnosis in women. There was no significant difference in the proportion of female breast cancer cases in each stage at diagnosis between people living in areas of Wales with different levels of deprivation.

Between 2001 and 2017 the breast cancer death rate has decreased by nearly a quarter (24.8%), although the steady decline slowed-down

slightly from around 2012. In 2017 there were 622 deaths from breast cancers in Wales.

- **Sustainable Breast Test Wales workforce**

Breast Test Wales requires a multidisciplinary team of clinical staff to deliver all the components of the breast screening service. This team consists of Allied Health Professionals (Radiographers), Nurses and Medical staff. The medical component of the team includes Breast Radiologists (Consultants), Surgeons and Breast Clinicians (Associate Specialists or Speciality doctor grade).

The service faces longstanding challenges in recruiting to vacant medical posts, in particular radiology and breast clinician positions. Breast Test Wales has a mixture of substantive appointments and shared staff via honorary contracts with Health Boards throughout Wales. The current medical vacancy includes three whole time speciality doctor posts despite several recruitment attempts.

The main operational impact of the current workforce situation is that we do not sustainably meet our stringent timeliness standards. We have developed our strategic workforce strategy to try to mitigate the current risks to the service.

- **Breast Screening Incident in England**

On 2 May 2018, the breast screening programme in England announced that while reviewing their age extension trial, they had identified a problem with how older women had been invited for breast screening. There were also problems with routine programme invitations, dating back to 2009. Around 450,000 women were affected in England and would be contacted.

We investigated the issues that affected England by robustly interrogating our breast screening database, patient records, policies and protocols in place and could confirm that they did not affect our programme in Wales. However, it was identified that there was no failsafe in place to check that women had been offered a screen within the three years before they were 70 years of age.

A review of women resident in Wales aged 70, 71, or 72 was undertaken to check that they had been offered screening in the 3 years prior to their 70th birthday. 24 women were identified who hadn't had a screening invitation offered which was mostly due to slippage in the round length because of the implementation of the digital breast screening programme

The 24 women were sent a letter to explain that they had not been invited for screening in the 3 years before their 70th birthday and asking them to contact the service if they wanted to take up the offer of a screening appointment.

4. Recommendation

The Board/Committee is asked to:

- Receive assurance through the presentation to the committee on the 15 January that the breast screening programme is being delivered to the expected quality standards.
- To consider the issues outlined and support the necessary work to ensure a sustainable workforce.

Position Statement: Breast Screening Incident

Author: Heather Lewis Consultant in Public Health/ Sharon Hillier, Director of Screening

Date: December 2018

Version: 11

Distribution: Incident Management Team, Public Health Wales Board, Welsh Government officials involved with screening policy.

Purpose and Summary of Document: This report outlines the investigations and actions undertaken by a Public Health Wales led Incident Management Team in relation to whether the issues affecting the English breast screening programme had similarly affected the Welsh breast screening programme (Breast Test Wales).

Position Statement of the Public Health Wales Incident Management Team August 2018

Background

This report outlines the investigations and actions undertaken by a Public Health Wales led Incident Management Team (IMT) in relation to whether the issues affecting the English breast screening programme had similarly affected the Welsh breast screening programme (Breast Test Wales, BTW).

Public Health Wales also supported Public Health England by making contact with and offering screening to current Welsh residents who had been affected by the English breast screening incident. Details of the Public Health Wales actions relating to this are also contained in this report.

The report is structured in sections for ease of reference but in reality much of the work to support the English incident and to investigate whether there was a similar problem in Wales happened concurrently.

Section1: The English Breast Screening Programme

The problem:

Public Health England verbally identified four elements which had led to the situation in England. These were:

> **Issue 1:** They implemented the age extension trial which had created a situation where some older women had not been offered their last screen and instead they had been randomised into the trial's control group.
>
> **Issue 2:** Their manual processes around protocols had created inconsistencies in England.
>
> **Issue 3**: England specify that their breast screening offer is 70 years and 364 days and they were not delivering to this specification.
>
> **Issue 4**: Their NHAIS and NBSS IT systems were missing calling women for their final screen due to how the batches were called using these systems and the associated protocol.

On 11 May 2018 Public Health England (PHE) circulated a briefing document in preparation for a teleconference between themselves and Public Health Wales later the same day. For ease of reference the briefing paper is replicated in Appendix 1 at the end of this report.

The briefing was also circulated prior to and discussed at the Public Health Wales IMT held on 16 May 2018. In this briefing note the four issues previously identified as affecting the English screening programme had been amended and now included: "An increase in round length affecting this group of women, so that they did not receive their final invitation", as the fourth issue.

Public Health Wales investigated whether it was affected by the original four issues identified by PHE and also the 'new' fourth issue. The approach used and the findings are set out in sections 3 and 4 below.

Section 2: Public Health Wales' input in support of the English breast screening incident

Public Health England identified 94 women that were resident in Wales, and registered with a Welsh GP, that had been affected by the incident. A letter was sent to these women by PHE on 31May 2018 explaining the situation.

At the request of PHE, Public Health Wales was requested to adopt a two tiered approach which differed according to the current age of the women being written to:

- Women aged under 72
- Women aged 72 and over

Women aged under 72

This group of women received a letter from PHE advising that there was no need for them to do anything more, unless they had questions or queries, and that they would be contacted with an appointment for a breast screen. In England this was done via a second letter containing a breast screening appointment from the regional breast screening centre for the geographical area the woman lived in. In Wales it was agreed that these women would be proactively contacted by telephone where possible or by letter asking them to make contact with the office, if numerous attempts at telephone contact failed.

There were 27 women in this group. Twenty three were successfully contacted by telephone and 4 were sent the letter described above. The

outcome (as at December 17th) has been that 15 women have already attended for their appointment, 1 woman did not attend her appointment and 1 woman has opted to wait until the mobile screening unit returns to their local area. Seven women have declined the offer and 3 women have not responded to the letter they were sent.

Women aged 72 and over (up to age 79)

This group of women received a different letter from PHE advising them to contact the PHE helpline if they wanted to have a breast screening appointment. The contact details of these women were then passed via secure portal to Public Health Wales and proactive telephone contact made by Breast Test Wales staff in order to make an appointment for a breast screen.

There were 67 women in this group and as at 8 August, 11 women had made contact with the helpline to request a breast screen. The outcome has been that 5 women have attended, 1 woman has an appointment booked, another has cancelled, one woman has been written to and asked to contact the office as telephone contact has not been possible and 2 women have opted to wait until the mobile screening unit returns to their local area. The final woman had a breast screen in 2016 and is therefore not eligible for a further breast screen until 2019. As at December 17th there had been no change to these numbers.

The results of all women affected by the PHE incident and screened by BTW on behalf of PHE will be emailed to PHE.

It is important to note that 183 other Welsh women resident in Wales have been written to by PHE but as they are registered with an English GP they will be followed up within the English system and not via Public Health Wales.

All women resident in Wales over the age of 70 can self refer for breast screening.

Section 3: Reviewing if Wales had similar problems relating to the four issues identified:

Issue 1: *England implemented the age extension trial which had created a situation where some older women had not been offered their last screen and instead they had been randomised into the trial's control group*.

Breast Test Wales has never participated in the age extension trial. To clarify a related matter, Breast Test Wales invites women who are resident in Wales even if they are registered with an English GP so invitations will have been sent to all eligible women resident in Wales. **Therefore this issue does not relate to Breast Test Wales.**

Issue 2: *Manual processes around protocols have created inconsistencies in England.*

Unlike England there is no regional or site specific variation in delivery against the protocols. Breast screening in Wales is delivered via Breast Test Wales using national standard operating procedures which are consistently delivered across the regional centres. **Therefore this issue does not relate to Breast Test Wales.**

Issue 3: *England specify that their breast screening offer is 70 years and 364 days and they were not delivering to this specification*.

The Policy and our Intention

UK Policy

Current UK policy from the UK National Screening Committee does not clearly define the upper age limit of eligibility for breast screening. It specifies that women aged between 50 and 70 years should be offered population based screening but there is no clarity on whether 70 includes 70 year olds or whether it is up to 70 (i.e. 69 years and 364 days).

Discussion at UK level since England identified this issue has led to the UK National Screening Committee being tasked to define the upper age limit, outlining the evidence base for the decision. This is expected to be completed by the end of this year.

The Marmott review regarding the evidence base for breast screening was undertaken in 2012 and in its conclusion and recommendations it states that the impact of breast screening outside the ages 50-69 years is very uncertain.

Wales Policy

To understand the intention of the Wales policy (as it was not clearly defined in the current documentation) the original documentation from 2002 relating to expanding the routine breast screening age was reviewed.

It is important to note that no hard copy of the document existed and that it was a long serving member of staff with extensive organisational memory of the screening division who was able to locate the document in the archived files.

The 2002 paper sets out the Breast Test Wales position to expand the age group of women invited for breast screening from 64 years of age as the upper limit to 69 years (up to the 70th birthday). As explained above this was based on a UK National Screening Committee recommendation that was accepted as policy by the Welsh Assembly Government. So it is clear that the intention of the programme and the policy was to screen up to a woman's 70th birthday (i.e. 69 years and 364 days).

Review of policy documentation and correspondence has also been undertaken by Welsh Government and this review confirms the policy for Wales was agreed as up to 70 years.

In order to implement the expanded age range to 69 years and 364 days, standard operating procedures were drafted and a protocol was implemented. It is the case that women may have been called as early as 49 years to as late as 70 years to ensure that no woman was missed within the defined age parameters. This is the tolerance that was built into the protocols at the time and is why some women in Wales are called for breast screening at age 70.

Whatever date cut off is used there will always be women who have passed their 70th birthday before receiving a final invitation to attend for screening, as the invitation for breast screening is dependent on when the mobile units are in the woman's locality during their three year round length.

The processes and systems put in place to implement the expansion of the screening age to 69 has not changed since that time. When a new Next Test Due (NTD) failsafe was introduced in 2016 it was implemented to the exact parameters of the original protocols (up to 70 years, meaning 69 years and 364 days).

Discussions with key staff members have not identified any measure such as a communication, policy, or verbal agreement which contradicts that the programme offers breast screening up to the age of 70 years (69 years and 364 days). However what has happened is that the clarity of the messaging around the upper age limit of the programme has become ambiguous through the passage of time.

To sum up, in terms of the intention of the programme, it is now clear that the programme intent is to call women for breast screening up to their 70th birthday (69 years and 364 days) with a built in tolerance to ensure no woman is missed.

Information to women

Scrutiny of the information women have been provided with via routine recall letters, leaflets and our website, show that there is inconsistency in the terminology used to describe the breast screening offer. Most literature specifies that women are not invited routinely after the age of 70 however it is not clear whether this means up to their 70th or 71st birthday and it is a matter of individual interpretation whether 'after 70' includes when you are 70. This matter needs to be remedied going forward.

Wales offers all women over 70 years of age the ability to self refer into the breast screening programme by calling one of the regional breast screening centres. This is clear in all Public Health Wales public facing material and information to this effect is provided to women when they reach the age of their final routine breast screen.

So in relation to issue 3, the breast screening offer in Wales is up to a woman's 70th birthday (i.e. 69 years plus 364 days). The Public Health Wales messaging needs to be made clearer but our review shows that we are inviting women appropriately to deliver the breast screening offer. **Therefore this issue does not relate to Breast Test Wales.**

Issue 4: *The NHAIS and NBSS IT systems (in England) were missing calling women for their final screen due to how the batches were called using these systems and the associated protocols*.

Wales uses the same NHAIS and NBSS IT systems as England so there was a possibility that the batch calling system was missing women in Wales as it was in England.

It should be noted that the breast screening offer is complex due to the screening being offered on a three year round and organised via invited GP practices rather than inviting individuals as happens in other cancer screening programmes.

This was the model set up from the start of the programme in 1989 as it was considered the best way to ensure that screening was offered locally to eligible women.

In order to ascertain whether we were calling women appropriately for their breast screening it was important to firstly understand the precise cohort of women who were eligible to participate in the screening programme.

In Wales, our breast screening offer is to invite women starting from age 50, 51 or 52 (this can be a few months earlier to keep woman in line with when their GP practice is called). There is a failsafe in place to ensure that all women are invited before they reach their 53rd birthday. Women will receive their final screen in their 68th, 69th or 70th year ie when they are 67, 68 or 69 (again this can be a few months later).

An initial review of the protocols and data on screened women identified that there was potential for inconsistency in inviting women when they are aged 70. This was because the calling of women was dependent on the day and month of birth and the batch selection date, which is the date that screening starts for their GP practice. However, now that we have clarified that the intention of the programme is to invite women up to 70 years of age, we have understood that the women invited at 70 are invited so as not to miss their last screening offer if their GP practice has not been called in the round length up to that time.

So in relation to issue 4, we have not identified a systematic error in our protocols meaning that women have been invited according to our policy albeit that some manual errors have been identified. **Therefore this issue does not relate to Breast Test Wales.**

As outlined in Section 1 above, on the 16 May a PHE briefing document referred to a different issue 4 than had previously been communicated and this was also reviewed by Public Health Wales.

New Issue 4: *An increase in round length affecting this group of women, so that they did not receive their final invitation*.

PHW identified a potential issue with round length **therefore this issue could relate to Breast Test Wales. Details of the investigation are outlined in section 4 below.**

Section 4: Public Health Wales investigation

In order to investigate the effects of round length and assess whether we were appropriately inviting women to our upper age limit, an analysis was undertaken of whether any eligible woman had not been offered breast screening in the last 3 years before they turned 70. For woman aged 70, 71 or 72.

We did this by interrogating our database to investigate if women who are currently aged 70, 71, or 72 have had a final invitation for breast screening appropriately, meaning that they have been offered screening in the last 3 years before they turned 70.

The interrogation of the database and further review of individual participant records identified 201 women who did not receive an offer of breast screening in the three years prior to their 70th birthday. A thematic review of the reasons for the missed offer was undertaken details of which are outlined in the document; Breast Test Wales – data review and process findings dated 01/06/2018. The headlines of the thematic review are that programme slippage (135 women), next test due failsafe batch processing error (6 women), invitation across calendar years (13 women) and time taken for a new registration (1 woman) were the factors leading to the missed offer of breast screening for 155 of these women.

The remainder of the women identified in the total 201 figure were found to have no issue with the screening process and were removed for reasons such as: transfer outside Wales, screened appropriately elsewhere before moving into or back to Wales, appropriately deducted due to returned mail and no forwarding address (FP69 code), and NHAIS registration errors and duplicates.

Of the 155 women with a missed offer of breast screening, 8 had a diagnosis of breast cancer. All 8 were investigated (ref paper 4 circulated for agenda item 7 incident meeting 14 June), and two were identified as needing further investigation.

Whilst investigating the two cancer cases outlined above a final validation stage was undertaken both on the two cases and on the remainder of the 155 women to examine whether they had a screening appointment offered appropriately in the 3 years before their 70th birthday.

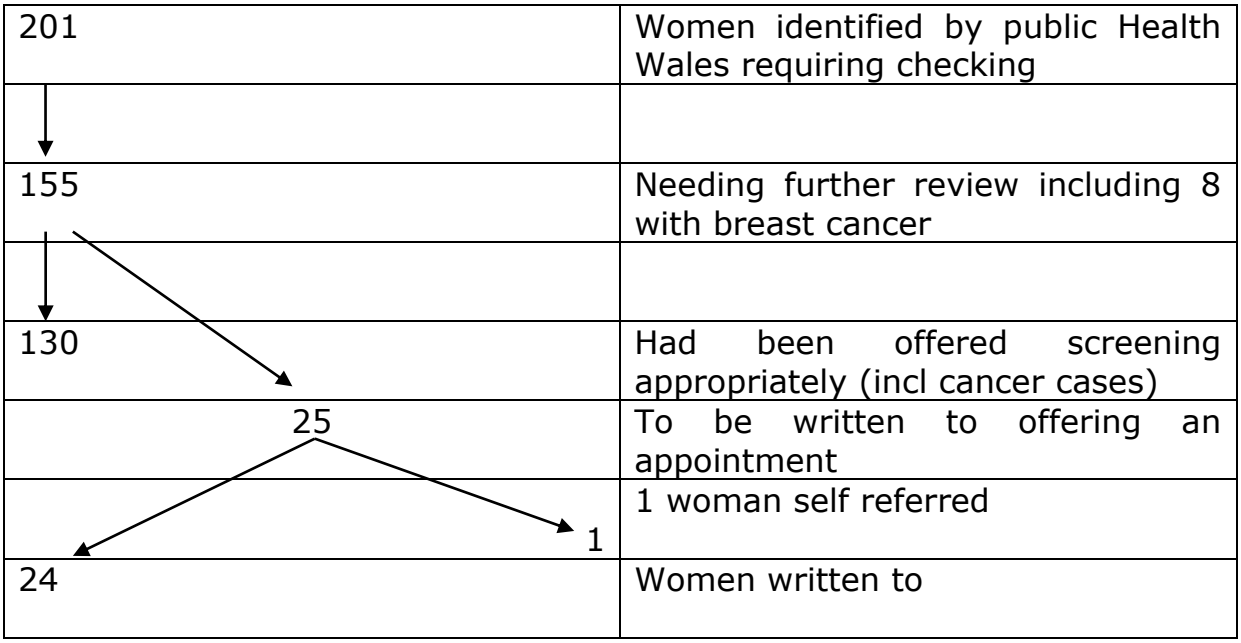
Of the 155 women 130 had been offered a screening appointment within 3 years of their 70th birthday and no further action was required. The two

cancer cases were part of this group of 130 and did not need any further action as they had been offered a breast screen in the 3 years prior to their 70th birthday.

Of the remaining 25 women that were confirmed as definitely not offered an appointment appropriately, one woman had recently contacted the screening centre and been given an appointment. Of the remaining 24 women, their delay was caused by;

- slippage in the screening round length (19 women)
- a processing error (4 women)
- time taken for a new registration (1 woman).

Figure 1: Flow chart of investigation into women who may not have been offered a breast screen in the 3 years before their 75th birthday



Another group of women were identified, defined as women who were deceased and were not offered a breast screen in the 3 years prior to the 70th birthday, fully investigated and no further action deemed necessary (reference paper 3.1 circulated for agenda item 6, 30 May 2018).

Two other groups of women, defined as women no longer living in Wales but moved more than 3 years after their last invitation (numbering 310) and women that cannot be traced easily and need further exploration (numbering 88), were sent via secure, electronic link to PHE to ascertain whether these women had been screened in England.

PHE advised that of the 398 women sent to them, 293 women had had a screening episode in England since moving from Wales, 1 woman was involved in the PHE incident and 1 had a symptomatic diagnosis of breast cancer, leaving 103 women who required follow up. However, more clarification on these 103 women was required from PHE as the initial file returned to Public Health Wales only contained 93 women and addresses were only provided for 9 of these 93 women. The intention was that women from this group would be investigated to ascertain the reasons for their missed offer of a breast screen.

In the IMT meeting held on 26 June (reference paper 3 circulated for agenda item 7, 26/06/18), the informatics team advised that despite additional requests, Public Health England could only provide addresses for 9 women out of the 93 women in the file they returned to Public Health Wales. These 9 women were reviewed and when a specific age parameter was applied ie the women must be 67 years or older at the point of deduction ie the three years before they turned 70 years old, only three of the nine women fulfilled this criteria and required follow up. However when these three were individually investigated it was ascertained that they had been deducted correctly so they had not missed an invitation for breast screening in Wales.

When the same age parameter (ie 67 years or older at the point of deduction) was applied to the remaining 84 (93 minus 9) women, only three fulfilled the criteria and would need to be written to. As Public Health England could not provide contact details for these 3 women it was agreed that PHW would contact Scotland and Northern Ireland to ascertain if the women now lived there and could be contacted. It was agreed that this final check with Scotland and Northern Ireland exhausted all avenues of trying to identify these women and if not successful it was reluctantly accepted that the women could not be contacted. In July 2018, Scotland and Northern Ireland colleagues confirmed that one of the women was identified as living in Scotland and had been screened appropriately and the other two women were not known to Scotland or Northern Ireland.

Figure 2: Flow chart of investigation into women no longer living in Wales and women that cannot be traced easily

398	Women identified by Public Health Wales and sent to Public Health England for checking
↘	
293	Screened in England
1	Involved in PHE incident
1	Symptomatic diagnosis of cancer
↙	
103	Required PHW follow up (398 – 295)
↓	
93	Checked by PHE and returned to PHW: 10 women could not be identified
↘ ↓	
9	With addresses in England: Checked – No Further Action
84	No addresses available: Checked – 3 needed further action
↓	
3	Checked with Scotland and NI whether women were resident. 1 woman identified. 2 women could not be identified.

PHW requested the details of the woman symptomatically diagnosed with breast cancer by Public Health England so that an investigation could be undertaken to ascertain whether the missed offer caused harm to the woman. As at December 2018 this information had not been provided.

Section 5: Conclusion and Recommendations

Public Health Wales has investigated the issues that affected England and can confirm that they do not affect Wales. Breast Test Wales use the same IT platform but it is administered in a different way in Wales and against different age parameters. Public Health Wales can confirm that no systematic problems with screening invitations have been identified.

However, by undertaking the level of scrutiny that the Programme has, areas for improvement have been identified.

Recommendations

Public Health Wales needs to make its public messaging regarding the upper age limit of the breast screening programme clearer.

Consideration should be given to the capture of key policy decisions and intentions throughout screening programmes so that key information is not lost through the passage of time.

The parliamentary debate on 2nd May 2018 regarding the issues in England has put a spotlight on the oversight and quality assurance of screening programmes, in particular the cancer screening programmes (in the UK we have cervical and bowel cancer screening programmes). Public Health Wales should review its cancer screening programmes to ensure appropriate quality assurance and oversight is in place.

Public Health Wales in partnership with Welsh Government colleagues should develop explanatory lines outlining why the policy in Wales in relation to the upper age limit in the breast screening programmes is different to that of England.

Section 6: Outcome of debrief

The debrief took place on 1 October 2018.

Participants were asked to discuss the following questions:

i. What aspects of the response **did not** go so well?

ii. What aspects of the response **did go well** or could be identified as good practice?

iii. What observations or recommendations for change should be acknowledged or implemented to **improve the response** to incidents in the future?

OBSERVATIONS AND RECOMMENDATIONS

This report does not attribute comments to any specific division or person.

To be clear and concise, observations have been grouped under these headings:

- Incident Management
- Information Sharing
- Information Management and Record Keeping
- Informatics
- Staff and Resource

INCIDENT MANAGEMENT

Discussions relating to the management of the incident concluded that the Incident Management Team was well led and supported by colleagues. The response was professional and thorough given the constraints on the team.

Decisions were constructively challenged and valuable conversations took place. The inclusion of an independent member of the Incident Management Team provided a fresh perspective on the incident, enabled a challenge of discussion, provided objective opinion and asked questions of the team that had not been considered.

Recommendation: Inclusion of a critical friend during an incident to provide objectivity and challenge

Due to the quantity of information being received by the Incident Management Team, as well as the high profile nature of the incident, there were significant time constraints that prevented the required detailed level of discussions. It was felt that the establishment of an operational ('bronze') group sitting beneath the Incident Management Team would have provided an opportunity to discuss the necessary level of detail.

Administration of the meetings was praised with high quality minutes of the meetings being turned around quickly.

INFORMATION SHARING

Throughout the course of the incident the Incident Management Team felt uncomfortable with the information that was being provided by partner agencies in England. There was a lack of understanding on the nature of

the issue and Public Health Wales had to make a number of assumptions and act on verbal information.

The timeline from NHS England would frequently change, often at the last minute. Public Health Wales' received 3 days' notice (including a weekend) that the Secretary of State would be making an announcement. This led to increased pressure and demands on staff due to the requirement to work to timeframes outside the control of Public Health Wales.

INFORMATION MANAGEMENT AND RECORD KEEPING

Observations were made on the recording of decisions by the Incident Management Team as well as historical decisions and how organisational memory is maintained. The utilisation of either a loggist or minute taker allows for the decisions of the Incident Management Team to be centrally recorded and provide evidence for future enquiries. The decision log would further aid organisational memory providing a source of information relating to historical decision made and rationale. Consideration should also be given to how key decisions can be accessed.

Discussions took place relating to the integrity of historic records and their accessibility. The absence of a single secure repository of internal and external documentation relating to individual programmes provided additional complexities in the management of the incident. The retention of documents in a single repository would ensure staff had access to required information.

Recommendation: The Division needs to determine a method for the recording of decisions so that they are kept in a single repository and easily accessible

Recommendation: All IMT members agreed on the benefits of a position statement that was kept up to date throughout the incident response. The Division should continue with the use of position statements in incident response

The recording of meetings chaired by partner agencies could have been improved as records of discussions and actions were not circulated or accessible.

INFORMATICS

The complexity of the data handling required was acknowledged. Each patient has a number of dates as part of their individual pathway including date of episode, date of appointment and date of correspondence. Lack of a shared understanding in the case definition led to uncertainty as to which date should be used to acquire the necessary data to assess whether an invitation had been missed.

The support the Incident Management Team received from the Informatics team was highly praised. Access to required data was timely and efficient. This highlighted the benefit of a consolidated specialist informatics resource in a single location.

STAFF AND RESOURCE

The incident was well supported by staff. Staff were readily accessible should decision be required or implemented. Staff continued to undertake their core duties despite the impact the incident had on their workload.

Recommendation: Although the incident response was effective, the pressure on staff to continue with their 'day job' was considerable. Consideration should be given to reprioritisation of staff and work programmes and potentially dedicated staff time to devote to the incident response.

The Incident Management Team wished to express their gratitude to staff across the organisation who were involved in the incident for their support and professionalism.

PARTICPANTS IN THE DEBRIEF

Name	Job Title	Division	Directorate
Anna Ashman	Communications Manager for Media Relations	Communications	Operations and Finance
Dean Phillips (Teleconference)	Head of Programme Breast Test Wales	Screening	Public Health Services
Guy Stevens	Deputy Informatics and Data Services Manager	Informatics	Operations and Finance
Heather Lewis	Consultant in Public	Screening	Public

	Health		Health Services
Heather Payne (Teleconference)	Welsh Government		
Helen Clayton	Lead Informatics and Data Services Manager	Informatics	Operations and Finance
Joanna Haimes (Teleconference)	Lead Screening Centre Manager	Screening	Public Health Services
Sharon Hillier	Director Screening Division	Screening	Public Health Services
Sikha De Souza	Consultant in Public Health	Screening	Public Health Services
Quentin Sandifer	Director of Public Health Services & Medical Director	Public Health Services	Public Health Services

Appendix 1

Breast Screening Age Parameter Incident

Briefing Note: Wales teleconference. 11th May 2018.

Background.

PHE has been holding teleconferences to ensure shared understanding of the current Breast Screening Age Parameter incident which was publicly articulated in a Statement by the Secretary of State for Health on 2nd May 2018.

Although all four UK countries have an ambition to achieve maximum uptake of evidence based screening interventions for breast cancer, differential policies and implementation processes may appropriately apply in different countries.

Aim

A number of individual technical meetings with each country are being progressed to enable:

- Clear understanding by each UK country of the problems which have been detected in the English breast screening programme
- The specific relevance of these to the programme in Wales
- Relevant actions, and any which can be supported by PHE and
- Agreed communications and practical management of affected women

Plan

This note provides a starting point for the technical teleconference.it is planned that each identified problem listed below will be discussed at the meeting. Where it is clear that further action needs to be taken for each point, the technical detail will be discussed further so individual countries can form action plans relevant to their own Ministerial and service needs.

What has happened?

The installation of Breast Screening Select in July2016 allowed services to see for the first time the actual age of women in batches and for national

audits of practice to be undertaken. PHE became aware that in some instances women less than 71 years who were eligible for a screen were not being included in batches.

PHE identified a number of complex issues that had led to this, including:

- The Age X trial algorithm incorrectly applying an AR code to women before they reached their 71st birthday
- Incorrect specification of RISP batches that did not include women up to 70y11m
- Incorrect specification of NTDD failsafe that did not go up to 70y11m
- An increase in round length affecting this group of women, so that they did not receive their final invitation.

What has PHE done to mitigate these risks?

PHE has carried out a thorough investigation of the whole system and a detailed analysis of the data since 2009. This is when the roll out of the current offer for a screen to women 50-70 years of age was completed across England in all BS services for all women. Where 70 is described as the offer of breast screening up to the woman's of 71st birthday as stated in the 2013/4 service specification.

A number of IT improvements and changes to processes across all services have now been made to the screening invitation system and the issue has now been fixed. These include:

- A manual check on women being given an AR code. This is being run by SQAS
- An interim fix to AgeX algorithm to stop women being placed in the control arm of the trial. A permanent fix will be in place by September.
- Advising and auditing services about the importance of using failsafe up to 70y11m

What is PHE and NHS England putting in place to manage the Patient Notification Exercise?

- PHE with the support of NHS Digital is writing to all women who have been affected by this incident. This will tell women who have

not had an invitation and have not had their 72nd birthday on 1/4/12018 that they will be sent a catch-up invitation for a screen by their BSO. Women who are 72 and over to 79 years on 1/4/2018 will be given information and offered the chance to make a self-referral via the dedicated helpline.

- PHE has implemented a helpline for women who want further information and for women who have cancer. We have support from Breast Cancer Care and Macmillan helplines to take calls from women who are distressed.
- NHS Choices has specific information for women affected by this incident.
- NHS Digital and PHE have created an auto-batching system which will allow it to transfer through Breast Screening Select to each BSO the details of the women that need an appointment.
- PHE is working with clinicians to provide a risk assessment based on published criteria for each affected woman who has had a diagnosis of breast cancer after the age of 71years. This will consider whether or not the missed invitation could have altered when their cancer was diagnosed and whether, if it was diagnosed earlier, this could have affected their treatment or prognosis. If women request a risk assessment, the findings will be sent to their breast screening service. We will ask women how they want the findings fed back to them.
- NHS England and PHE has written to stakeholders including charities and Royal Colleges and GPs so that they are aware of what is happening and so they can provide support for women.

What will Breast Screening Services need to do?

The number of women who require screening invitations varies between services. and is being supplied to local services by NHSE. Additional capacity is being put in place to prevent any impact on the routine 50-70 screening cohort.

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales	**Name of Meeting** Quality, Safety and Improvement Committee **Date of Meeting** 15 January 2019 **Agenda item:** 4.3.1.QSIC.150119

Quality and Impact Framework Implementation Plan 6 month update	
Executive lead:	Sian Bolton – Acting Director of Quality Nursing and Allied Health Professionals
Author:	Sian Bolton – Acting Director of Quality Nursing and Allied Health Professionals

Approval/Scrutiny route:	Quality Safety and Improvement Committee

Purpose
The purpose of this paper is to provide the Committee with an update on the Quality and Impact Framework Implementation Plan which was developed at the end of 2016

Recommendation:				
APPROVE ☐	CONSIDER ☐	RECOMMEND ☐	ADOPT ☐	ASSURANCE ☒
The Committee is asked to: • **Receive assurance** that the Quality and Impact Framework implementation plan is progressing and progress is monitored				

Link to Public Health Wales Strategic Plan Public Health Wales has an agreed strategic plan, which has identified seven strategic priorities. **This report contributes to the following:** All Public Health Wales Strategic Priorities

Summary impact analysis	
Equality and Health Impact Assessment	An Equality and Health Impact Assessment has not been undertaken as this is an internal piece of work.
Risk and Assurance	Quality and impact are reflected throughout the Board Assurance Framework and the Corporate Risk Register.
Health and Care Standards	This report supports and/or takes into account the Health and Care Standards for NHS Wales Quality Themes Governance, Leadership and Accountability
Financial implications	In order to implement the Plan there are a number of actions where investment has been identified as being required
People implications	The document is reliant on staff embracing a culture of quality and continuous improvement with a focus on impact

1. Purpose / situation

The purpose of this paper is to provide the Committee with an update on the Quality and Impact Framework Implementation Plan in order to receive assurance on progress.

2. Background

The Quality and Impact Framework ('the Framework') was developed in 2016, following extensive consultation with staff. Its overall aim was 'to create a culture where staff, regardless of their location, Directorate or focus of work, have the will, knowledge and support to ensure that Public Health Wales is an organisation known for quality and achieving outcomes which impact positively in the health and wellbeing of the people of Wales'.

Following approval of the Framework by the Board in November 2016, a high level implementation plan was developed setting out key milestones/ deliverables for delivery by April 2019.

3. Description/Assessment

Whilst the overview and monitoring of the Quality and Impact Framework sits with the Quality, Nursing and Allied Health Professionals Directorate, the responsibility for ensuring quality and measuring impact/ outcomes is the responsibility of all staff within Public Health Wales. This is reflected within last years Integrated Medium Term Plan (IMTP), and the draft for 2019 which placed an increased focus on outcomes.

An update on the implementation plan has been reported to the Quality Safety and Improvement Committee on a six monthly basis during 2017 and 2018. To date this has included a brief update against each of the actions identified.

Earlier in 2018 the update report informed Committee members that the majority of the actions had been completed, or were on track to complete within the original timescales identified, with only two actions identified as being behind schedule. These related to:

- Implementing 'Our Approach to Engagement'; and
- Demonstrating improvements year on year against their identified indicators.

Further work has been undertaken in relation to these actions. Supporting Guidance has been developed for 'Our Approach to Engagement' which is being considered at the People and Organisational Development Committee

in January 2019; it is proposed that an action plan for implementation is then developed. In addition, the first iteration of the Quality and Impact indicators that have been incorporated into the corporate performance report; these will be reviewed in Quarter 4 2018/19.

Discussion during the February 2018 Quality Safety and Improvement Committee identified that Committee members would benefit from the written updates focusing more on actions where additional work was still required; these are set out in section 4 below. In addition, to enable Committee members to gain a deeper understanding of these ongoing actions specific time has been allocated within the Committee agenda going forward, to facilitate time for presentations to be given. In addition, quality and impact will also be part of the Deep Dives scheduled into future Quality Safety and Improvement Committee. It should be noted that whilst the update (Appendix A) indicates that the majority of deliverables are green (on target), the organisation will need to continue to monitor and develop systems and processes to support continuous improvement with a focus on impact.

4. Areas for further development

Establishment of Quality Hub: A Quality and Impact Hub was initially established in June 2017 and a number of sessions were held enabling staff to join virtually or face to face. However, feedback from these sessions indicated that staff felt that they were a duplicate of the Lunch and Learn sessions, which were well received.

With the appointment of a new Quality Lead in summer 2018 and with support from 1000 Lives a Task and Finish Group was established to plan a new approach; this included the two Institute of Healthcare Improvement (IHI) Improvement Advisors from within the organisation (out with of 1000 Lives). The first event of the re-established Quality and Impact Hub (named Dolan – welsh for link) will be held at the end of January 2019. It is proposed that at a future Committee meeting a verbal presentation is provided on Dolan.

Evaluation: A Senior Researcher and Assistant Researcher have been employed to increase the use of evaluation throughout the organisation. An additional item (presentation) has been added to the Committee's agenda to enable members to gain insight into the evaluation work that is currently being undertaken.

Quality and Impact Indicators: An initial set of Quality and Impact Indicators have been developed via a bottom up approach which have now been incorporated quarterly into the corporate integrated performance report. A number of reports have previously been presented to the Committee in relation to their development. Further work is currently under

way to work with Directorates/ Divisions to review and revise these indicators to ensure that they remain relevant and that they focus on outcomes/ impact.

5. Recommendation

The Committee is asked to **receive assurance** that the Quality and Impact Framework implementation plan is progressing and progress is monitored.

Appendix A: Deliverables identified within the Quality and Impact Framework

Objective	Deliverable	RAG Rating current position
Objective 1: We will make achieving quality and impact a top priority for all our staff 	• Production of the Quality and Impact Framework • Establishment of Quality Hub (to engage staff in sharing learning from innovation, improvement activities, research experience and evaluations) • Evidence that the views of staff, are collected, collated and used to improve quality and the impact of our work across the organisation • Collation, review and regular reporting on incidents, concerns, complaints and any serious incidents	
Objective 2: We will promote and encourage listening and gaining feedback from our service users, the public and each other to improve our understanding of how we can work better together 	• Evidence of clear, transparent, timely and relevant communication to staff, the public and people who are affected by our services, programmes and functions • Evidence that the views of people who use our services, communities and the wider public are collated and used to improve quality and the impact of our work to achieve our strategic priorities • Further compliance with equality duties and best practice standards that relate to involvement and public engagement	

Objective 3: We will provide the right education, training and support for our staff so that they can deliver quality and impact- 	• Organisational Development (OD) and Learning Framework in place which supports
	  ○ improving skills
	  ○ cross organisational knowledge development in research (including evidence) and evaluation
	  ○ quality improvement methodologies	

Objective	Deliverable	RAG Rating current position
Objective 4: we will develop leadership skills at all levels and empower staff to take decisions and make changes 	• Quality and Impact Framework reflected within the organisation's strategic objectives, Integrated Medium Term Plan (IMTP) and local operational plans, stressing the importance of considering quality and the impact of our work in conjunction with performance, finance and workforce issues • Clear lines of accountability and schemes of delegation evident • All Directorates demonstrate improvements year on year against their identified indicators (see Objective 7)	 Unable to measure at present
Objective 5: We will monitor and evaluate the impact that our work has. This will be embedded in all new work we undertake 	• Reporting and monitoring on a quarterly basis of quality and impact indicators (see Objective 7), embedded within the wider performance reporting arrangements • All new major projects/ programmes will have evidence and evaluation built into their initiation document against expected outcomes and necessary costs and resources to evaluate identified • Any refreshed or new IMTP will have reviewed work undertaken to determine its impact, and made a decision on whether work should be continued, amended or stopped • Evidence that knowledge is used (arising from research evidence, good practice , improvement projects, experiences and evaluation) is used transparently, appropriately, proportionally to inform decision making	 Presentation: 15/01/2019 (QSIC)
Objective 6: We will ensure externally applied standards, where they exist, are in place and monitored 	• Actively determine and adopt appropriate standards for the organisation • Reporting and monitoring on a quarterly basis against robust meaningful standards (both internal and external) eg Health and Care Standards, ISO Standards	
Objective 7: We will improve outcome and quality measurement and report on	• Development of the quality and impact indicators in collaboration with Directorates/Divisions to link in with existing and future performance reporting mechanisms	

Objective	Deliverable	RAG Rating current position
progress against our Quality and Impact Framework 	• Develop a Quality and Impact reporting dashboard in collaboration with existing and future performance reporting mechanisms	
Objective 8: We will promote the use of recognised improvement and evaluation techniques and ensure that there is sufficient capacity and capability within the organisation to use them effectively 	• Appropriate methodologies for improvement, use of evidence, evaluation (both process and outcome) and engagement approaches available and utilised (link to Objective 3) • Participation in local, national and international research will increase year on year • External benchmarking (of quality and effectiveness) with other health organisations, both in Wales and wider undertaken	
Objective 9: We will strengthen existing and establish new dynamic partnerships across health, social care, local government, housing, third sector, academia and industry to help us deliver improved health and wellbeing for the population 	• An active *Cymru Well Wales (CWW)* strategic partnership that delivers against its founding principles • Strong and constructive partnerships with other health organisations at a national and local level to learn and share lessons and improve quality • Methods of measuring the impact of our work against our strategic objectives available and utilised	

On target – processes/ deliverables in place but will required continued focus

Ongoing work – will not be delivered by April 2019

Unable to deliver

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales	**Name of Meeting** Quality, Safety and Improvement Committee **Date of Meeting** 15 January 2019 **Agenda item:** *4.3.2.QSIC.150119*

Public Health Wales Evaluation Appraisal: Executive Summary

Executive lead:	Sian Bolton, Executive Director of Quality, Safety and Improvement Committee
Author:	Genevieve Riley, Senior Researcher (Evaluation & Impact),

Approval/Scrutiny route:	Policy and Strategy Executive Committee 10th October 2018

Purpose

To provide the Committee with a summary of the findings from the recent appraisal undertaken by the Evaluation and Impact Team across PHW, which intended to establish a baseline of evaluation activity for the last two years; and inform the development of the evaluation programme for PHW.

This paper was submitted to the BET meeting on the 19th November 2018 for their consideration and is included here in support of the presentation.

Recommendation:

APPROVE	CONSIDER	RECOMMEND	ADOPT	ASSURANCE
☐	☒	☐	☐	☐

The Committee is asked to:

- **Consider** this paper in support of this presentation.

Public Health Wales Evaluation Appraisal: Executive Summary

Authors: Genevieve Riley, Senior Researcher (Evaluation & Impact),

Rhiannon Norfolk, Senior Public Health Research Assistant.

Dr Alisha Davies (Head of Research and Development)

Date: 5th October 2018	Version: 1.0
Sponsoring Executive Director: Prof. Mark Bellis	
Who will present: Genevieve Riley and Alisha Davies	
Date of Executive Team meeting: **Policy and Strategy Executive Committee 10th October 2018**	
Committee/Groups that have received or considered this paper:	
The Executive Team are asked to: (please select one only)	
Approve the recommendation(s) proposed in the paper.	□
Discuss and scrutinise the paper and provide feedback and comments.	
Receive the paper for information only.	

Link to Public Health Wales commitment and priorities for action:							
(please tick which commitment(s) is/are relevant)							
	%7		□				□
Priorities for action				include relevant priority for action(s)			

Executive Summary

1. Introduction

Evaluating impact is a principal function of Public Health Wales. There is a need to better understand the current extent of our evaluation activity to help inform different approaches and strengthen our actions to deliver robust evidence. Without rigorous evaluation, it remains unclear if interventions are effective, for whom and when.

This paper summarises the findings from the recent appraisal undertaken by the Evaluation and Impact Team across PHW, which intended to establish a baseline of evaluation activity for the last two years; and inform the development of the evaluation programme for PHW (including the need for a quality assurance framework for future evaluation activities, training gaps, approaches and investment in evaluation).

2. Key findings

Information on a total of 99 evaluations was submitted for the time period June 2016 – June 2018, (including 46 completed evaluations, 45 current, 5 discontinued and 46 planned over the next three years).

Reviewing the responses the findings highlighted three key areas for action:

1. Clarity of terminology
2. Quality and planning of evaluation
3. Skills and training

2.1 Clarity on terminology

Terminology associated with evaluation is interpreted differently across the organisation, and it used interchangeably with monitoring and Key Performance Indicators. What some divisions described as evaluation was a continuous form of programme monitoring, rather than evaluation of a programme against core objectives, understanding if the programme has an impact on short medium and long term outcomes (logic models), including the mechanisms of effect, the effectiveness and cost effectiveness.

Clear guidance on the role, scope and definition of evaluation is lacking.

2.2 Quality and planning of evaluation

There is much evaluation activity taking place but the robustness of design and implementation are unclear, there is limited evidence that findings inform decisions.

We found limited use of steering groups to help engage stakeholders on complex issues and establish decision making processes (particularly important for formative evaluations where evaluation methods helps to inform activities as they are in progress where situation
reflexivity can be critical).

Fundamental good practice elements such as defined protocols, clear objectives, standard methods, validated tools, dissemination, and records of impact were limited. Our appraisal also found no evidence of health economic evaluation.

Only 19% reported the use of validated measures (or a mix), with 81% reporting either that they didn't use validated measures or they didn't know if they had used validated measures, highlighting important implications for staff capabilities, access to training and appropriate resources, demonstrating key skills gaps in the organisation.

2.3 Evaluation of core activities

This review has demonstrated that evaluation activity across PHW is ad hoc, and there is limited understanding of the contribution of the activities to population health or the value of the actions taken. Overall, of the 99 evaluations reported over the last two years funding details were only provided by six evaluations (4 were in progress and 2 completed) and equated to a total of £181,480; indicating that the organisation does not track how much spend is dedicated to evaluation.

3. Recommendations

Recommendation 1: To address confusion over language Public Health Wales will define 'evaluation' providing a common language across all directorates, services and programmes. *Lead: E&I Team*

Recommendation 2: Develop the quality assurance framework for evaluation to encourage application of robust approaches and methods

The Evaluation and Impact Team will develop a quality assurance (QA) framework which will provide staff with a non-prescriptive but transparent structure for designing evaluation. A QA Framework will set out key points for teams to consider including what is proportional, clarity on aims and objectives, logic model approaches, useful methods, measuring outcomes, importance of validated tools, where health economic components could add value, and dissemination, and consideration of the need for internal or externally commissioned support for evaluation. *Lead: E&I Team*

Recommendation 3: Consider whether an ongoing register for evaluation activity across PHW would help to disseminate and share best practice.

PHW should consider whether an ongoing register for evaluation activity across PHW would help support better dissemination of knowledge and evidence generated from evaluation and shared best practice.

Recommendation 4: There is a need to strengthen our understanding of the return on investment and value of our actions to population health.

The Evaluation and Impact Team will continue to develop work on the value proposition for public health services in line with the principles of value based health care to aid further understanding on the use of economic approaches in public health. *Lead: E&I Team*

Recommendation 5: With support from the People and Organisational Development Division, PHW should consider a cross-division review of evaluation skills training to help identify a sustainable and integrated way to ensure staff can access the most appropriate training when needed.

Recommendation 6: There is a need for a focused programme of evaluation to understand the value and impact of PHWs actions to improve health and wellbeing and reduce health inequalities.

The Evaluation and Impact team will develop a work programme over the next 12-18 months to evaluate the core functions of Public Health Wales to ascertain the impact of our actions on population health.

We are proposing beginning within the areas of

- Smoking prevention
- Alcohol prevention
- Obesity prevention

These areas are aligned to the strategic priorities, are significant contributors to poor health and inequalities in Wales, and are core public health programmes which we can ascertain the impact on population health, and with health economics support understand the value too. We would discuss the focus within each area with the programme leads to inform where evaluation would be of value.

4. Next steps

The Executive Board is asked to consider the recommendations above and, if in support, these will inform the work programmes of the Evaluation and Impact Team within PHW to provide specialist capacity and to create a culture of excellence and leadership in evaluation.

Appraisal of Evaluation in PHW

Genevieve Riley

15th January 2019

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales

What is evaluation?

National & Local Drivers

Why evaluation?

"Local innovation needs to be guided and supported by common principles and implementation support through a national programme of transformation, and **robust evaluation**."

Objective 8:

We will promote the use of recognised improvement and evaluation techniques and ensure that there is sufficient capacity and capability within the organisation to use them effectively.

Objective 5:

We will monitor and evaluate the impact that our work has.
This will be imbedded in all new work we undertake

Benefits of evaluation

What difference can it make?

- A way of learning what works, why and how

  …and why things don't work
- Leads to change and improvement
- Enhances quality – safety, effectiveness and experience
- Shows accountability and organisational learning
- Contributes to the evidence base

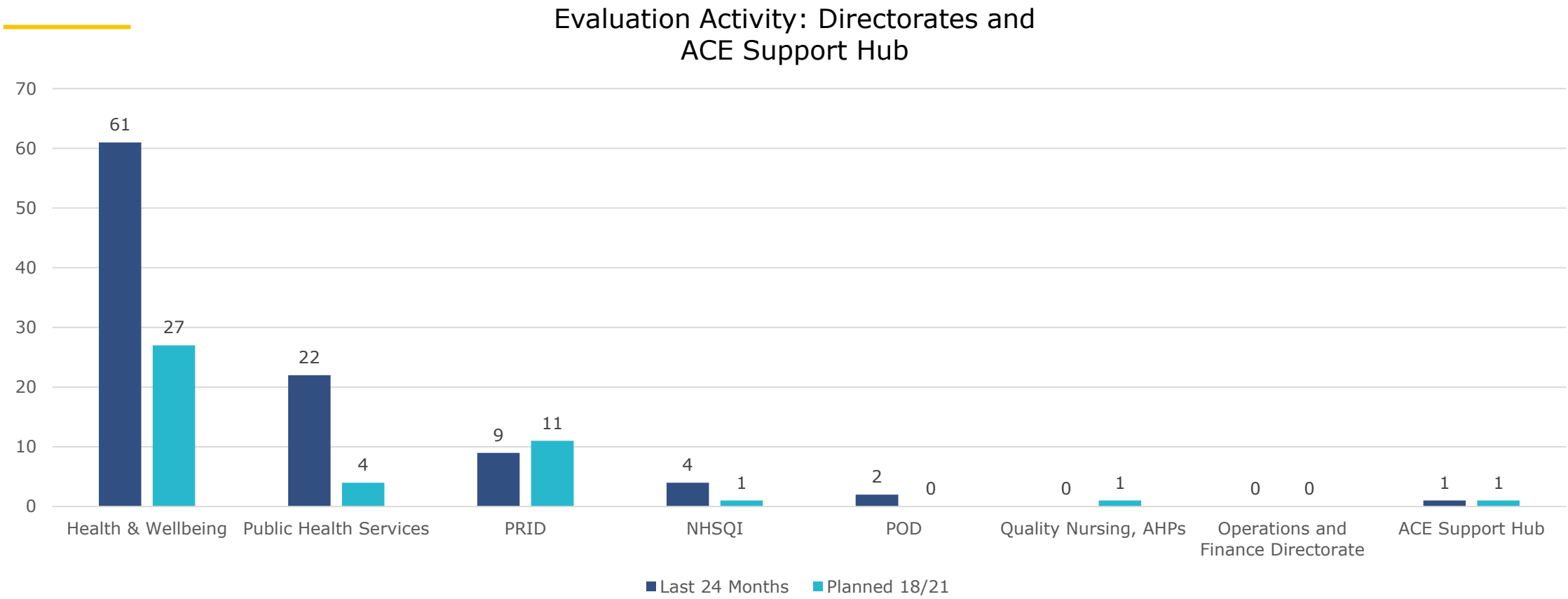
Establishing a PHW Baseline for Evaluation

What did we do?

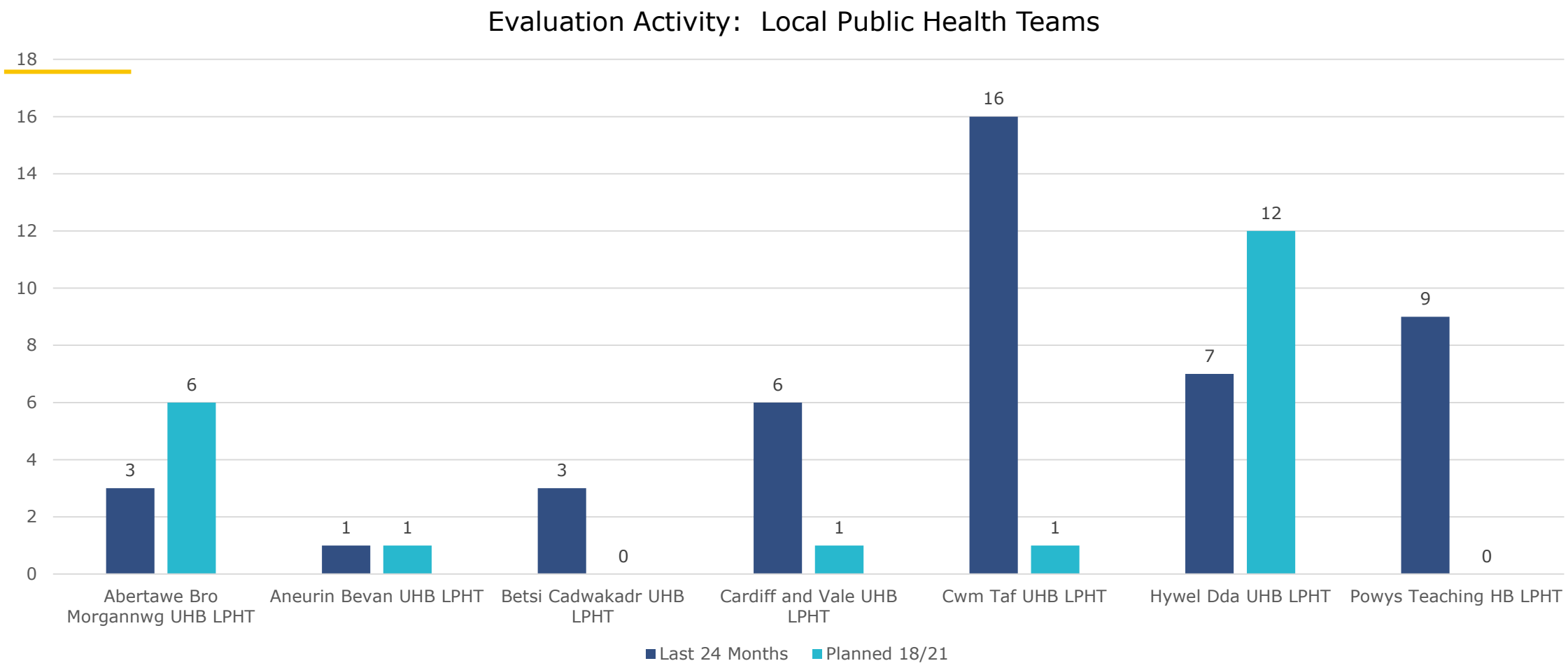
- Asked all divisions to self report for the two preceding years on all their evaluation activity
- Returns were received from all Directorates with the exception of Operations and Finance.
- Information on a total of 99 evaluations was submitted for the time period June 2016 – June 2018, (including 46 completed evaluations, 45 current, 5 discontinued and 46 planned over the next three years)

Evaluation Activity

Directorates & ACE Hub

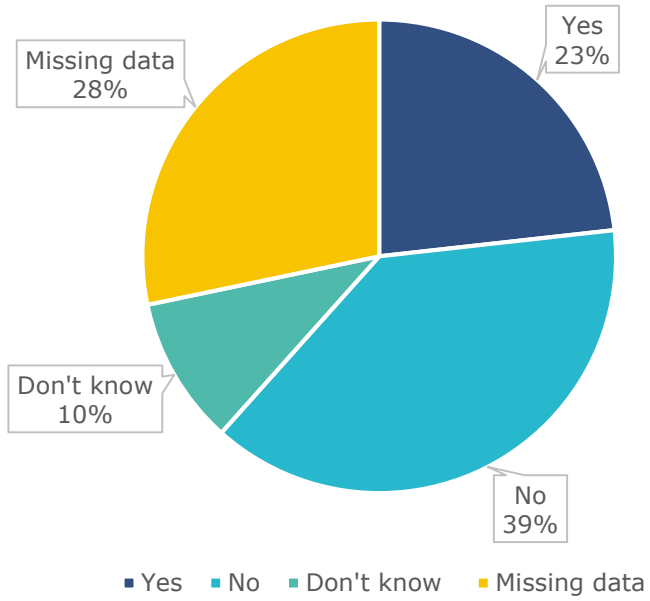


LPHTs

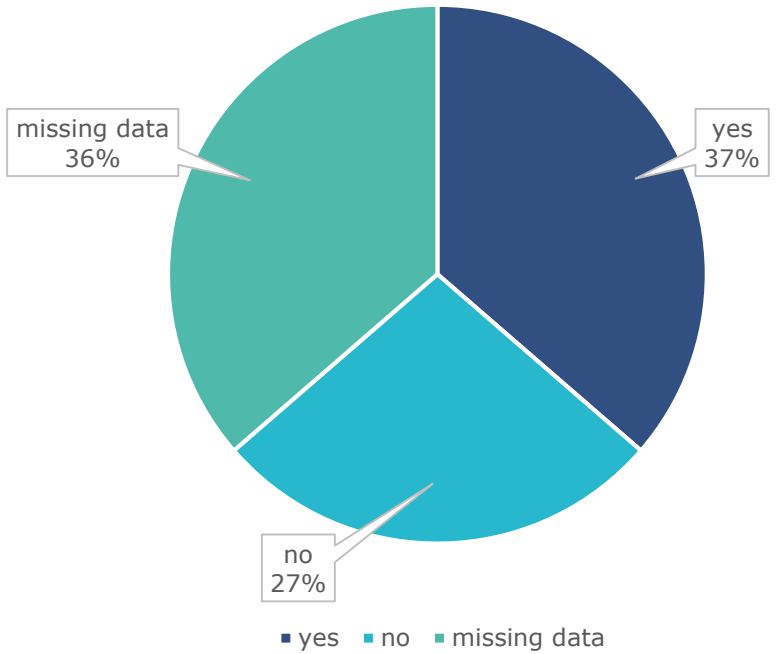

Evaluation Activity: Local Public Health Teams
18
16
14
12
10
8
6
4
2
0
3
6
1
1
3
0
6
1
16
1
7
12
9
0
Abertawe Bro Morgannwg UHB LPHT
Aneurin Bevan UHB LPHT
Betsi Cadwakadr UHB LPHT
Cardiff and Vale UHB LPHT
Cwm Taf UHB LPHT
Hywel Dda UHB LPHT
Powys Teaching HB LPHT
Last 24 Months
Planned 18/21

Evidence of Evaluation Planning

Did you use a standardised framework? N=99



Did you have a Steering Group?



Evaluations linked by Strategic Priority

Current, Completed Discontinued Evaluations 2016/18	
(6) – Supporting the development of a sustainable health and care system focused on prevention and early intervention	39
(3) - Promoting healthy behaviours	28
(5) – Protecting the public from infections and environmental threats to health	28
(7) – Building and mobilising knowledge and skills to improve health and well-being across Wales	18
(4) – Securing a health future for the next generation through a focus on early years	14
(2) – Improving mental well-being and building resilience	10
(1) – Influencing the wider determinants of health	6

Planned Evaluations 2018/21	
(6) – Supporting the development of a sustainable health and care system focused on prevention and early intervention	18
(7) – Building and mobilising knowledge and skills to improve health and well-being across Wales	15
(3) - Promoting healthy behaviours	14
(5) – Protecting the public from infections and environmental threats to health	8
(4) – Securing a health future for the next generation through a focus on early years	7
(1) – Influencing the wider determinants of health	7
(2) – Improving mental well-being and building resilience	6

Findings

Need for clarity on terminology

- Terminology associated with evaluation is interpreted differently across the organisation, and ongoing records of evaluations were not being held systematically
- Some divisions described as evaluation was a continuous form of programme monitoring, which is more akin to Key Performance Indicators
- Policy documentation within PHW often blends terminology for monitoring and evaluation, and lacks clarity to help deliver clear guidance on the role, scope and definition of what evaluation is

Findings
Quality and Planning of Evaluation

- Limited use of steering groups to help engage stakeholders on complex issues and establish decision making processes
- Fundamental good practice elements such as defined protocols, clear objectives, standard methods, validated tools, dissemination, records of impact were limited
- No evidence of health economic evaluation

Recommendations

- **Recommendation 1: Improve understanding of evaluation**
- Public Health Wales should define 'evaluation' providing a common language across all directorates, services and programmes. This will provide staff with clarity on what is evaluation
- **Recommendation 2: Improve application of robust approaches and methods**
- The Evaluation and Impact Team will develop a quality assurance (QA) framework which will provide staff with a non-prescriptive but transparent structure for designing evaluation
- **Recommendation 3: Share learning and evidence from evaluation to inform action**
- PHW should consider an annual self-report of evaluation activity and ongoing register for evaluation activity across PHW,
- **Recommendation 4: Skills development**
- PHW should consider a cross-division review of evaluation skills training to help identify a sustainable and integrated way to ensure staff can access the right training for the right project when it is needed.

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales	**Name of Meeting** Quality, Safety and Improvement Committee **Date of Meeting** 15 January 2019 **Agenda item:** 5.1.QSIC.150119

Register of policies and written control documents: quarter 3 update

Executive lead:	Cathie Steele, Acting Board Secretary and Head of Corporate Governance
Author:	Eleanor Higgins, Corporate Governance Manager

Approval/Scrutiny route:	Not applicable

Purpose

The report provides the Quality, Safety and Improvement Committee with an update on the status of the policies, procedures and other written control documents for which it is the approving body.

Appendix 1 is an extract taken from the central Policy and Control Document Register and shows the status of documents at end of quarter 3.

Recommendation:

APPROVE	CONSIDER	RECOMMEND	ADOPT	ASSURANCE
☐	☐	☐	☐	☒

The Committee is asked to:

- **Receive assurance** on the prioritisation and progress being made to review Quality, Safety and Improvement policies, procedures and other written control documents.

Link to Public Health Wales Strategic Plan Public Health Wales has an agreed strategic plan, which has identified seven strategic priorities and well-being objectives. This report contributes to seven of the strategic priorities and well-being objectives.

Summary impact analysis	
Equality and Health Impact Assessment	An Equality and Health Impact Assessment is not required in support of this report. An impact assessment should be undertaken for each of the respective policies when they are developed or reviewed.
Risk and Assurance	A risk assessment has been undertaken for each policy which has passed its review date. These are captured in the accompanying register (see Appendix 1) and a summary is detailed below.
Health and Care Standards	This report supports and/or takes into account the Health and Care Standards for NHS Wales Quality Themes Governance, Leadership and Accountability
Financial implications	Not applicable
People implications	Not applicable

1. Purpose / situation

The report provides the Quality, Safety and Improvement Committee with an update on the status of the policies, procedures and other written control documents (policies) for which it is the approving body.

Appendix 1 is an extract taken from the central Policy and Control Document Register and shows the status of documents at end of quarter 3.

2. Background

The Board approved a new organisation-wide Policy and Written Control Documents Policy and Procedure in September 2016. All new/revised documents are now developed and approved in accordance with the provisions and processes set out in these documents.

Section 4.2 of the procedure specifies that the Register will be reported annually to the Board, and the relevant sections reported to board committees twice yearly. This provides the Board and committees with assurance that required policies, procedures and other written control documents are being developed and maintained. The Board received an annual update in May 2017 when it was agreed that risk assessments would be undertaken where documents had passed their review date to assess the potential risk to the organisation.

3. Description/Assessment

3.1 Status of policies and other written control documents

There are twenty eight policies on the policy register, which were approved by the Quality, Safety and Improvement Committee or have been delegated to the Committee by the Board. Fourteen (50%) policies are in date and fourteen (50%) policies are due for review. This is considerable improvement on the number reported to the Committee in October 2018 where only seven (23%) policies were in date.

Appendix 1 is an extract taken from the central Policy and Control Document Register.

Table 1 provides information regarding the status of policies due for review at the end of quarter 3 and a summary of the outcome of the risk assessments undertaken.

Policy review status	Policy not yet approved but low risk presented	Policy not yet approved and moderate risk presented.	Policy not yet approved and high risk presented.	Risk assessment awaited	Number of Policies
Date passed - action underway	1	9	0	3	13
Date passed - awaiting national policy	1	0	0	0	1

Table 1

3.2 Approved policies/control documents

There were seven policies and procedures approved by the Committee in Quarter 3 of the financial year 2018/19.

One policy was approved via Chair's Action in November 2018 and will be sent for ratification at the Quality, Safety and Improvement Committee in January 2019.

3.3 Well-being of Future Generations (Wales) Act 2015

Organisational policies, procedures and written control documents provide the organisation with long-term controls for risks.

Organisational policies, procedures and written control documents provide staff within instruction and guidance, to prevent non-compliance.

A number of policies, procedures and written control documents are interdependent with one another. Content is cross-referenced and integrated as appropriate.

All policies, procedures and written control documents (and associated EHIAs) are developed on a collaborative basis.

During development and review policies and written control document are made available to Public Health Wales staff so that they can provide comment for consideration

4. Recommendation

The Quality, Safety and Improvement Committee is asked to:

- **Receive assurance** on the prioritisation and progress being made to review policies, procedures and other written control documents.

Policy title	Policy ref.	Version	Status (select from dropdown)	Approval date	Review date	Approving body (from Annex within Policy for Policies)	Accountable Executive Lead (Select from dropdown)	Policy Lead/Author	Web	Policy classification (link to policy/Control document page)	EHIA (Y/N) (Select from dropdown)	Implementation plan (Y/N) (Select from dropdown)	Policy Risk Assessment RAG score	Comments / Updates from quarterly reviews	Expected Date for issuing of revised policy
Adults at Risk procedure	PHW03/TP01	1	Policy in date	04/10/18	04/10/21	Safeguarding Group	Executive Director of Quality, Nursing and Allied Health Professionals	Ian Smith	Y	Safeguarding Children and Vulnerable Adults	Yes		Approved		
Children at Risk procedure	PHW03/TP02	1	Policy in date	04/10/18	04/10/21	Quality, Safety and	Executive Director of Quality, Nursing and Allied Health Professionals	Ian Smith	Y	rding Children and Vulnerabl	Yes		Approved	Future approval through the Safeguarding Group	
Claims Management Procedure	PHW16/TP01	2	Policy in date	06/04/16	01/04/19	Quality, Safety and Improvement Committee	Executive Director of Quality, Nursing and Allied Health Professionals	Sharon Atkins (Corporate Services Manager)	Y	Risk Management (including Health & Safety and Estates)			Approved	Approved initially by the Executive Team.	In date
Consent to Examination, Screening or Intervention policy	PHW 59	2	Policy in date	16/05/17	01/05/20	Quality, Safety and Improvement Committee	Executive Director of Quality, Nursing and Allied Health Professionals	Sian Bolton	Y	Clinical Governance and Infection Control	Yes	No	Approved	Superceded Black 92. Published with guidance for screening programmes and Stop Smoking Wales.	In date
Decontamination policy	PHW28	1	Policy review date passed - action underway/required	31/01/13	01/01/15	Quality, Safety and Improvement Committee	Executive Director of Quality, Nursing and Allied Health Professionals	Sam Ray	Y	Clinical Governance and Infection Control	Yes		Overdue for review - moderate risk presented	3.12.2018 Decontamination Policy has been out for Consulation, minor formatting comments received. Ready for submission to SLT in Jan 2019 20/9/2018: This Policy will be forwarded to the October meeting of SLT. 3.7.2018 This policy/procedure document has been submitted for consultation	1.5.18 (Consultation)
Violence against Women, Domestic Abuse and sexual violence procedure	PHW03/TP03	1	Policy in date	04/10/18	04/10/21	Quality, Safety and Improvement Committee	Executive Director of Quality, Nursing and Allied Health Professionals	Ian Smith	Y	Safeguarding Children and Vulnerable Adults	Yes		Approved	Previous reference PHW 41.	In date
Environmental Cleanliness policy	PHW31	1	Policy review date passed - action underway/required	11/07/13	01/07/16	Quality, Safety and Improvement Committee	Executive Director of Quality, Nursing and Allied Health Professionals	Sam Ray	Y	Clinical Governance and Infection Control	Yes		Overdue for review - moderate risk presented	12.12.2018 The key points in this policy are to be incorporated into the IP&C policy. The Environmental Policy and National Standards for Cleaning document have been forwarded to Facilities to ensure the recommendations within the National Standards are incorporated into Cleaning contract arrangements for Healthcare environments used by clinical services. Procedure document can be covered by NIPCM. 3.7.2018 - There is consultation to assess if the National Infection Prevention and Control Manual policy is sufficient to replace this document. 3.4.18 - The policy is being reviewed and consideration is being given to amalgamating with Infection Prevention and Control for Building Development, Change and Adaptation policy (PHW44) to enable all IPC environmental policies to be within one policy. 15.11.17 - New IPC Nurse commenced in post 13.11.17	1.1.18 (Consultation)
Exposure Injury Policy (including needlestick injury) and safe use of sharps	TBC		Policy review date passed - action underway/required		TBC	Quality, Safety and Improvement Committee	Executive Director of Quality, Nursing and Allied Health Professionals	Sam Ray					Overdue for review - moderate risk presented	3.12.2018 Policy and Procedure document ready for Consultation with the intention to submit to SLT in Jan 2 3.7.2018 This policy is currently being revised as a priority in close association with Breast Test Wales. 3.4.18 - It is intended that this policy adopted from the Health Protection Scotland Infection Control Manual once fully approved and implemented by Welsh Government. It is anticipated that the Manual will be available at the end of April 2018. 15.11.17 - New Infection, Prevention and Control Nurse commenced in post 13.11.17. Work on suite of policy/control documents in the Quality, Nursing and Allied Health Professionals directorate to commence.	1.1.18 (Consultation)
Guidance on Records Retention	PHW13 / CD01	2	Policy in date	16/08/18	16/08/19	Information Governance Working Group	Executive Director of Quality, Nursing and Allied Health Professionals	John Lawson	Y	Information Governance and Information Management & Technology	No	No	Approved	Superseded Recrords Retention Procedure	
Incident reporting policy	PHW32	1	Policy review date passed - action underway/required	27/06/13	01/06/16	Quality, Safety and Improvement Committee	Executive Director of Quality, Nursing and Allied Health Professionals	John Lawson (originally Gay Reynolds)	Y	Risk Management (including Health & Safety and Estates)	Yes		Overdue for review - moderate risk presented	1/12/18 - Policy submitted for consultation 20/9/2018: Policy has been drafted but awaiting completion of the Datix review and will be published by the end of the financial year. 2/7/18 - Slight delay to the work due to workload re GDPR in April/May 2018. Now expected to go to formal consultation by the end of July 2018 3.4.18 - The Incident Reporting Policy is due to go out for consultation at the end of April 2018. 3.11.17 - Workshops now programmed in for Nov/Dec and Policy and Procedure to be redrafted following this.	31.03.17
Incident reporting procedure	PHW32/TP01	1	Policy review date passed - action underway/required	27/06/13	01/06/16	Quality, Safety and Improvement Committee	Executive Director of Quality, Nursing and Allied Health Professionals	John Lawson (originally Gay Reynolds)	Y	Risk Management (including Health & Safety and Estates)	Yes		Overdue for review - moderate risk presented	20/9/2018: Policy has been drafted but awaiting completion of the Datix review and will be published by the end of the financial year. 2/7/18 - Slight delay to the work due to workload re GDPR in April/May 2018. Now expected to go to formal consultation by the end of July 2018 3.4.18 - The Incident Reporting Procedure is due to go out for consultation at the end of April 2018. 3.11.17 - Workshops now programmed in for Nov/Dec and Policy and Procedure to be redrafted following this.	31.03.17
Infection control policy	PHW27	1	Policy review date passed - action underway/required	31/01/13	01/01/15	Quality, Safety and Improvement Committee	Executive Director of Quality, Nursing and Allied Health Professionals	Beverly Gregory (originally Karen Jones, Infection Prevention and Control nurse)	Y	Clinical Governance and Infection Control	Yes		Overdue for review - moderate risk presented	3.12.2018 Policy to be submitted to SLT in Jan 2019, it is being ammended to incorporate Environmental Cleanliness 20/9/2018: The Policy is to be forwarded to the October meeting of SLT. 20.8.2018 Amendments required to draft submitted to Corporate Governance Team. These have been made and the document is now available on the consultation database 3.7.2018 This policy/procedure document has been submitted for consultation 3.4.18 - Infection Prevention Control Policy circulated to the Infection Prevention Control Group prior to circulation for internal consultation by the end of April 2018. 15.11.17 - New Infection, Prevention and Control Nurse commenced in post 13.11.17. Work on suite of	1.1.18 (Consultation)
Information Governance policy	PHW13	1	Policy in date	29/08/17	29/08/20	Quality, Safety and Improvement Committee	Executive Director of Quality, Nursing and Allied Health Professionals	John Lawson	Y	Information Governance and Information Management & Technology	Yes	Yes	Approved	1.12.18 Policy awaiting approval at QSIC, Jan 2019 1.9.17 - Information Governance Policy approved by QSIC and subsumed PHW23 NHS Number Compliance, PHW37 Data Quality policy, and PHW39 Confidentiality and Disclosure policy. Replaced the Data Protection policy	In date
Information Security policy	PHW61	1	Policy in date	24/10/17	24/01/20	Quality, Safety and Improvement Committee	Executive Director of Quality, Nursing and Allied Health Professionals	John Lawson	Y	Risk Management (including Health & Safety and Estates)	Yes	Yes	Approved	1.12.18 Policy awaiting approval at QSIC, Jan 2019 20/9/2018: This policy will be superseded by the All Wales Information Security Policy which has been forwarded to the October meeting of the Quality, Safety and Improvement Committee for approval.	In date
Managing allegations of abuse by staff procedure	PHW03/TP04	2	Policy in date	04/10/18	04/10/21	Quality, Safety and Improvement Committee	Director of People and Organisational Development	HR Lead/ Safe Guarding Lead - Ian Smith	Y	Safeguarding Children and Vulnerable Adults	Yes		Approved		In date
Medical Devices and Equipment Management Policy	Black 94	1	Policy in date	27/11/18		Quality, Safety and Improvement Committee	Executive Director of Public Health Services/Medical Director	Cara Tingle, Compliance Manager	No	Clinical Governance and Infe	Yes	No	Approved	Policy approved via Chair's action. Will be ratified at the QSIC 15.01.18.	27.11.18
Medicines management policy and code of practice	PHW26	1	Policy review date passed - action underway/required	31/01/13	31/01/16	Quality, Safety and Improvement Committee	Executive Director of Public Health Services/Medical Director	Karen Fitzgerald, Consultant in Pharmaceutical Public Health	Yes	Clinical Governance and Infe	Yes		Overdue for review - moderate risk presented	13.12.18 - It is expected that a Professional Lead for Pharmacy will be secured in Public Health Services in April 2019. Once this resource is in place, work on the policy and code of practice will be undertaken. 13.09.18 - Status as given in July 2018. 3.7.18 - Discussions are ongoing to explore whether a Professional Lead for Pharmacy can be secured in Public Health Services. Once this resource is in place, work on the policy and code of practice will be undertaken. 16.3.18 - Consultant in Pharmaceutical Public Health has left the organisation. Responsibility for policy to be determined. Professional Lead for Health Protection has been contacted and awaiting response. 10.10.17 - Directorate Compliance Manager has contacted the Consultant in Pharmaceutical Public Health for an update. Currently awating reponse. Moved from Quality, Nursing and AHP remit (noted Q2 16/17 directorate remit).	TBC
National Intelligent Integrated Audit Solution	PHW60	1	Policy review date passed - action underway/required	09/06/17	09/06/18	Information Governance Working Group	Executive Director of Quality, Nursing and Allied Health Professionals	John Morley and Jane Evans	Y	Information Governance and Information Management & Technology	Yes		Risk assessment awaited	20/9/2018: This is a procedure and can therefore be removed. Awaiting decision on whether or not this procedure is still required. Not in the Information Governance Framework.	

Policy title	Policy ref.	Version	Status (select from dropdown)	Approval date	Review date	Approving body (from Annex within Policy for Policies)	Accountable Executive Lead (Select from dropdown)	Policy Lead/Author	Web	Policy classification (link to policy/Control document page)	EHIA (Y/N) (Select from dropdown)	Implementation plan (Y/N) (Select from dropdown)	Policy Risk Assessment RAG score	Comments / Updates from quarterly reviews	Expected Date for issuing of revised policy
Outbreak Management Policy	PHW 40	0c	Policy review date passed - awaiting national policy	01/04/14	01/04/17	Quality, Safety and Improvement Committee	Executive Director of Public Health Services/Medical Director	Karen Jones, Infection Prevention and Control Nurse	Yes	Clinical Governance and Infection Control			Overdue for review - low risk presented	13.12.18 - update awaited. 13.09.18 - Further to the update provided in July 2018, the working group has met multiple times and it is expected that the revised plan will be available in the next couple of months. 3.7.18 - Gwen Lowe, Consultant In Communicable Disease Control, is leading on this area for Health Protection. The Communicable Disease Outbreak Plan For Wales is currently undergoing review. A working group has been established to review the Plan based on lessons learned from recent outbreaks. An assessment to determine whether an Outbreak Management Policy is required will be undertaken by the Lead as part of the review of the Plan. 16.3.18 - Professional Lead for Health Protection has been contacted and awaiting response. 10.10.17 - Directorate Compliance Manager has contacted the Professional Lead for Health Protection for an update. Currently awating response. Policy replaces the Decontamination Policy (Yellow 04), Decontamination of Health Care Equipment Policy (Yellow 05) and Single Use Devices (Yellow 12). 11.8.17 - Policy still valid. The Welsh Government Health Protection Committee has not convened for some time so no amendments have been issued. An update on the review timetable will be provided by the lead consultant.	TBC
Policy and procedure for the receipt and dissemination of alerts/safety notices within Public Health Wales	PHW30	Final	Policy review date passed - action underway/required	18/04/13	01/04/16	Quality, Safety and Improvement Committee	Executive Director of Quality, Nursing and Allied Health Professionals	John Lawson	Y	Safeguarding Children and Vulnerable Adults			Overdue for review - moderate risk presented	Policy approved at SLT, awaiting sign off from QSIC, Jan 2019 20/9/2018: Policy due to go to October SLT. 2/7/18 - Consultation complete - Document now in final preparation for approval by Information Governance Working Group Sept 2018. 3.4.18 - Policy is out for consultation until 16 April 2018. 11.8.17 - Policy being developed and will incorporate the Dissemination of NICE guidance	
Policy for the transport of patholo	Yellow 11	2	Policy review date passed - action underway/required	01/10/09	01/04/15	Quality, Safety and Improvement Committee	Executive Director of Public Health Services/Medical Director	Mel Baker	Yes	Clinical Governance and Infection Control			Overdue for review - moderate risk presented	11.12.18 - Document has been developed by Microbiology Health and Safety Lead. The Screening Health and Safety Lead has now contributed to the development of the procedure and following discussions with the Lead Nurse for Infection Prevention Control (Quality, Nursing and Allied Health Professionals directorate) it will progress through the Trust policy/procedural approval processes. Mitigations are in place to account for the expired procedural policy i.e. staff continue to follow the existing arrangements, which have been deemed sufficiently robust. 13.09.18 - Further to the update provided in July 2018, discussions with the Lead Nurse for Infection Prevention Conrol (Quality, Nursing and Allied Health Professionals directorate) will be undertaken. Further work required to ensure that documentation being developed is compliant with regulations. 3.7.18 - Meeting to be held on 17 July 2018 to discuss the update of the policy document. Discussions ongoing to identify the relevant Standing Operating Procedures in Breast Test Wales (which will be used to inform the document). 18.06.18 - The policy has been drafted by Julie Woolls and Gail Lusardi. Julie has advised that she has discussed with Rhys Blake obtaining the relevant SOPs from Screening so that they can be referenced within the policy. The timeline for completion is 3 months. (Update provided by Gay Reynolds). 15.06.18 - reassigned to Executive Director of Public Health Services/Medical Director from Director of Quality, Nursing and Allied Health Professionals. 15.11.17 - New IPC Nurse commenced in post 13.11.17. Review of suite of policy/control documents in the Quality, Nursing and Allied Health Professionals directorate underway. 10.10.17 - Policy with the Quality, Nursing and Allied Health Professionals Directorate. Awaiting for the newly appointed Infection Protection Control Nurse to commence role. Transformed to Public Health Wales on 1 October 2009. Policy been rewritten and going through consultation prior	
Prevent policy and referral process	Unknown	0e	Policy review date passed - action underway/required	27/05/15	27/05/18	Quality, Safety and Improvement Committee	Executive Director of Quality, Nursing and Allied Health Professionals	Ian Smith	y	Safeguarding Children and Vulnerable Adults			Overdue for review - low risk presented	12/12/2018 - Prevent Policy is still relevant therefore a low risk. However once the National discussion have taken place it will be reviewed as amended as appropriate. 20/9/2018: The Policy is under review, however National discussions are taking place which may impact on the Policy. 3.7.18: The policy is to be reviewed and updated in line with national guidance 2.10.17 - Policy developed in 2015. Due for review 2018	In date
Privacy Impact Assessment Procedure	PHW13/TP01	1	Policy in date	22/01/18	22/01/20	Information Governance Working Group	Executive Director of Quality, Nursing and Allied Health Professionals	John Lawson, Chief Risk Officer	Y	Information Governance and Information Management & Technology	No		Approved	22.01.18 - approved by Information Governance Working Group.	
Release of Information Procedure	PHW13/TP02	1	Policy in date	22/01/18	22/01/20	Information Governance Working Group	Executive Director of Quality, Nursing and Allied Health Professionals	John Lawson, Chief Risk Officer	Y	Information Governance and Information Management & Technology	No		Approved		
Remote Working Procedure	PHW13/TP03	1	Policy in date	22/01/18	22/01/20	Information Governance Working Group	Executive Director of Quality, Nursing and Allied Health Professionals	John Lawson, Chief Risk Officer	Y	Information Governance and Information Management & Technology	No		Approved		
Safeguarding policy	PHW03	1	Policy in date	04/10/18	04/10/21	Quality, Safety and Improvement Committee	Executive Director of Quality, Nursing and Allied Health Professionals	Ian Smith	Y	Safeguarding Children and Vulnerab	Yes		Approved		In date
Small numbers publishing guidance	PHW48	2	Policy review date passed - action underway/required	31/07/17	01/10/18	Information Goverance Working Group	Executive Director of Quality, Nursing and Allied Health Professionals	IGWG data handlers	Y	Information Governance and Information Management & Technology	No	No	Risk assessment awaited		
Transmission Based Precautions P	PHW55	1a	Policy review date passed - action underway/required	12/04/16	01/12/18	Quality, Safety and Improvement Committee	Executive Director of Quality, Nursing and Allied Health Professionals	Karen Jones, Infection Prevention and Control Nurse	Y	Clinical Governance and Infe	No		Risk assessment awaited		

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales	**Name of Meeting** Quality, Safety and Improvement Committee **Date of Meeting** 15 January 2019 **Agenda item:** *5.2.1.QSIC.150119*

Public Health Wales Alerts, Safety Notices and other guidance Policy and Procedure

Executive lead:	Sian Bolton, Acting Executive Director of Quality, Nursing and Allied Health Professionals
Author:	John Lawson, Chief Risk Officer

Approval/Scrutiny route:	Executive Team

Purpose
Introduce the revised Policy and Procedure for disseminating and implementing Alerts, Safety Notices and other guidance.

Recommendation:				
APPROVE ☒	CONSIDER ☐	RECOMMEND ☐	ADOPT ☐	ASSURANCE ☐

The Committee is asked to:

- **Approve** the Policy and Procedure.

Link to Public Health Wales Strategic Plan Public Health Wales has an agreed strategic plan, which has identified seven strategic priorities. This Policy contributes to all Strategic Priorities	
Strategic Priority	Choose an item.
Strategic Priority	Choose an item.

Summary impact analysis	
Equality and Health Impact Assessment	This report has been presented many times previously but is now presented in a new format. There is no significant change in content and therefore no Equality and Health Impact Assessment is required.
Risk and Assurance	This report will provide assurance that the Information Governance Management System is operating effectively. The performance report includes the latest version of the Information Governance Risk Register.
Health and Care Standards	This report supports and/or takes into account the Health and Care Standards for NHS Wales Quality Themes Governance, Leadership and Accountability
Financial implications	No financial implications.
People implications	No people implications.

1. Purpose / situation

The purpose of this report is to provide the Quality, Safety and Improvement Committee with the revised and updated policy on the management of alerts and other safety notices. The policy and procedure are for approval.

2. Background

The previous policy/ procedure has been in place for some time and is in need of updating. In the interests of maintaining patient safety, Public Health Wales must be able to respond in a timely manner to all alerts and other safety notices issued.

3. Description/Assessment

NHS Wales organisations are required to implement and maintain systems for the dissemination and implementation of alerts, safety notices and other guidance. This policy and its accompanying procedure will outline the system for the dissemination of alerts/ safety notices and other guidance as issued from time to time and requiring attention within Public Health Wales.

3.1 Well-being of Future Generations (Wales) Act 2015

The requirement for timely dissemination and implementation of Alerts, Safety Notices and other guidance will continue for the foreseeable future. These documents represent a sustainable system approach to policy implementation.

Appropriate action on Alerts will ensure that key patient safety issues are not missed, and contribute to preventing harm to patients, service users and staff.

The System for Alerts will be fully integrated into the Public Health Wales governance framework.

This work represents a collaborative approach with Welsh Government and other regulators who issue notices.

All staff have been involved in the consultation and development of the Policy and Procedure.

4. Recommendation

The Committee is asked to:

- **Approve** the revised Policy and Procedure.

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales	**Reference Number:** xxxx **Version Number:** 2.0 **Date of next review:** 1/10/2021

ALERTS, SAFETY NOTICES AND OTHER GUIDANCE POLICY

Policy Statement

NHS Wales organisations are required to implement and maintain systems for the dissemination and implementation of alerts, safety notices and other guidance. This policy and its accompanying procedure will outline the system for the dissemination of alerts/ safety notices and other guidance as issued from time to time and requiring attention within Public Health Wales.

The aim of the policy and procedure is to ensure an effective and auditable management system for the distribution, monitoring and record keeping of all alerts, safety notices and other guidance throughout Public Health Wales.

Public Health Wales is committed to providing, so far as is reasonably practicable, safe and healthy working conditions, equipment and systems of work that minimise risk to the health and safety of all its employees, service users and others who may be working on Trust premises or undertaking work on behalf of Public Health Wales at locations across Wales.

This policy covers a wide variety of alerts, safety notices and other guidance issued from numerous bodies, including:

- The Department of Health Estates and Facilities (DHEFD)
- Shared Services Partnership – Facilities Management
- Public Health Links from the Welsh Government
- The National Patient Safety Agency (NPSA)
- The Medicines and Healthcare Products Regulatory Agency (MHRA) (Medical Devices and Pharmaceutical Alerts)
- Health and Safety Executive (HSE)
- National Institute for Clinical Excellence (NICE)

The list is not exhaustive and from time to time other documents may be received which require an equivalent response by the Trust.

Alerts / safety notices related to Chief Medical Officer's Public Health and Pharmaceutical Public Health Links will be issued via the Public Health Alert System but will be managed internally under this policy.

Policy Commitment

Public Health Wales is committed to the protection of its service users and staff through systems that ensure that alerts, safety notices and other guidance requiring attention are distributed and acted upon within the required timescales.

This policy and procedure will ensure alerts / safety notices are communicated effectively across the organisation by cascading all safety related information received from the Welsh Government, MHRA etc, using a consistent approach throughout Public Health Wales.

The Policy does not replace the duty and professional accountability of staff to report any adverse incident with a medical device, hazardous product or unsafe procedure.

This policy supports compliance with the following key legislative and regulatory obligations:

- Medical Devices Regulations 2002
- Medical Devices (Amended) Regulations 2008
- Health and Safety at Work Act 1974
- Health and Safety at Work Regulations 1999
- Supply of Machinery Safety Regulation 2008
- Provision and Use of Work Equipment Regulation 1998
- Lifting Operations and Lifting Equipment Regulation 1998
- Welsh Health and Care Standards 2017

Scope

This policy refers to all staff working within Public Health Wales. In the interests of brevity, the term staff is used throughout this document to refer to staff, contractors, agency staff, volunteers, and secondees.

All staff are required to comply with this Policy and to follow the Alerts, Safety Notices and other Guidance Procedure and any failure to do so may result in disciplinary proceedings.

Equality and Health Impact Assessment	Attached
Approved by	Quality, Safety and Improvement Committee
Approval Date	
Review Date	
Date of Publication:	
Group with authority to approve supporting	Senior Leadership Team

procedures	
Accountable Executive Director/Director	Sian Bolton, Acting Executive Director Quality, Nursing and Allied Health Professionals
Author	John Lawson, Chief Risk Officer

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or Corporate Governance.

Summary of reviews/amendments				
Version number	**Date of Review**	**Date of Approval**	**Date published**	**Summary of Amendments**
2.0	01/10/2018			Complete re-write to put document into Policy form which is now underpinned by a Procedure.

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales	**Reference Number:** xxx**x** **Version Number:** 1.0 **Date of Next review:** 1/10/2021

ALERTS, SAFETY NOTICES AND OTHER GUIDANCE PROCEDURE

Introduction and Aim

This procedure underpins the Alerts, Safety Notices and other Guidance Policy.

The aim of this procedure is to provide an effective and auditable management system for the distribution, monitoring and record keeping of all alerts, safety notices and other guidance throughout Public Health Wales.

It should be noted that the term alerts is used throughout this document to refer to alerts, safety notices and other guidance.

Linked Policies, Procedures and Written Control Documents

Alerts, Safety Notices and other Guidance Policy

Scope

This policy refers to all staff working within Public Health Wales. In the interests of brevity, the term staff is used throughout this document to refer to staff, contractors, agency staff, volunteers, and secondees.

Equality and Health Impact Assessment	This Procedure is covered by the EHIA for the Alerts, Safety Notices and other Guidance Policy
Approved by	Information Governance Working Group
Approval Date	
Review Date	
Date of Publication:	
Accountable Executive Director/Director	
Author	John Lawson, Chief Risk Officer

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Corporate Governance.

Summary of reviews/amendments				
Version number	**Date of Review**	**Date of Approval**	**Date published**	**Summary of Amendments**
1.0	1/10/2021			New document

1. Introduction

The aim of this procedure is to provide an effective and auditable management system for the distribution, monitoring and record keeping of all alerts throughout Public Health Wales.

Public Health Wales is committed to providing, so far as is reasonably practicable, safe and healthy working conditions, equipment and systems of work that minimise risk to the health and safety of all its employees, service users and others who may be working on Trust premises or undertaking work on behalf of Public Health Wales at locations across Wales.

This policy covers a wide variety of alerts issued from numerous bodies, including:

- The Department of Health Estates and Facilities (DHEFD)
- Shared Services Partnership – Facilities Management
- Public Health Links from the Welsh Government
- The National Patient Safety Agency (NPSA)
- The Medicines and Healthcare Products Regulatory Agency (MHRA) (Medical Devices and Pharmaceutical Alerts)
- Health and Safety Executive (HSE)
- National Institute for Clinical Excellence (NICE)

The list is not exhaustive and from time to time other documents may be received which require an equivalent response by the Trust.

This Procedure should be read in conjunction with the Alerts, Safety Notices and other guidance Policy.

2. Roles and Responsibilities

All staff will:

- Comply with the requirements of any alert issued through the Chief Risk Officer

The Chief Risk Officer will:

- Receive all alerts issued to Public Health Wales
- Maintain a register of all alerts and related actions taken
- Ensure that all alerts are assessed for applicability to Public Health Wales
- Where required, ensure that all alerts are disseminated, without delay to the relevant Directorate Business Manager

- Provide any required response to the issuing authority within the timescales defined
- Provide quarterly reports to the Public Health Wales Quality, Safety and Improvement Committee on the performance of the system
- From time to time audit the system to ensure compliance

Directorate Business Managers will:

- Receive all alerts issued through the Chief Risk Officer
- Ensure that all alerts are assessed without delay for applicability to their Directorate
- Within 7 days establish whether or not the alert is applicable to their Directorate and confirm the same to the Chief Risk Officer
- Ensure that any and all action required to comply with the alert are carried out within the timescales set out
- Respond to the Chief Risk Officer within the timescales set out confirming that all actions are complete or providing an explanation for any delays / non-compliances

3. Procedure

Grades of alert

Alerts / safety notices normally fall into four categories as follows:

Immediate Action

Used in cases of actual death or serious injury, or where death or serious injury would have occurred but for fortuitous circumstances or the timely intervention of healthcare professional (or a carer):

- Where the medical device is or is likely to be implicated:
- Where the recipient is expected to take immediate action on the advice.

Action

Used where the recipient is expected to take action on the advice, where it is necessary to repeat warnings on long standing problems, or to support or follow-up manufacturers' field modifications.

Update

Used to update the recipient about previously reported incidents or series of incidents, possibly on a topical or device group bases, and where further follow-up safety information is judged to be beneficial.

Information Request

Used to alert users about specific issues that may become a problem and where feedback is requested.

Receipt of alerts and initial assessment

Alerts will be received through the Chief Risk Officer's team, usually by email and will be recorded on a central database.

The Chief Risk Officer will make an initial assessment in consultation with the business to establish if the alert applies to Public Health Wales. If it is immediately clear that the alert is not applicable, then a response will be sent to the issuing authority with no further action required on behalf of Directorates.

If there is any suggestion that the alert is applicable however, then this procedure will be followed.

Alerts requiring action

The Chief Risk Officer will distribute the alert, together with the Public Health Wales response form (see Appendix A) to all Directorate Business Managers.

Business Managers will be required to establish in consultation with their Directorate colleagues whether or not the alert applies to their Directorate.

If the Business Manager is satisfied that it does not, then they must complete the form (Appendix A) and return it to the Chief Risk Officer within 7 days of receipt.

If the alert does apply to the Directorate then the Business Manager must notify the Chief Risk Officer within 7 days of receipt, and provide an assessment of how much work is required to comply with the alert, along with confirmation that any deadlines given within the alert can be met. The Business Manager will then

complete Appendix A detailing the action taken and return the form as above.

Responding to issuing authorities

The Chief Risk Officer will ensure that any required responses are sent to issuing authorities within the deadlines set out by them when the alert is issued.

4. Training requirements

The Chief Risk Officer will provide training to all Business Managers in the implementation of this procedure.

5. Monitoring compliance

The Chief Risk Officer will from time to time audit the system to ensure compliance. A quarterly report will be provided to the Quality, Safety and Improvement Committee on the performance of the system.

Appendix A

Alert / Safety Notice Circulation Response Form (A)

Circulation of Alerts / Safety Notices	
Title of Alert / Safety Notice:	Date Received:
Directorate Business Manager to complete this section and return to the Chief Risk Officer within **seven days**	
Applicable to Division: Yes ☐ No ☐ If applicable please state action taken:	
Directorate Business Manager Signature:	Date

Form to be returned electronically to the Chief Risk Officer within seven days of receipt

Equality & Health Impact Assessment for

Alerts, Safety Notices and other guidance Policy and Procedure

Please read the Guidance Notes in Appendix 1 prior to commencing this Assessment

Completed : 24/10/2018

Please note:

- The completed Equality & Health Impact Assessment (EHIA) must be
  - Included as an appendix with the cover report when the strategy, policy, plan, procedure and/or service change is submitted for approval
  - Published on the PHW intranet and internet pages as part of the consultation (if applicable) and once agreed.
- Formal consultation must be undertaken, as required
- Appendices 1-3 must be deleted prior to submission for approval

Please answer all questions:-

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	N/A
2.	Name of Directorate and title of lead member of staff, including contact details	Quality Nursing and Allied Healthcare Professionals. John Lawson - Chief Risk Officer John.lawson@wales.nhs.uk 02920 104307
3.	Objectives of strategy/ policy/ plan/ procedure/ service	This policy sets out the organisational requirements for dealing with Alerts, Safety Notices and other guidance

4.	Evidence and background information considered. For example • population data • staff and service users data, as applicable • needs assessment • engagement and involvement findings • research • good practice guidelines • participant knowledge • list of stakeholders and how stakeholders have engaged in the development stages • comments from those involved in the designing and development stages Population pyramids are available from Public Health Wales Observatory and the 'Shaping Our Future Wellbeing' Strategy provides an overview of health need.	This has been widely consulted upon throughout the organisation, from Board level to operational and support staff.
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	This is an internal policy which will have no direct impact upon service users, visitors or other groups external to Public Health Wales. All staff are required to comply with this policy.

6. EQIA / How will the strategy, policy, plan, procedure and/or service impact on people?

Questions in this section relate to the impact on people on the basis of their 'protected characteristics'. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Directorate.** Make reference to where the mitigation is included in the document, as appropriate
6.1 Age For most purposes, the main categories are: • under 18; • between 18 and 65; and • over 65	The policy and procedure protects staff and the population in general.	None	
6.2 Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes	None	None	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.3 People of different genders: Consider men, women, people undergoing gender reassignment **NB** Gender-reassignment is anyone who proposes to, starts, is going through or who has completed a process to change his or her gender with or without going through any medical procedures. Sometimes referred to as Trans or Transgender	None	None	
6.4 People who are married or who have a civil partner.	None	None	
6.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are	None	None	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Directorate. Make reference to where the mitigation is included in the document, as appropriate
breastfeeding. They are protected for 26 weeks after having a baby whether or not they are on maternity leave.			
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	None	None	
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	None	None	
6.8 People who are attracted to other people of: • the opposite sex (heterosexual);	None	None	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Directorate. Make reference to where the mitigation is included in the document, as appropriate
• the same sex (lesbian or gay); • both sexes (bisexual)			
6.9 People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design Well-being Goal – A Wales of vibrant culture and thriving Welsh language	None. Staff who communicate using Welsh Language can identify through their line manager as per other PHW policies.	None, will be monitored on an ongoing basis.	
6.10 People according to their income related group: Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health	None	None	
6.11 People according to where they live: Consider people living in areas	None	None	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Directorate. Make reference to where the mitigation is included in the document, as appropriate
known to exhibit poor economic and/or health indicators, people unable to access services and facilities			
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service			

7. HIA / How will the strategy, policy, plan, procedure and/or service impact on the health and well-being of our population and help address inequalities in health?

Questions in this section relate to the impact on the overall health of individual people and on the impact on our population. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Directorate** Make reference to where the mitigation is included in the document, as appropriate
7.1 People being able to access the service offered: Consider access for those living in areas of deprivation and/or those experiencing health inequalities Well-being Goal - A more equal Wales	None	None	
7.2 People being able to improve /maintain healthy lifestyles: Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking cessation, reducing the harm caused	None	None	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Directorate Make reference to where the mitigation is included in the document, as appropriate
by alcohol and /or non-prescribed drugs plus access to services that support disease prevention (eg immunisation and vaccination, falls prevention). Also consider impact on access to supportive services including smoking cessation services, weight management services etc Well-being Goal – A healthier Wales			
7.3 People in terms of their income and employment status: Consider the impact on the availability and accessibility of work, paid/ unpaid employment, wage levels, job security, working conditions	None	None	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Directorate Make reference to where the mitigation is included in the document, as appropriate
Well-being Goal – A prosperous Wales			
7.4 People in terms of their use of the physical environment: Consider the impact on the availability and accessibility of transport, healthy food, leisure activities, green spaces; of the design of the built environment on the physical and mental health of patients, staff and visitors; on air quality, exposure to pollutants; safety of neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces Well-being Goal – A resilient Wales	None	None	
7.5 People in terms of social and community	None	None	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Directorate Make reference to where the mitigation is included in the document, as appropriate
influences on their health: Consider the impact on family organisation and roles; social support and social networks; neighbourliness and sense of belonging; social isolation; peer pressure; community identity; cultural and spiritual ethos Well-being Goal – A Wales of cohesive communities			
7.6 People in terms of macro-economic, environmental and sustainability factors: Consider the impact of government policies; gross domestic product; economic development; biological diversity; climate Well-being Goal – A globally responsible Wales	None	None	

Please answer question 8.1 following the completion of the EHIA and complete the action plan

8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service	This policy aims to ensure that all PHW staff are fully aware of their responsibilities in relation to Alerts, safety Notices and other guidance. This will help to ensure that any alerts and safety notices issued by Welsh Government are acted upon swiftly and effectively, thereby protecting the interests of service users and staff.

Action Plan for Mitigation / Improvement and Implementation

	Action	**Lead**	**Timescale**	**Action taken by Directorate**
8.2 What are the key actions identified as a result of completing the EHIA?	N/A			

	Action	Lead	Timescale	Action taken by Directorate
8.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment required? This means thinking about relevance and proportionality to the Equality Act and asking: is the impact significant enough that a more formal and full consultation is required?	No			

8.4 What are the next steps? Some suggestions:- • Decide whether the strategy policy, plan, procedure and/ service proposal: ○ continues unchanged as there are no significant negative impacts ○ adjusts to account for the negative impacts ○ continues despite potential for adverse impact or missed opportunities to advance equality (set out the justifications for doing so) ○ stops. • Have your strategy, policy, plan, procedure and/or service proposal approved • Publish your report of this impact assessment • Monitor and review	Policy to be approved	JL	ASAP	

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales	**Name of Meeting** Quality, Safety and Improvement Committee **Date of Meeting** 15 January 2019 **Agenda item:** *5.2.2.QSIC.150119*

All Wales Information Governance Policies

Executive lead:	Sian Bolton, Executive Director
Author:	John Lawson, Chief Risk Officer

Approval/Scrutiny route:	Executive Team

Purpose
To introduce two new and two revised all Wales Information Governance policies for adoption by Public Health Wales.

APPROVE	CONSIDER	RECOMMEND	ADOPT	ASSURANCE
☐	☒	☐	☒	☐

The Committee is asked to:

Consider the report and **adopt** the All Wales policies referred to.

Link to Public Health Wales Strategic Plan Public Health Wales has an agreed strategic plan, which has identified seven strategic priorities. This report contributes to all of the Strategic Priorities	
Strategic Priority	Choose an item.
Strategic Priority	Choose an item.
Strategic Priority	Choose an item.

Summary impact analysis	
Equality and Health Impact Assessment	These Policies were considered by the Quality, Safety and Improvement Committee in October and it was requested that further work be done on a Public Health Wales Equality and Health Impact Assessment. This has now been carried out and the document is submitted along with the Policies.
Risk and Assurance	This report provides assurance around all seven strategic risks.
Health and Care Standards	This report supports and/or takes into account the Health and Care Standards for NHS Wales Quality Themes Governance, Leadership and Accountability
Financial implications	No financial implications
People implications	All staff will be required to comply with these policies and the underpinning procedures

1. Purpose / situation

This paper introduces four all Wales Information Governance based policies which have been approved by the Wales Information Governance Board (WIGB) and which all NHS Wales organisations are expected to adopt.

2. Background

The Information Governance Management Advisory Group (IGMAG) was tasked some time ago by WIGB with reviewing, updating and where necessary publishing new all Wales policies on a range of Information Governance topics, the intention being to establish consistency in approach across all NHS Wales organisations.

In 2015 policies were issued for:

- E-mail use
- Internet use

These policies were approved by WIGB and all NHS organisations were asked to adopt them.

In 2018, the IGMAG task and finish group reviewed these policies and published updated versions, together with new policies for:

- Information Governance
- Information Security

3. Description/Assessment

The four policies which have been published are now required to be adopted by all NHS Wales organisations. The policies were developed by a task and finish group of IGMAG on which I represented Public Health Wales. All policies have been widely consulted on across Wales and inside Public Health Wales through the organisations consultation process.

3.1 Well-being of Future Generations (Wales) Act 2015

As the expectation nationally is that all NHS Wales organisations will adopt these policies, no decision is required.

4. Recommendation

The Committee is asked to **consider** the report and **adopt** the All Wales policies referred to.

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales	**Reference Number:** xxxx **Version Number:** xxx **Date of next review:** xxx

ALL WALES NHS INFORMATION GOVERNANCE POLICY

Policy Statement

Public Health Wales is an organisation which relies on large amounts of data and information in order to fulfil its statutory functions. The organisation recognises that the people of Wales entrusts it with their personal information in order to carry out those functions. The people whose information we process have the absolute right to know that every care will be taken to ensure that it is processed fairly and within the law and this Policy is the organisation's statement on how this will be achieved.

The Policy will make clear the roles and responsibilities of those charged with delivery of the requirements of this policy, it will outline the legislative framework within which it operates and it will give clear direction to its staff on what is expected of them with regards to Information Governance.

Any failure to comply with the provisions of this policy may result in disciplinary proceedings.

Equality and Health Impact Assessment	All Wales assessment completed
Approved by	
Approval Date	
Review Date	
Date of Implementation/ Publication:	
Group with authority to approve supporting procedures	
Accountable Executive Director/Director	
Author	

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date by contacting Corporate Governance.

Summary of reviews/amendments				
Version number	**Date of Review**	**Date of Approval**	**Date published**	**Summary of Amendments**

NHS Wales
Information Governance Policy

Author: Information Governance Management Advisory Group Policy Sub Group
Approved by: Information Governance Management Advisory Group
Approved by: Wales Information Governance Board
Version: 1
Date: 26/06/2018
Review date: 26/06/2018

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Contents

1. Introduction 7
2. Purpose 7
3. Scope 7
4. Roles and responsibilities 8
5. Policy 8

5.1 Data Protection and Compliance 8

5.1.1 Personal Data 8
5.1.2 Special Categories of Personal Data 9
5.1.3 Fair and Lawful Processing 9
5.1.4 Individual's Rights 9
5.1.5 Accuracy of Personal Data 10
5.1.6 Data Minimisation 10
5.1.7 Data Protection Impact Assessment (DPIA) 10
5.1.8 Incident Management and Breach Reporting 10
5.1.9 Information Governance Compliance 10
5.1.10 Information Asset Management 10
5.1.11 Third Parties and Contractual Arrangements 11

5.2 Information Security 11

5.2.1 Senior Information Risk Owner 11

5.3 Records Management 11

5.4 Access to Information 12

5.5 Confidentiality 12

5.5.1 Confidentiality: Code of Practice for Health and Social Care in Wales 12
5.5.2 Caldicott 12

5.6 Sharing Personal Data 13

5.6.1 Wales Accord for the Sharing of Personal Information (WASPI) 13
5.6.2 One-off Disclosures of Personal Data 13

5.7 Welsh Control Standard for Electronic Health and Care Records 13

5.7.1 The Control Standard 13
5.7.2 The Register for Information Sharing Systems 14

5.8 Data Quality 14

6. Training and Awareness 14

7. Monitoring and compliance 15
8. Review 16
9. Equality Impact Assessment 16
Annex: Policy Development - Version Control 17
Annex 2: Equality Impact Assessment 19

1. Introduction

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

2. Purpose

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

The objectives of the Policy are to:

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

3. Scope

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

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

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

4. Roles and responsibilities

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

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

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

5. Policy

5.1 Data Protection and Compliance

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

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

5.1.1 Personal Data

For the purpose of this policy, the use of the term “personal data” relates to information relating to both living and deceased identifiable persons.

Examples of key identifiable personal data include (but are not limited to) name, address, full postcode, date of birth, NHS number, National Insurance number, images, recordings, IP addresses, email addresses etc.

5.1.2 Special Categories of Personal Data

Special categories of personal data are defined by data protection legislation as including any data concerning an individual's racial or ethnic origin, political opinions, religious or philosophical beliefs, trade union membership, health, sex life, sexual orientation, genetic and biometric data where processed to uniquely identify an individual.

5.1.3 Fair and Lawful Processing

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

In order for the processing to be fair, NHS Wales organisations will be open and transparent about the way it processes personal data by informing individuals using a variety of methods. The most common way to provide this information is in a privacy notice.

In order to provide assurance, NHS Wales organisations will identify and record the lawful basis for the information it processes in all privacy notices and in an information asset register.

Privacy notices must be clear, straightforward and appropriate to the level of understanding of the intended audience, and produced in line with ICO guidance.

5.1.4 Individual's Rights

Individuals have certain rights with regard to the processing of their personal data. NHS Wales organisations must ensure that appropriate arrangements are in place to manage these rights.

5.1.5 Accuracy of Personal Data

Arrangements must be in place to ensure that any personal data held by NHS Wales organisations is accurate and up to date.

5.1.6 Data Minimisation

NHS Wales organisations will use the minimum amount of identifiable information required when processing personal data. Where appropriate, personal data must be anonymised or pseudonymised. Local arrangements must be followed.

5.1.7 Data Protection Impact Assessment (DPIA)

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

5.1.8 Incident Management and Breach Reporting

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

5.1.9 Information Governance Compliance

NHS Wales organisations must have arrangements in place to monitor information governance compliance . Any risks identified must be managed in line with local risk management arrangements.

5.1.10 Information Asset Management

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

5.1.11 Third Parties and Contractual Arrangements

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

5.2 Information Security

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

5.2.1 Senior Information Risk Owner

Every NHS Wales organisation must have a designated Senior Information Risk Owner (SIRO). The SIRO provides an essential role in ensuring that information security and information governance risks are managed. All organisations must have arrangements in place to support staff to adequately manage risks in a robust manner.

5.3 Records Management

NHS Wales organisations must have a systematic and planned approach to the management of records in the organisation from their creation to their disposal. This will ensure that organisations can control the quality and quantity of the information that it generates, can maintain that information in an effective manner, and can dispose of information efficiently when it is no longer required and outside the retention period.

5.4 Access to Information

NHS Wales organisations are in some circumstances required by law to disclose information. Examples include information requested under the Freedom of Information Act, the Environmental Information Regulations or requests for personal data.

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

5.5 Confidentiality

5.5.1 Confidentiality: Code of Practice for Health and Social Care in Wales

NHS Wales has adopted the Confidentiality: Code of Practice for Health and Social Care in Wales. All staff have an obligation of confidentiality regardless of their role and are required to respect the personal data and privacy of others.

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

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

5.5.2 Caldicott

NHS Wales will uphold the following Caldicott Principles in relation to patient information.
Each organisation must appoint a Caldicott Guardian whose role is to safeguard the processing of patient information.

5.6 Sharing Personal Data

5.6.1 Wales Accord for the Sharing of Personal Information (WASPI)

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

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

5.6.2 One-off Disclosures of Personal Data

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

Personal data may need to be shared externally on a one-off basis, where an ISP or equivalent sharing document does not exist. It is important that this sharing follows all the principles of good information governance and that local arrangements are made and followed to ensure suitable processes are followed.

5.7 Welsh Control Standard for Electronic Health and Care Records

5.7.1 The Control Standard

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

committed to abide by the Control Standard. The Control Standard will be underpinned by local level policies and procedures to ensure electronic records are accessed and used appropriately.

5.7.2 The Register for Information Sharing Systems

A register of core national systems is maintained by the NHS Wales Informatics Service and sets out how shared electronic health and care records are held. NHS Wales organisations may include 'local' systems in the register. Cooperation must be maintained between organisations and the NHS Wales Informatics Service in order to ensure that the information is accurate and up to date.

5.8 Data Quality

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

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

6. Training and Awareness

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

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

7. Monitoring and compliance

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

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

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

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

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

8. Review

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

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

9. Equality Impact Assessment

This policy has been subject to an equality assessment.

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

Annex: Policy Development - Version Control

Revision History

Date	Version	Author	Revision Summary
05/10/2017	V0.1	Andrew Fletcher (on behalf of the IGMAG policy sub group)	IG Leads in sub group first draft.
08/12/2017	V0.2	Andrew Fletcher (on behalf of the IGMAG policy sub group)	Comments from IG Leads in sub group applied to policy.
07/02/2018	V0.3	Andrew Fletcher (on behalf of the IGMAG policy sub group)	Comments from all IG Leads in IGMAG applied
08/03/2018	V0.4	Andrew Fletcher (on behalf of IGMAG)	Version control information updated
08/05/2018	V0.5	Andrew Fletcher (on behalf of IGMAG)	Changes following Equality Impact Assessment

Reviewers

This document requires the following reviews:

Date	Version	Name	Position
07/02/2018	V0.3	Internet and Email policy sub group	Sub group of the Information Governance Management and Advisory Group
08/03/2018	V0.4	Information Governance Management Advisory Group	All Wales Information Governance Leads
30/04/2018	V0.4	Welsh Partnership Forum	All Wales workforce leads and trade unions
08/05/2018	V0.4	Equality Impact Assessment	
26/06/2018	V0.5 For Approval	Wales Information Governance Board	Advisory Board to the Minister for Health and Social Care (Welsh Government)

Approvers

This document requires the following approvals:

Date	Version	Name	Position
07/06/2018	V0.5	Information Governance Management and Advisory Group	All Wales Information Governance Leads

26/06/2018	V2	Wales Information Governance Board	Advisory Board to the Minister for Health and Social Care (Welsh Government)

Annex 2: Equality Impact Assessment

Equality Impact Assessment (EQIA) Form		
Ref no: POL/IGMAG/IG/v1		
Name of the policy, service, scheme or project:	Service Area	
NHS Wales Information Governance Policy	Information Governance	
Preparation		
Aims and Brief Description	The policy is a new All Wales Information Governance Policy. The policy will replace all local policies in this area.	
Which Director is responsible for this policy/service/scheme etc	All Wales policy developed in conjunction with Health Boards/Trusts	
Who is involved in undertaking the EQIA	Andrew Fletcher and EQIA group	
Have you consulted with stakeholders in the development of this policy?	Yes. A sub group has developed this policy with a membership consisting of information governance leads and an OSSMB representative. IM&T leads and the Wales Partnership Forum have been consulted. The NHS Wales Information Governance Management and Advisory Group have approved the text of this Policy. The policy will be approved by the Wales Information Governance Board.	
Does the policy assist services or staff in meeting their most basic needs such as; Improved Health, fair recruitment etc	Yes. The policy will provide consistency throughout NHS Wales in having a single policy. This will ensure that staff who work across boundaries have a consistent standard to work to, hence strengthening the governance framework. A key driver during the process was the need to recognise that organisations needed to trust their staff.	
Who and how many (if known) may be affected by the policy?	All NHS Wales staff within the Health Boards and NHS Trusts.	
What guidance have you used in the development of this service, policy etc?	The policy is based on good practice and legal obligations as set out by the Information Commissioners Office and in the legislation. The policy has also been constructed from existing agreed principles and the corporate knowledge of its stakeholders.	

Equality Duties

Key	
✓	Yes
x	No
-	Neutral

The Policy/service/project or scheme aims to meet the specific duties set out in equality legislation.	Protected Characteristics										
	Race	Sex/Gender	Disability	Sexual orientation	Religion and Belief	Age	Gender reassignment	Pregnancy and Maternity	Marriage & civil Partnerships	Welsh Language	Carers
To eliminate discrimination and harassment	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Promote equality of opportunity	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Promote good relations and positive attitudes	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Encourage participation in public life	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

In relation to disability only, should the policy / service / project or scheme take account of difference, even if involves treating some individuals more favourably?	✓

Human Rights Based Approach – Issues of Dignity & Respect

The Human Rights Act contains 15 rights, all of which NHS organisations have a duty. The 7 rights that are relevant to healthcare are listed below.

Consider is the policy/service/project or scheme relevant to:	Yes	No	N/A
Article 2: The Right to Life	X		
Article 3: the right not to be tortured or treated in a inhumane or degrading way	X		
Article 5: The right to liberty	X		
Article 6: the right to a fair trial	X		
Article 8: the right to respect for private and family life	X		
Article 9: Freedom of thought, conscience and religion	X		
Article 14: prohibition of discrimination	X		

Measuring the Impact

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

Outcome report

Equality Impact Assessment: Recommendations

Please list below any recommendations for action that you plan to take as a result of this impact assessment

Recommendation		**Action Required**	**Lead Officer**	**Time-scale**	**Resource implications**	**Comments**
1	Communication of the changes	Make sure staff aware of the changes	AF	ASAP	Time	
2	Updated EQIA statement	Inclusion of reference to protected characteristics	AF	ASAP	Time	

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

Risk Assessment based on above recommendations

Reputation and compromise position	**Outcome**
It is providing security and reassurance to stakeholders that the information we hold is used appropriately and any breach may lead to fines and reputational damage.	To ensure that information is used and protected appropriately and a framework in place to ensure that happens.
Training and dissemination of policy	
More training and dissemination in Health Boards on this policy.	

Is the policy etc lawful?	**Yes** ☒	**No** ☐	**Review date**

Does the EQIA group support the policy be adopted?	**Yes** ☒	**No** ☐	**3 years**
Signed on behalf of NWIS Equal Impact Assessment Group	S Brooks	Lead Officer	
Date:	8 May 2018	Date: 8 May 2018	

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

Risk Grading Descriptors

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

Equality & Health Impact Assessment for

All Wales Information Governance Policy

Please read the Guidance Notes in Appendix 1 prior to commencing this Assessment

Completed : 25/10/2018

Please note:

- The completed Equality & Health Impact Assessment (EHIA) must be
  - Included as an appendix with the cover report when the strategy, policy, plan, procedure and/or service change is submitted for approval
  - Published on the PHW intranet and internet pages as part of the consultation (if applicable) and once agreed.
- Formal consultation must be undertaken, as required
- Appendices 1-3 must be deleted prior to submission for approval

Please answer all questions:-

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	N/A
2.	Name of Directorate and title of lead member of staff, including contact details	Quality Nursing and Allied Healthcare Professionals. John Lawson - Chief Risk Officer John.lawson@wales.nhs.uk 02920 104307
3.	Objectives of strategy/ policy/ plan/ procedure/ service	This policy sets out the organisational requirements for dealing with Information Governance

4.	Evidence and background information considered. For example • population data • staff and service users data, as applicable • needs assessment • engagement and involvement findings • research • good practice guidelines • participant knowledge • list of stakeholders and how stakeholders have engaged in the development stages • comments from those involved in the designing and development stages Population pyramids are available from Public Health Wales Observatory and the 'Shaping Our Future Wellbeing' Strategy provides an overview of health need.	This has been widely consulted upon throughout NHS Wales and Public Health Wales, from Board level to operational and support staff. The Information Commissioner has been a key stakeholder in its development and the document has been through several iterations in its development, with comments and feedback being discussed and where appropriate incorporated at each stage.
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	This polcy will have no direct impact upon service users, however the effect of it will be to improve the confidentiality, integrity and availability of personal data, which in turn will lead to increased public confidence. All staff are required to comply with this policy

6. EQIA / How will the strategy, policy, plan, procedure and/or service impact on people?

Questions in this section relate to the impact on people on the basis of their 'protected characteristics'. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Directorate.** Make reference to where the mitigation is included in the document, as appropriate
6.1 Age For most purposes, the main categories are: • under 18; • between 18 and 65; and • over 65	The policy and procedure protects staff and the population in general.		
6.2 Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes	This policy applies to all staff regardless of disability	None	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.3 People of different genders: Consider men, women, people undergoing gender reassignment **NB** Gender-reassignment is anyone who proposes to, starts, is going through or who has completed a process to change his or her gender with or without going through any medical procedures. Sometimes referred to as Trans or Transgender	This policy applies to all staff regardless of gender	None	
6.4 People who are married or who have a civil partner.	This policy applies to all staff regardless of marital status	None	
6.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are	This policy applies to all staff	None	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Directorate. Make reference to where the mitigation is included in the document, as appropriate
breastfeeding. They are protected for 26 weeks after having a baby whether or not they are on maternity leave.			
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	This policy applies to all staff regardless of race, colour, culture or ethnic origin	None	
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	This policy applies to all staff regardless of religious beliefs	None	
6.8 People who are attracted to other people of: • the opposite sex (heterosexual);	This policy applies to all staff regardless of sexual orientation	None	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Directorate. Make reference to where the mitigation is included in the document, as appropriate
• the same sex (lesbian or gay); • both sexes (bisexual)			
6.9 People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design Well-being Goal – A Wales of vibrant culture and thriving Welsh language	For staff who communicate using Welsh Language can identify through their line manager. This policy is available in Welsh if required	None, will be monitored on an ongoing basis	
6.10 People according to their income related group: Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health	This policy applies to all staff regardless of their income group	None	
6.11 People according to where they live: Consider people living in areas	None	None	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Directorate. Make reference to where the mitigation is included in the document, as appropriate
known to exhibit poor economic and/or health indicators, people unable to access services and facilities			
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service			

7. HIA / How will the strategy, policy, plan, procedure and/or service impact on the health and well-being of our population and help address inequalities in health?

Questions in this section relate to the impact on the overall health of individual people and on the impact on our population. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Directorate** Make reference to where the mitigation is included in the document, as appropriate
7.1 People being able to access the service offered: Consider access for those living in areas of deprivation and/or those experiencing health inequalities Well-being Goal - A more equal Wales	None	None	
7.2 People being able to improve /maintain healthy lifestyles: Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking cessation, reducing the harm caused	None	None	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Directorate Make reference to where the mitigation is included in the document, as appropriate
by alcohol and /or non-prescribed drugs plus access to services that support disease prevention (eg immunisation and vaccination, falls prevention). Also consider impact on access to supportive services including smoking cessation services, weight management services etc Well-being Goal – A healthier Wales			
7.3 People in terms of their income and employment status: Consider the impact on the availability and accessibility of work, paid/ unpaid employment, wage levels, job security, working conditions	None	None	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Directorate Make reference to where the mitigation is included in the document, as appropriate
Well-being Goal – A prosperous Wales			
7.4 People in terms of their use of the physical environment: Consider the impact on the availability and accessibility of transport, healthy food, leisure activities, green spaces; of the design of the built environment on the physical and mental health of patients, staff and visitors; on air quality, exposure to pollutants; safety of neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces Well-being Goal – A resilient Wales	None	None	
7.5 People in terms of social and community	None	None	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Directorate Make reference to where the mitigation is included in the document, as appropriate
influences on their health: Consider the impact on family organisation and roles; social support and social networks; neighbourliness and sense of belonging; social isolation; peer pressure; community identity; cultural and spiritual ethos Well-being Goal – A Wales of cohesive communities			
7.6 People in terms of macro-economic, environmental and sustainability factors: Consider the impact of government policies; gross domestic product; economic development; biological diversity; climate Well-being Goal – A globally responsible Wales	None	None	

Please answer question 8.1 following the completion of the EHIA and complete the action plan

8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service	This policy aims to ensure that all PHW staff are fully aware of their responsibilities in relation to Information Governance. This will help to ensure that the personal information of staff, service users and stakeholders in general will be processed fairly and lawfully in accordance with the requirements of the Data Protection Act and other associated legislation.

Action Plan for Mitigation / Improvement and Implementation

	Action	Lead	Timescale	Action taken by Directorate
8.2 What are the key actions identified as a result of completing the EHIA?	N/A			

	Action	Lead	Timescale	Action taken by Directorate
8.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment required? This means thinking about relevance and proportionality to the Equality Act and asking: is the impact significant enough that a more formal and full consultation is required?	No			

8.4 What are the next steps? Some suggestions:- • Decide whether the strategy policy, plan, procedure and/ service proposal: ○ continues unchanged as there are no significant negative impacts ○ adjusts to account for the negative impacts ○ continues despite potential for adverse impact or missed opportunities to advance equality (set out the justifications for doing so) ○ stops. • Have your strategy, policy, plan, procedure and/or service proposal approved • Publish your report of this impact assessment • Monitor and review	Policy to be approved	JL	ASAP	

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales	**Reference Number:** xxxx **Version Number:** xxx **Date of next review:** xxx

ALL WALES NHS INFORMATION SECURITY POLICY

Policy Statement

Public Health Wales is an organisation which relies on large amounts of data and information in order to fulfil its statutory functions, and yet the organisation exists in a world in which the threats to the security of information, particularly electronic information are becoming increasingly complex and sophisticated. At the same time, it is foolhardy for any organisation to believe that it can rely on technical and digital means to secure its information.

Public Health Wales recognises the trust that the people of Wales places in it to look after their information and takes its responsibilities under the Data Protection Act 1998 and associated legislation extremely seriously. This policy gives a clear direction to the organisation on how everyone involved must play their role in maintaining information security, by outlining roles and responsibilities, explaining the training that will be given to staff and outlining the governance structure surrounding Information Security.

Equality and Health Impact Assessment	All Wales assessment completed
Approved by	
Approval Date	
Review Date	
Date of Implementation/ Publication:	
Group with authority to approve supporting procedures	
Accountable Executive Director/Director	
Author	

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date by contacting Corporate Governance.

Summary of reviews/amendments				
Version number	**Date of Review**	**Date of Approval**	**Date published**	**Summary of Amendments**

NHS Wales
Information Security Policy

Author: Information Governance Management Advisory Group Policy Sub Group
Approved by: Information Governance Management Advisory Group
Approved by: Wales Information Governance Board
Version: 1
Date: 26/06/2018
Review date: 26/06/2018

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Contents

1. Introduction 6
2. Purpose 6
3. Scope 6
4. Roles and responsibilities 7
5. Policy 7
5.1 User Access Controls 7
5.1.1 Physical Access Controls 8
5.1.2 Passwords 8
5.1.3 Remote Working 8
5.1.4 Staff Leavers and Movers 9
5.1.5 Third Party Access to Systems 9
5.2 Storage of Information 9
5.3 Portable Devices and Removable Media 10
5.4 Secure Disposal 10
5.4.1 Paper 10
5.4.2 Electronic 11
5.4.3 Other Items 11
5.5 Transporting and relocation of information 11
5.5.1 Transporting Information 11
5.5.2 Relocating information 11
6. Training and Awareness 11
7. Monitoring and compliance 12
8. Review 12
9. Equality Impact Assessment 13
Annex: Policy Development - Version Control 14
Annex 2: Equality Impact Assessment 16

1. Introduction

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

2. Purpose

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

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

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

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

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

3. Scope

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

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

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

4. Roles and responsibilities

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

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

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

5. Policy

5.1 User Access Controls

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

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

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

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

5.1.1 Physical Access Controls

All organisations are responsible for determining the security measures required based on local risk assessment.

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

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

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

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

5.1.2 Passwords

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

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

5.1.3 Remote Working

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

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

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

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

5.1.4 Staff Leavers and Movers

Managers will be responsible for ensuring that local leaving procedures are followed when any member of the workforce leaves or changes roles to ensure that user accounts are revoked / amended as required and any equipment and/or files are returned. Confidential, patient or staff information must not be transferred to a new role unless authorised by the relevant heads of service. A leaver's checklist should be completed in all cases.

5.1.5 Third Party Access to Systems

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

5.2 Storage of Information

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

Information in an electronic format should be stored on a dedicated network drive or be securely protected by encryption.

Copying or storing of anything that is not work related onto organisational devices is a breach of this policy. Users are not permitted to use their personal devices for the purposes of NHS Wales business unless they have been explicitly authorised to do so.

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

5.3 Portable Devices and Removable Media

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

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

All portable devices must either be encrypted, or access the network via NHS Wales approved applications (e.g. Mobile Device Management Software).

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

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

All removable media such as CDs must be encrypted if used to transport confidential information and should only be used if no other secure method of transfer is available. Users must not send details of how to unencrypt with the removable media.

5.4 Secure Disposal

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

5.4.1 Paper

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

5.4.2 Electronic

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

5.4.3 Other Items

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

5.5 Transporting and relocation of information

5.5.1 Transporting Information

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

5.5.2 Relocating information

When information is to be relocated to another location, local procedures must be formulated and followed to ensure no information is left at the original location.

6. Training and Awareness

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

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

7. Monitoring and compliance

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

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

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

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

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

8. Review

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

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

9. Equality Impact Assessment

This policy has been subject to an equality assessment.

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

Annex: Policy Development - Version Control

Revision History

Date	Version	Author	Revision Summary
05/10/2017	V0.1	Andrew Fletcher (Chair of the IGMAG policy sub group)	IG Leads in sub group first draft.
08/12/2017	V0.2	Andrew Fletcher (Chair of the IGMAG policy sub group)	Comments from IG Leads in sub group applied to policy.
07/02/2018	V0.3	Andrew Fletcher (Chair of the IGMAG policy sub group)	Comments from all IG Leads in IGMAG applied
08/03/2018	V0.4	Andrew Fletcher (Chair of the IGMAG policy sub group)	Version control information updated
08/05/2018	V0.5	Andrew Fletcher (Chair of the IGMAG policy sub group)	Changes following Equality Impact Assessment
26/06/2018	V1	Andrew Fletcher (Chair of the IGMAG policy sub group)	Minor amendment by Wales Information Governance Board incorporated

Reviewers

This document requires the following reviews:

Date	Version	Name	Position
07/02/2018	V0.3	Internet and Email policy sub group	Sub group of the Information Governance Management and Advisory Group
08/03/2018	V0.4	Information Governance Management Advisory Group	All Wales Information Governance Leads
30/04/2018	V0.4	Welsh Partnership Forum	All Wales workforce leads and trade unions

08/05/2018	V0.4	Equality Impact Assessment	NWIS Equality Impact Assessment Group
26/06/2018	V0.5 For Approval	Wales Information Governance Board	Advisory Board to the Minister for Health and Social Care (Welsh Government)

Approvers

This document requires the following approvals:

Date	Version	Name	Position
07/06/2018	V0.5	Information Governance Management and Advisory Group	All Wales Information Governance Leads
26/6/2018	V1	Wales Information Governance Board	Advisory Board to the Minister for Health and Social Care (Welsh Government)

Annex 2: Equality Impact Assessment

Equality Impact Assessment (EQIA) Form		
Ref no: POL/IGMAG/IS/v1		
Name of the policy, service, scheme or project:	Service Area	
NHS Wales Information Security Policy	Information Governance	
Preparation		
Aims and Brief Description	The policy is a new All Wales Information Security Policy. The policy will replace all local policies in this area.	
Which Director is responsible for this policy/service/scheme etc	All Wales policy developed in conjunction with Health Boards/Trusts	
Who is involved in undertaking the EQIA	Andrew Fletcher and EQIA group	
Have you consulted with stakeholders in the development of this policy?	Yes. A sub group has developed this policy with a membership consisting of information governance leads and an OSSMB representative. IM&T leads and the Wales Partnership Forum have been consulted. The NHS Wales Information Governance Management and Advisory Group have approved the text of this Policy. The policy will be approved by the Wales Information Governance Board.	
Does the policy assist services or staff in meeting their most basic needs such as; Improved Health, fair recruitment etc	Yes. The policy will provide consistency throughout NHS Wales in having a single policy. This will ensure that staff who work across boundaries have a consistent standard to work to, hence strengthening the governance framework. A key driver during the process was the need to recognise that organisations needed to trust their staff.	
Who and how many (if known) may be affected by the policy?	All NHS Wales staff within the Health Boards and NHS Trusts.	
What guidance have you used in the development of this service, policy etc?	The policy is based on good practice and legal obligations as set out by the Information Commissioners Office and in the legislation. The policy has also been constructed from existing agreed principles and the corporate knowledge of its stakeholders.	

Equality Duties

Key	
✓	Yes
x	No
-	Neutral

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

Human Rights Based Approach – Issues of Dignity & Respect

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

Measuring the Impact

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

Pregnancy and maternity	
Marriage and civil partnership	
Other areas	
Welsh language	
Carers	

Outcome report

Equality Impact Assessment: Recommendations Please list below any recommendations for action that you plan to take as a result of this impact assessment						
Recommendation		**Action Required**	**Lead Officer**	**Time-scale**	**Resource implications**	**Comments**
1	Updated statement in policy	Inclusion of reference to protected characteristics rather than homophobic, bi-phobic, racist etc so inclusive of all in the statement	AF	ASAP	Time	
2	Communication of the changes	Make sure staff aware of the changes	AF	ASAP	Time	
3	Updated EQIA statement	Inclusion of reference to protected characteristics	AF	ASAP	Time	

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

Risk Assessment based on above recommendations

Reputation and compromise position			**Outcome**
It is providing security and reassurance to stakeholders that the information we hold is used appropriately and any breach may lead to fines and reputational damage.			To ensure that information is used and protected appropriately and a framework in place to ensure that happens.
Training and dissemination of policy More training and dissemination in Health Boards on this policy.			
Is the policy etc lawful?	**Yes** ☒	**No** ☐	**Review date**
Does the EQIA group support the policy be adopted?	**Yes** ☒	**No** ☐	**3 years**
Signed on behalf of NWIS Equal Impact Assessment Group	S Brooks	Lead Officer	
Date:	8 May 2018	Date: 8 May 2018	

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

Risk Grading Descriptors

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

Equality & Health Impact Assessment for

All Wales Information Security Policy

Please read the Guidance Notes in Appendix 1 prior to commencing this Assessment

Completed : 25/10/2018

Please note:

- The completed Equality & Health Impact Assessment (EHIA) must be
  - Included as an appendix with the cover report when the strategy, policy, plan, procedure and/or service change is submitted for approval
  - Published on the PHW intranet and internet pages as part of the consultation (if applicable) and once agreed.
- Formal consultation must be undertaken, as required
- Appendices 1-3 must be deleted prior to submission for approval

Please answer all questions:-

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	N/A
2.	Name of Directorate and title of lead member of staff, including contact details	Quality Nursing and Allied Healthcare Professionals. John Lawson - Chief Risk Officer John.lawson@wales.nhs.uk 02920 104307
3.	Objectives of strategy/ policy/ plan/ procedure/ service	This policy sets out the organisational requirements for dealing with Information Security

4.	Evidence and background information considered. For example • population data • staff and service users data, as applicable • needs assessment • engagement and involvement findings • research • good practice guidelines • participant knowledge • list of stakeholders and how stakeholders have engaged in the development stages • comments from those involved in the designing and development stages Population pyramids are available from Public Health Wales Observatory and the 'Shaping Our Future Wellbeing' Strategy provides an overview of health need.	This has been widely consulted upon throughout NHS Wales and Public Health Wales, from Board level to operational and support staff. The Information Commissioner has been a key stakeholder in its development and the document has been through several iterations in its development, with comments and feedback being discussed and where appropriate incorporated at each stage.
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	This policy will have no direct impact upon service users, however the effect of it will be to improve the confidentiality, integrity and availability of personal data, which in turn will lead to increased public confidence. All staff are required to comply with this policy

6. EQIA / How will the strategy, policy, plan, procedure and/or service impact on people?

Questions in this section relate to the impact on people on the basis of their 'protected characteristics'. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Directorate.** Make reference to where the mitigation is included in the document, as appropriate
6.1 Age For most purposes, the main categories are: • under 18; • between 18 and 65; and • over 65	The policy and procedure protects staff and the population in general.		
6.2 Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes	This policy applies to all staff regardless of disability	None	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.3 People of different genders: Consider men, women, people undergoing gender reassignment **NB** Gender-reassignment is anyone who proposes to, starts, is going through or who has completed a process to change his or her gender with or without going through any medical procedures. Sometimes referred to as Trans or Transgender	This policy applies to all staff regardless of gender	None	
6.4 People who are married or who have a civil partner.	This policy applies to all staff regardless of marital status	None	
6.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are	This policy applies to all staff	None	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Directorate. Make reference to where the mitigation is included in the document, as appropriate
breastfeeding. They are protected for 26 weeks after having a baby whether or not they are on maternity leave.			
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	This policy applies to all staff regardless of race, colour, culture or ethnic origin	None	
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	This policy applies to all staff regardless of religious beliefs	None	
6.8 People who are attracted to other people of: • the opposite sex (heterosexual);	This policy applies to all staff regardless of sexual orientation	None	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Directorate. Make reference to where the mitigation is included in the document, as appropriate
• the same sex (lesbian or gay); • both sexes (bisexual)			
6.9 People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design Well-being Goal – A Wales of vibrant culture and thriving Welsh language	For staff who communicate using Welsh Language can identify through their line manager. This policy is available in Welsh if required	None, will be monitored on an ongoing basis	
6.10 People according to their income related group: Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health	This policy applies to all staff regardless of their income group	None	
6.11 People according to where they live: Consider people living in areas	None	None	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Directorate. Make reference to where the mitigation is included in the document, as appropriate
known to exhibit poor economic and/or health indicators, people unable to access services and facilities			
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service			

7. HIA / How will the strategy, policy, plan, procedure and/or service impact on the health and well-being of our population and help address inequalities in health?

Questions in this section relate to the impact on the overall health of individual people and on the impact on our population. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Directorate** Make reference to where the mitigation is included in the document, as appropriate
7.1 People being able to access the service offered: Consider access for those living in areas of deprivation and/or those experiencing health inequalities Well-being Goal - A more equal Wales	None	None	
7.2 People being able to improve /maintain healthy lifestyles: Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking cessation, reducing the harm caused	None	None	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Directorate Make reference to where the mitigation is included in the document, as appropriate
by alcohol and /or non-prescribed drugs plus access to services that support disease prevention (eg immunisation and vaccination, falls prevention). Also consider impact on access to supportive services including smoking cessation services, weight management services etc Well-being Goal – A healthier Wales			
7.3 People in terms of their income and employment status: Consider the impact on the availability and accessibility of work, paid/ unpaid employment, wage levels, job security, working conditions	None	None	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Directorate Make reference to where the mitigation is included in the document, as appropriate
Well-being Goal – A prosperous Wales			
7.4 People in terms of their use of the physical environment: Consider the impact on the availability and accessibility of transport, healthy food, leisure activities, green spaces; of the design of the built environment on the physical and mental health of patients, staff and visitors; on air quality, exposure to pollutants; safety of neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces Well-being Goal – A resilient Wales	None	None	
7.5 People in terms of social and community	None	None	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Directorate Make reference to where the mitigation is included in the document, as appropriate
influences on their health: Consider the impact on family organisation and roles; social support and social networks; neighbourliness and sense of belonging; social isolation; peer pressure; community identity; cultural and spiritual ethos Well-being Goal – A Wales of cohesive communities			
7.6 People in terms of macro-economic, environmental and sustainability factors: Consider the impact of government policies; gross domestic product; economic development; biological diversity; climate Well-being Goal – A globally responsible Wales	None	None	

Please answer question 8.1 following the completion of the EHIA and complete the action plan

8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service	This policy aims to ensure that all PHW staff are fully aware of their responsibilities in relation to Information Governance. This will help to ensure that the personal information of staff, service users and stakeholders in general will be processed fairly and lawfully in accordance with the requirements of the Data Protection Act and other associated legislation.

Action Plan for Mitigation / Improvement and Implementation

	Action	Lead	Timescale	Action taken by Directorate
8.2 What are the key actions identified as a result of completing the EHIA?	N/A			

	Action	Lead	Timescale	Action taken by Directorate
8.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment required? This means thinking about relevance and proportionality to the Equality Act and asking: is the impact significant enough that a more formal and full consultation is required?	No			

8.4 What are the next steps? Some suggestions:- • Decide whether the strategy policy, plan, procedure and/ service proposal: ○ continues unchanged as there are no significant negative impacts ○ adjusts to account for the negative impacts ○ continues despite potential for adverse impact or missed opportunities to advance equality (set out the justifications for doing so) ○ stops. • Have your strategy, policy, plan, procedure and/or service proposal approved • Publish your report of this impact assessment • Monitor and review	Policy to be approved	JL	ASAP	

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales	**Reference Number:** xxxx **Version Number:** xxx **Date of next review:** xxx

ALL WALES INTERNET USE POLICY

Policy Statement

NHS Wales trusts its workforce in using NHS Wales equipment.

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

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

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

The effectiveness of this policy will be assessed to provide assurance that risks to information and likelihood and impact of information security incidents are being reduced.

Equality and Health Impact Assessment	All Wales assessment completed
Approved by	
Approval Date	
Review Date	
Date of Implementation/ Publication:	
Group with authority to approve supporting procedures	
Accountable Executive Director/Director	
Author	

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date by contacting Corporate Governance.

Summary of reviews/amendments				
Version number	**Date of Review**	**Date of Approval**	**Date published**	**Summary of Amendments**

NHS Wales
Internet Use Policy

Author: Information Governance Management Advisory Group Policy Sub Group
Approved by: Information Governance Management Advisory Group
Approved by: Wales Information Governance Board
Version: 2
Date: 26/06/2018
Review date: 26/06/2018

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Contents

1. Introduction 6
2. Purpose 6
3. Scope 6
4. Roles and responsibilities 7
5. Policy 7
5.1 Position Statement 7
5.2 Conditions & Restrictions 7
5.3 Personal Use 8
6. Training and Awareness 9
7. Monitoring and compliance 9
8. Review 10
9. Equality Impact Assessment 10

Appendix A - Inappropriate use 11

Annex 1: Policy Development - Version Control 13

Annex 2: Equality Impact Assessment 15

1. Introduction

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

2. Purpose

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

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

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

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

3. Scope

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

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

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

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

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

4. Roles and responsibilities

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

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

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

5. Policy

5.1 Position Statement

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

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

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

5.2 Conditions & Restrictions

To avoid inadvertent breaches of this policy, inappropriate content will be blocked by default where possible. Inappropriate material must not be accessed. Exceptions may be authorised for certain staff where access to

particular web pages are a requirement of the role. Subject matter considered inappropriate is detailed in appendix A.

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

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

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

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

5.3 Personal Use

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

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

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

Staff who use NHS equipment outside NHS Wales premises (for example – in a home environment) are permitted to connect to the internet. Use of the internet under these circumstances must be through the secure VPN

connection provided by the NHS Wales organisation. Use of the equipment for such purposes is still subject to the same conditions as laid out in this policy.

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

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

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

6. Training and Awareness

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

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

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

7. Monitoring and compliance

NHS Wales trusts its workforce.

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

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

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

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

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

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

8. Review

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

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

9. Equality Impact Assessment

This policy has been subject to an equality assessment.

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

Appendix A - Inappropriate use

For the avoidance of doubt, NHS Wales organisations will generally consider any of the following inappropriate use:

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

- Access to internet based e-mail providers such as Hotmail, Freeserve, Tiscali etc is prohibited for reasons of security with the exception of:

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

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

Annex 1: Policy Development - Version Control

Revision History

Date	Version	Author	Revision Summary
01/2017	V1	Andrew Fletcher (on behalf of the Internet and Email policy sub group)	Original policy as approved January 2017
12/09/2017	V1.1	Andrew Fletcher (on behalf of the IGMAG policy sub group)	Policy text applied to new template. Duplicate and substitute statements replaced with template text except insofar as they were not covered by these statements.
05/10/2017	V1.2	Andrew Fletcher (on behalf of the IGMAG policy sub group)	Comments from IG Leads in sub group applied to the policy.
04/12/2017	V1.3	Andrew Fletcher (on behalf of the IGMAG policy sub group)	Comments from IM&T Leads applied to the policy.
10/01/2018	V1.4	Andrew Fletcher (on behalf of the IGMAG policy sub group)	IGMAG Policy Sub Group changes applied to the policy.
07/02/2018	V1.5	Andrew Fletcher (on behalf of the IGMAG policy sub group)	Comments from all IG Leads applied. Draft for approval
08/03/2018	V1.6	Andrew Fletcher (on behalf of IGMAG)	Version control information updated
30/04/2018	V1.7	Andrew Fletcher (on behalf of IGMAG)	Version control information updated – No changes following Welsh Partnership Forum Consultation.
08/05/2018	V1.8	Andrew Fletcher (on behalf of IGMAG)	Changes following Equality Impact Assessment. Completed equality impact assessment added.

Reviewers

This document requires the following reviews:

Date	Version	Name	Position
07/02/2018	V1.4	IGMAG Policy sub group	Sub group of the Information Governance Management and Advisory Group
08/03/2018	V1.5	Information Governance Management and Advisory Group	All Wales Information Governance Leads
30/04/2018	V1.6	Welsh Partnership Forum	All Wales workforce leads and trade unions
08/05/2018	V1.7	Equality Impact Assessment	NWIS Equality Impact Assessment Group
07/06/2018	V1.8	Information Governance Management and Advisory Group	All Wales Information Governance Leads
26/06/2018	V1.8 for approval	Wales Information Governance Board	Advisory Board to the Minister for Health and Social Care (Welsh Government)

Approvers

This document requires the following approvals:

Date	Version	Name	Position
07/06/2018	V1.8	Information Governance Management and Advisory Group	All Wales Information Governance Leads
26/06/2018	V2	Wales Information Governance Board	Advisory Board to the Minister for Health and Social Care (Welsh Government)

Annex 2: Equality Impact Assessment

Equality Impact Assessment (EQIA) Form		
Ref no: POL/IGMAG/Internet Use/v1		
Name of the policy, service, scheme or project:	Service Area	
NHS Wales Internet Use Policy	Information Governance	
Preparation		
Aims and Brief Description	The policy is the product of the review of the All Wales Internet Use Policy.	
Which Director is responsible for this policy/service/scheme etc	All Wales policy developed in conjunction with Health Boards/Trusts	
Who is involved in undertaking the EQIA	Andrew Fletcher and EQIA group	
Have you consulted with stakeholders in the development of this policy?	Yes. A sub group has developed this policy with a membership consisting of information governance leads and an OSSMB representative. IM&T leads and the Wales Partnership Forum have been consulted. The NHS Wales Information Governance Management and Advisory Group have approved the text of this Policy. The policy will be approved by the Wales Information Governance Board.	
Does the policy assist services or staff in meeting their most basic needs such as; Improved Health, fair recruitment etc	Yes. The policy will stand as a single internet use policy for NHS Wales. As per the original all-Wales Policy, it removes many of the restrictions which were in place in some organisations, while strengthening the governance framework. A key driver during the process was the need to recognise that organisations needed to trust their staff.	
Who and how many (if known) may be affected by the policy?	All users of the NHS Wales internet service within the Health Boards and NHS Trusts.	
What guidance have you used in the development of this service, policy etc?	The policy is based on good practice and legal obligations as set out by the Information Commissioners Office and in the legislation. The policy has also been constructed from existing agreed principles and the corporate knowledge of its stakeholders.	

Equality Duties

Key	
✓	Yes
x	No
-	Neutral

The Policy/service/project or scheme aims to meet the specific duties set out in equality legislation.	Protected Characteristics										
	Race	Sex/Gender	Disability	Sexual orientation	Religion and Belief	Age	Gender reassignment	Pregnancy and Maternity	Marriage & civil Partnerships	Welsh Language	Carers
To eliminate discrimination and harassment	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Promote equality of opportunity	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Promote good relations and positive attitudes	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Encourage participation in public life	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

In relation to disability only, should the policy / service / project or scheme take account of difference, even if involves treating some individuals more favourably?	✓

Human Rights Based Approach – Issues of Dignity & Respect

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

Measuring the Impact

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

Outcome report

Equality Impact Assessment: Recommendations

Please list below any recommendations for action that you plan to take as a result of this impact assessment

Recommendation		**Action Required**	**Lead Officer**	**Time-scale**	**Resource implications**	**Comments**
1	Communication of the changes	Make sure staff aware of the changes	AF	ASAP	Time	
2	Updated EQIA statement	Inclusion of reference to protected characteristics	AF	ASAP	Time	

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

Risk Assessment based on above recommendations

Reputation and compromise position	**Outcome**
The policy is clear so that all staff aware of responsibilities and therefore reputation of organisation is preserved.	A clear understanding of the policy and responsibilities of staff in the use of IT in the workplace.
Training and dissemination of policy	
The policy is clear so that all staff aware of responsibilities and therefore reputation of organisation is preserved.	

Is the policy etc lawful?	**Yes** ☒	**No** ☐	**Review date**
Does the EQIA group support the policy be adopted?	**Yes** ☒	**No** ☐	**3 years**
Signed on behalf of	S Brooks	Lead Officer	

NWIS Equal Impact Assessment Group			
Date:	8 May 2018	Date: 8 May 2018	

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

Risk Grading Descriptors

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

Equality & Health Impact Assessment for

All Wales Internet Policy

Please read the Guidance Notes in Appendix 1 prior to commencing this Assessment

Completed : 25/10/2018

Please note:

- The completed Equality & Health Impact Assessment (EHIA) must be
  - Included as an appendix with the cover report when the strategy, policy, plan, procedure and/or service change is submitted for approval
  - Published on the PHW intranet and internet pages as part of the consultation (if applicable) and once agreed.
- Formal consultation must be undertaken, as required
- Appendices 1-3 must be deleted prior to submission for approval

Please answer all questions:-

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	N/A
2.	Name of Directorate and title of lead member of staff, including contact details	Quality Nursing and Allied Healthcare Professionals. John Lawson - Chief Risk Officer John.lawson@wales.nhs.uk 02920 104307
3.	Objectives of strategy/ policy/ plan/ procedure/ service	This policy sets out the organisational requirements for Staff accessing the internet.

4.	Evidence and background information considered. For example • population data • staff and service users data, as applicable • needs assessment • engagement and involvement findings • research • good practice guidelines • participant knowledge • list of stakeholders and how stakeholders have engaged in the development stages • comments from those involved in the designing and development stages Population pyramids are available from Public Health Wales Observatory and the 'Shaping Our Future Wellbeing' Strategy provides an overview of health need.	This has been widely consulted upon throughout NHS Wales and Public Health Wales, from Board level to operational and support staff. The Information Commissioner has been a key stakeholder in its development and the document has been through several iterations in its development, with comments and feedback being discussed and where appropriate incorporated at each stage.
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	This policy will have no direct impact upon service users. All staff are required to comply with this policy

6. EQIA / How will the strategy, policy, plan, procedure and/or service impact on people?

Questions in this section relate to the impact on people on the basis of their 'protected characteristics'. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Directorate.** Make reference to where the mitigation is included in the document, as appropriate
6.1 Age For most purposes, the main categories are: • under 18; • between 18 and 65; and • over 65	The policy and procedure protects staff and the population in general.		
6.2 Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes	This policy applies to all staff regardless of disability	None	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.3 People of different genders: Consider men, women, people undergoing gender reassignment **NB** Gender-reassignment is anyone who proposes to, starts, is going through or who has completed a process to change his or her gender with or without going through any medical procedures. Sometimes referred to as Trans or Transgender	This policy applies to all staff regardless of gender	None	
6.4 People who are married or who have a civil partner.	This policy applies to all staff regardless of marital status	None	
6.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are	This policy applies to all staff	None	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Directorate. Make reference to where the mitigation is included in the document, as appropriate
breastfeeding. They are protected for 26 weeks after having a baby whether or not they are on maternity leave.			
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	This policy applies to all staff regardless of race, colour, culture or ethnic origin	None	
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	This policy applies to all staff regardless of religious beliefs	None	
6.8 People who are attracted to other people of: • the opposite sex (heterosexual);	This policy applies to all staff regardless of sexual orientation	None	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Directorate. Make reference to where the mitigation is included in the document, as appropriate
• the same sex (lesbian or gay); • both sexes (bisexual)			
6.9 People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design Well-being Goal – A Wales of vibrant culture and thriving Welsh language	For staff who communicate using Welsh Language can identify through their line manager. This policy is available in Welsh if required	None, will be monitored on an ongoing basis	
6.10 People according to their income related group: Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health	This policy applies to all staff regardless of their income group	None	
6.11 People according to where they live: Consider people living in areas	None	None	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Directorate. Make reference to where the mitigation is included in the document, as appropriate
known to exhibit poor economic and/or health indicators, people unable to access services and facilities			
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service			

7. HIA / How will the strategy, policy, plan, procedure and/or service impact on the health and well-being of our population and help address inequalities in health?

Questions in this section relate to the impact on the overall health of individual people and on the impact on our population. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Directorate** Make reference to where the mitigation is included in the document, as appropriate
7.1 People being able to access the service offered: Consider access for those living in areas of deprivation and/or those experiencing health inequalities Well-being Goal - A more equal Wales	None	None	
7.2 People being able to improve /maintain healthy lifestyles: Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking cessation, reducing the harm caused	None	None	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Directorate Make reference to where the mitigation is included in the document, as appropriate
by alcohol and /or non-prescribed drugs plus access to services that support disease prevention (eg immunisation and vaccination, falls prevention). Also consider impact on access to supportive services including smoking cessation services, weight management services etc Well-being Goal – A healthier Wales			
7.3 People in terms of their income and employment status: Consider the impact on the availability and accessibility of work, paid/ unpaid employment, wage levels, job security, working conditions	None	None	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Directorate Make reference to where the mitigation is included in the document, as appropriate
Well-being Goal – A prosperous Wales			
7.4 People in terms of their use of the physical environment: Consider the impact on the availability and accessibility of transport, healthy food, leisure activities, green spaces; of the design of the built environment on the physical and mental health of patients, staff and visitors; on air quality, exposure to pollutants; safety of neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces Well-being Goal – A resilient Wales	None	None	
7.5 People in terms of social and community	None	None	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Directorate Make reference to where the mitigation is included in the document, as appropriate
influences on their health: Consider the impact on family organisation and roles; social support and social networks; neighbourliness and sense of belonging; social isolation; peer pressure; community identity; cultural and spiritual ethos Well-being Goal – A Wales of cohesive communities			
7.6 People in terms of macro-economic, environmental and sustainability factors: Consider the impact of government policies; gross domestic product; economic development; biological diversity; climate Well-being Goal – A globally responsible Wales	None	None	

Please answer question 8.1 following the completion of the EHIA and complete the action plan

8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service	This policy aims to ensure that all PHW staff are fully aware of their responsibilities in relation to Information Governance. This will help to ensure that the personal information of staff, service users and stakeholders in general will be processed fairly and lawfully in accordance with the requirements of the Data Protection Act and other associated legislation.

Action Plan for Mitigation / Improvement and Implementation

	Action	Lead	Timescale	Action taken by Directorate
8.2 What are the key actions identified as a result of completing the EHIA?	N/A			

	Action	Lead	Timescale	Action taken by Directorate
8.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment required? This means thinking about relevance and proportionality to the Equality Act and asking: is the impact significant enough that a more formal and full consultation is required?	No			

8.4 What are the next steps? Some suggestions:- • Decide whether the strategy policy, plan, procedure and/ service proposal: ○ continues unchanged as there are no significant negative impacts ○ adjusts to account for the negative impacts ○ continues despite potential for adverse impact or missed opportunities to advance equality (set out the justifications for doing so) ○ stops. • Have your strategy, policy, plan, procedure and/or service proposal approved • Publish your report of this impact assessment • Monitor and review	Policy to be approved	JL	ASAP	

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales	**Reference Number:** xxxx **Version Number:** xxx **Date of next review:** xxx

ALL WALES NHS EMAIL USE POLICY

Policy Statement

Public Wales trusts its workforce when using Public Health Wales equipment.

Email functionality is provided to staff to assist them in the performance of their duties and the provision of these facilities represents a major commitment on the part of Public Health Wales in terms of investment and resources.

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

Staff should be aware that the email system is not to be used as a facility for permanent retention of documentation. Business content in email messages and any attachment that need to be retained must be saved to the appropriate functional area of the corporate management filing system.

Public Health Wales will support its workforce in understanding how to safely use email services and it is important that users understand the legal professional and ethical obligations that apply to its use. If used correctly, email systems can increase efficiency and safety within patient care. Risks can be reduced by utilising email as an established form of NHS and patient communication.

Equality and Health Impact Assessment	All Wales assessment completed
Approved by	
Approval Date	
Review Date	
Date of Implementation/ Publication:	
Group with authority to approve supporting procedures	
Accountable Executive Director/Director	
Author	

Disclaimer **If the review date of this document has passed please ensure that the version you are using is the most up to date by contacting Corporate Governance.**	

Summary of reviews/amendments				
Version number	**Date of Review**	**Date of Approval**	**Date published**	**Summary of Amendments**

NHS Wales
Email Use Policy

Author: Information Governance Management Advisory Group Policy Sub Group
Approved by: Information Governance Management Advisory Group
Approved by: Wales Information Governance Board
Version: 2
Date: 26/06/2018
Review date: 26/06/2018

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Contents

1. Introduction 6
2. Purpose 6
3. Scope 6
4. Roles and responsibilities 6
5. Policy 7
5.1 Inappropriate emails 7
5.2 Personal Data and Business Sensitive Information: Filtering and Misdirection 7
5.3 Personal Use 8
5.4 Access to Information requests 8
6. Training and Awareness 9
7. Monitoring and compliance 9
8. Review 10
9. Equality Impact Assessment 10
Appendix A - Inappropriate use 11
Annex 1: Policy Development - Version Control 13
Annex 2: Equality Impact Assessment 14

1. Introduction

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

2. Purpose

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

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

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

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

3. Scope

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

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

This policy applies to all those making use of the NHS email services by any means regardless of the location from which accessed and the type of equipment used, for example corporate equipment, devices owned by a third party organisation or personal devices operated under a Bring Your Own Device Scheme.

4. Roles and responsibilities

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

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

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

5. Policy

5.1 Inappropriate emails

Inappropriate content and material must not be sent by email. Inappropriate content including prohibited language in emails may be blocked. Subject matter considered inappropriate is detailed in appendix A.

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

Some users may need to receive and send potentially offensive material as part of their role (for example - child protection). Arrangements must be authorised to facilitate this requirement.

5.2 Personal Data and Business Sensitive Information: Filtering and Misdirection

The NHS Wales network is considered to be secure for the transfer of any information including Personal Data and business sensitive information within NHS Wales. This includes all email addresses in the NHS email directory which include those email addresses that end in “wales.nhs.uk” which are hosted on the NHS Wales email service. However, to mitigate against the risk of misdirection users should consider the use of encryption or other security measures when transferring Personal Data or business sensitive information.

Transfer of Personal Data or business sensitive information to any email address not ending in “wales.nhs.uk” is not currently considered secure. Where this type of information needs to be sent, appropriate security

measures must be implemented, for example, the secure file sharing portal, secure mail systems or encryption.

Users must be vigilant in ensuring that all emails are sent to the correct recipient and to use the NHS address book to check that the correct email address or addresses have been selected. Misdirected emails should be reported via local incident reporting processes.

5.3 Personal Use

NHS email accounts must not be used as a personal private email account.

Private use of email is permitted in the following circumstances:

- Emails to occupational health
- Email for Health and Wellbeing
- Communications connected with approved personal development / training
- Communications with Trade Unions and Professional Bodies
- Emergency emails

Users must not subscribe to or provide any NHS email address to any third party organisation for personal use.

Please note: where local organisations have provided patients and staff with access to public Wi-Fi services, staff may use these to access personal email accounts on their own device in their own time.

5.4 Access to Information requests

Information held on computers, including those held in email accounts may be subject to requests for information under relevant legislation and regulation. All staff should be mindful that it may be necessary to conduct a search for information and this may take place with or without the author's knowledge or consent.

5.5 Records Management

The email system must not to be used as a storage facility.

- All emails should either be deleted or saved securely to the appropriate record (e.g. to a clinical / business record or network drive).
- Any emails that are retained within the email system should be automatically archived by the email system. This data should not be retained for any period of time greater than 6 years.

6. Training and Awareness

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

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

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

7. Monitoring and compliance

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

NHS Wales uses software to scan emails for inappropriate content and filters are in place to detect this. Where an email is blocked, emails may be checked for compliance when a user requests an email to be released. All email use will be logged to display date, time, username, email content; and the address to which the message is being sent.

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

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

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

In order for the NHS organisations to achieve good information governance practice staff must be encouraged to recognise the importance of good governance and report any breaches to enable lessons learned. They must be

provided with the necessary tools, support, knowledge and training to help them deliver their services in compliance with legislation. Ultimately a skilled workforce will have the confidence to challenge bad information governance practice, and understand how to use information legally in the right place and at the right time. This should minimise the risk of incidents occurring or re-occurring.

8. Review

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

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

9. Equality Impact Assessment

This policy has been subject to an equality assessment.

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

Appendix A - Inappropriate use

For the avoidance of doubt, NHS Wales will generally consider any of the following inappropriate use:

- Knowingly using another person's NHS Wales email account and its functions, or allowing their email account to be used by another person without the relevant permission. Note: If an email is required to be sent on another person's behalf then this must be performed using delegated permissions functionality and must be approved for use beforehand;
- Allowing access to NHS Wales email services by anyone not authorised to access the services, such as by a friend or family member;
- Communicating or disclosing confidential or sensitive information unless appropriate security measures and authorisation are in place;
- Communicating or saving any information or images which are unlawful, or could be regarded as defamatory, offensive, abusive, obscene, hateful, pornographic, violent, terrorist, indecent, being discriminatory in relation to the protected characteristics, or using the email system to inflict bullying or harassment on any person.
- Knowingly breaching copyright or Intellectual Property Rights (IPR)
- 'Hacking' into others' accounts or unauthorised areas;
- Obtaining or distributing unlicensed or illegal software by email;
- Deliberately attempting to circumvent security systems protecting the integrity of the NHS Wales network;
- Any purpose that denies service to other users (for example, deliberate or reckless overloading of access links or switching equipment);
- Deliberately disabling or overloading any ICT system or network, or attempting to disable or circumvent any system intended to protect the privacy or security of employees, patients or others;
- Intentionally introducing malicious software such as Viruses, Worms, and Trojans into the NHS Wales network;
- Expressing personal views that may bring NHS Wales into disrepute;
- Distributing unsolicited commercial or advertising materials;
- Communicating unsolicited personal views on political, social, or religious matters with the intention of imposing that view on any other person. This does not preclude Trade Union officials from communicating with staff on Trade Union related matters;
- Installing additional email related software, or changing the configuration of existing software without appropriate permission;
- Sending unlicensed or illegal software or data including executable software, such as shareware, public domain and commercial software without correct authorisation;
- Forwarding chain email or spam (unsolicited mail) within the organisation or to other organisations;

- Subscribing to a third party email notification using a NHS Wales email account for reasons not connected to work, membership of a professional body or trade union;
- Sending personal photos or videos;
- Registering a NHS Wales e-mail address with any third party company for personal use (e.g. department store accounts; online grocery shopping accounts);
- Access to internet based e-mail providers including services such as Hotmail, Freeserve, Tiscali etc is prohibited for reasons of security with the exception of:
    - Access to email services provided by a recognised professional body or a trade union recognised by the employer;
    - Any UK university hosted e-mail account (accounts ending in .ac.uk);
    - Any email account hosted by a body which the employee contributes to in conjunction with their NHS role, such as a local authority or tertiary organisation.

Annex 1: Policy Development - Version Control

Revision History

Date	Version	Author	Revision Summary
01/2017	V1	Andrew Fletcher (on behalf of the Internet and Email policy sub group)	Original policy as approved January 2017
12/09/2017	V1.1	Andrew Fletcher (on behalf of the IGMAG policy sub group)	Policy text applied to new template. Duplicate and substitute statements replaced with template text except insofar as they were not covered by these statements.
05/10/2017	V1.2	Andrew Fletcher (on behalf of the IGMAG policy sub group)	Comments from IG Leads in sub group applied to the policy.
04/12/2017	V1.3	Andrew Fletcher (on behalf of the IGMAG policy sub group)	Comments from IM&T Leads applied to the policy.
10/01/2018	V1.4	Andrew Fletcher (on behalf of the IGMAG policy sub group)	IGMAG Policy Sub Group changes applied to the policy.
07/02/2018	V1.5	Andrew Fletcher (on behalf of the IGMAG policy sub group)	Comments from all IG Leads applied. Draft for approval
08/03/2018	V1.6	Andrew Fletcher (on behalf of IGMAG)	Version control information updated
30/04/2018	V1.7	Andrew Fletcher (on behalf of IGMAG)	Version control information updated – No changes following Welsh Partnership Forum Consultation.
08/05/2018	V1.8	Andrew Fletcher (on behalf of IGMAG)	Changes following Equality Impact Assessment. Completed equality impact assessment added.

Reviewers

This document requires the following reviews:

Date	Version	Name	Position
07/02/2018	V1.4	IGMAG Policy sub group	Sub group of the Information Governance Management and Advisory Group
08/03/2018	V1.5	Information Governance Management and Advisory Group	All Wales Information Governance Leads
30/04/2018	V1.6	Welsh Partnership Forum	All Wales workforce leads and trade unions
08/05/2018	V1.7	Equality Impact Assessment	NWIS Equality Impact Assessment Group
07/06/2018	V1.8	Information Governance Management and Advisory Group	All Wales Information Governance Leads
26/06/2018	V1.8 for approval	Wales Information Governance Board	Advisory Board to the Minister for Health and Social Care (Welsh Government)

Approvers

This document requires the following approvals:

Date	Version	Name	Position
07/06/2018	V1.8	Information Governance Management and Advisory Group	All Wales Information Governance Leads
26/06/2018	V2	Wales Information Governance Board	Advisory Board to the Minister for Health and Social Care (Welsh Government)

Annex 2: Equality Impact Assessment

Equality Impact Assessment (EQIA) Form		
Ref no: POL/IGMAG/Email Use/v2		
Name of the policy, service, scheme or project:	Service Area	
NHS Wales Email Use Policy	Information Governance	
Preparation		
Aims and Brief Description	The policy maintains the aim of having a single Email Use Policy for all NHS Wales organisations, to promote the same principles and values across all NHS Wales organisations and it's workforce.	
Which Director is responsible for this policy/service/scheme etc	n/a All Wales policy developed in conjunction with Health Boards/Trusts	
Who is involved in undertaking the EQIA	Andrew Fletcher and EQIA Group	
Have you consulted with stakeholders in the development of this policy?	Yes. A sub group has developed this policy with a membership consisting of information governance leads and an OSSMB representative. IM&T leads and the Wales Partnership Forum have been consulted. The NHS Wales Information Governance Management and Advisory Group have approved the text of this Policy. The policy will be approved by the Wales Information Governance Board.	
Does the policy assist services or staff in meeting their most basic needs such as; Improved Health, fair recruitment etc	Yes. The policy will stand as a single email use policy for NHS Wales. As per the original all-Wales Policy, it removes many of the restrictions which were in place in some organisations, while strengthening the governance framework. A key driver during the	

	process was the need to recognise that organisations needed to trust their staff.
Who and how many (if known) may be affected by the policy?	All users of the NHS Wales Email service within the Health Boards and NHS Trusts.
What guidance have you used in the development of this service, policy etc?	The policy is based on good practice and legal obligations as set out by the Information Commissioners Office and in the legislation. The policy has also been constructed from existing agreed principles and the corporate knowledge of its stakeholders.

Equality Duties

Key	
✓	Yes
x	No
-	Neutral

The Policy/service/project or scheme aims to meet the specific duties set out in equality legislation.	Protected Characteristics										
	Race	Sex/Gender	Disability	Sexual orientation	Religion and Belief	Age	Gender reassignment	Pregnancy and Maternity	Marriage & civil Partnerships	Welsh Language	Carers
To eliminate discrimination and harassment	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Promote equality of opportunity	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Promote good relations and positive attitudes	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Encourage participation in public life	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

In relation to disability only, should the policy / service / project or scheme take account of difference, even if involves treating some individuals more favourably?	✓

Human Rights Based Approach – Issues of Dignity & Respect

The Human Rights Act contains 15 rights, all of which NHS organisations have a duty. The 7 rights that are relevant to healthcare are listed below.

Consider is the policy/service/project or scheme relevant to:	Yes	No	N/A
Article 2: The Right to Life	X		
Article 3: the right not to be tortured or treated in a inhumane or degrading way	X		
Article 5: The right to liberty	X		
Article 6: the right to a fair trial	X		
Article 8: the right to respect for private and family life	X		
Article 9: Freedom of thought, conscience and religion	X		
Article 14: prohibition of discrimination	X		

Measuring the Impact

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

Outcome report

Equality Impact Assessment: Recommendations Please list below any recommendations for action that you plan to take as a result of this impact assessment						
Recommendation		**Action Required**	**Lead Officer**	**Time-scale**	**Resource implications**	**Comments**
1	Communication of the changes	Make sure staff aware of the changes	AF	ASAP	Time	
2	Updated EQIA statement	Inclusion of reference to protected characteristics	AF	ASAP	Time	

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

Risk Assessment based on above recommendations

Reputation and compromise position			**Outcome**
The policy is clear so that all staff aware of responsibilities and therefore reputation of organisation is preserved.			A clear understanding of the policy and responsibilities of staff in the use of IT in the workplace.
Training and dissemination of policy			
The policy is clear so that all staff aware of responsibilities and therefore reputation of organisation is preserved.			
Is the policy etc lawful?	**Yes** ☒	**No** ☐	**Review date**
Does the EQIA group support the policy be adopted?	**Yes** ☒	**No** ☐	**3 years**

Signed on behalf of NWIS Equal Impact Assessment Group	S Brooks	Lead Officer	
Date:	8 May 2018	Date: 8 May 2018	

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

Risk Grading Descriptors

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

Equality & Health Impact Assessment for

All Wales Email Policy

Please read the Guidance Notes in Appendix 1 prior to commencing this Assessment

Completed : 25/10/2018

Please note:

- The completed Equality & Health Impact Assessment (EHIA) must be
  - Included as an appendix with the cover report when the strategy, policy, plan, procedure and/or service change is submitted for approval
  - Published on the PHW intranet and internet pages as part of the consultation (if applicable) and once agreed.
- Formal consultation must be undertaken, as required
- Appendices 1-3 must be deleted prior to submission for approval

Please answer all questions:-

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	N/A
2.	Name of Directorate and title of lead member of staff, including contact details	Quality Nursing and Allied Healthcare Professionals. John Lawson - Chief Risk Officer John.lawson@wales.nhs.uk 02920 104307
3.	Objectives of strategy/ policy/ plan/ procedure/ service	This policy sets out the organisational requirements for staff accessing and using Public Health Wales / NHS Wales email facilities.

4.	Evidence and background information considered. For example • population data • staff and service users data, as applicable • needs assessment • engagement and involvement findings • research • good practice guidelines • participant knowledge • list of stakeholders and how stakeholders have engaged in the development stages • comments from those involved in the designing and development stages Population pyramids are available from Public Health Wales Observatory and the 'Shaping Our Future Wellbeing' Strategy provides an overview of health need.	This has been widely consulted upon throughout NHS Wales and Public Health Wales, from Board level to operational and support staff. The Information Commissioner has been a key stakeholder in its development and the document has been through several iterations in its development, with comments and feedback being discussed and where appropriate incorporated at each stage.
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	This policy will have no direct impact upon service users. All staff are required to comply with this policy

6. EQIA / How will the strategy, policy, plan, procedure and/or service impact on people?

Questions in this section relate to the impact on people on the basis of their 'protected characteristics'. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Directorate.** Make reference to where the mitigation is included in the document, as appropriate
6.1 Age For most purposes, the main categories are: • under 18; • between 18 and 65; and • over 65	The policy and procedure protects staff and the population in general.		
6.2 Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes	This policy applies to all staff regardless of disability	None	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.3 People of different genders: Consider men, women, people undergoing gender reassignment **NB** Gender-reassignment is anyone who proposes to, starts, is going through or who has completed a process to change his or her gender with or without going through any medical procedures. Sometimes referred to as Trans or Transgender	This policy applies to all staff regardless of gender	None	
6.4 People who are married or who have a civil partner.	This policy applies to all staff regardless of marital status	None	
6.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are	This policy applies to all staff	None	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Directorate. Make reference to where the mitigation is included in the document, as appropriate
breastfeeding. They are protected for 26 weeks after having a baby whether or not they are on maternity leave.			
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	This policy applies to all staff regardless of race, colour, culture or ethnic origin	None	
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	This policy applies to all staff regardless of religious beliefs	None	
6.8 People who are attracted to other people of: • the opposite sex (heterosexual);	This policy applies to all staff regardless of sexual orientation	None	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Directorate. Make reference to where the mitigation is included in the document, as appropriate
• the same sex (lesbian or gay); • both sexes (bisexual)			
6.9 People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design Well-being Goal – A Wales of vibrant culture and thriving Welsh language	For staff who communicate using Welsh Language can identify through their line manager. This policy is available in Welsh if required	None, will be monitored on an ongoing basis	
6.10 People according to their income related group: Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health	This policy applies to all staff regardless of their income group	None	
6.11 People according to where they live: Consider people living in areas	None	None	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Directorate. Make reference to where the mitigation is included in the document, as appropriate
known to exhibit poor economic and/or health indicators, people unable to access services and facilities			
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service			

7. HIA / How will the strategy, policy, plan, procedure and/or service impact on the health and well-being of our population and help address inequalities in health?

Questions in this section relate to the impact on the overall health of individual people and on the impact on our population. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Directorate** Make reference to where the mitigation is included in the document, as appropriate
7.1 People being able to access the service offered: Consider access for those living in areas of deprivation and/or those experiencing health inequalities Well-being Goal - A more equal Wales	None	None	
7.2 People being able to improve /maintain healthy lifestyles: Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking cessation, reducing the harm caused	None	None	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Directorate Make reference to where the mitigation is included in the document, as appropriate
by alcohol and /or non-prescribed drugs plus access to services that support disease prevention (eg immunisation and vaccination, falls prevention). Also consider impact on access to supportive services including smoking cessation services, weight management services etc Well-being Goal – A healthier Wales			
7.3 People in terms of their income and employment status: Consider the impact on the availability and accessibility of work, paid/ unpaid employment, wage levels, job security, working conditions	None	None	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Directorate Make reference to where the mitigation is included in the document, as appropriate
Well-being Goal – A prosperous Wales			
7.4 People in terms of their use of the physical environment: Consider the impact on the availability and accessibility of transport, healthy food, leisure activities, green spaces; of the design of the built environment on the physical and mental health of patients, staff and visitors; on air quality, exposure to pollutants; safety of neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces Well-being Goal – A resilient Wales	None	None	
7.5 People in terms of social and community	None	None	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Directorate Make reference to where the mitigation is included in the document, as appropriate
influences on their health: Consider the impact on family organisation and roles; social support and social networks; neighbourliness and sense of belonging; social isolation; peer pressure; community identity; cultural and spiritual ethos Well-being Goal – A Wales of cohesive communities			
7.6 People in terms of macro-economic, environmental and sustainability factors: Consider the impact of government policies; gross domestic product; economic development; biological diversity; climate Well-being Goal – A globally responsible Wales	None	None	

Please answer question 8.1 following the completion of the EHIA and complete the action plan

8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service	This policy aims to ensure that all PHW staff are fully aware of their responsibilities in relation to Information Governance. This will help to ensure that the personal information of staff, service users and stakeholders in general will be processed fairly and lawfully in accordance with the requirements of the Data Protection Act and other associated legislation.

Action Plan for Mitigation / Improvement and Implementation

	Action	Lead	Timescale	Action taken by Directorate
8.2 What are the key actions identified as a result of completing the EHIA?	N/A			

	Action	Lead	Timescale	Action taken by Directorate
8.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment required? This means thinking about relevance and proportionality to the Equality Act and asking: is the impact significant enough that a more formal and full consultation is required?	No			

8.4 What are the next steps? Some suggestions:- • Decide whether the strategy policy, plan, procedure and/ service proposal: ○ continues unchanged as there are no significant negative impacts ○ adjusts to account for the negative impacts ○ continues despite potential for adverse impact or missed opportunities to advance equality (set out the justifications for doing so) ○ stops. • Have your strategy, policy, plan, procedure and/or service proposal approved • Publish your report of this impact assessment • Monitor and review	Policy to be approved	JL	ASAP	

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales	**Name of Meeting** Quality, Safety and Improvement Committee **Date of Meeting** 15 January 2019 **Agenda item:** 6.1.QSIC.150119

Interim Report of Annual Quality and Clinical Audit 2018/19

Executive lead:	Sian Bolton, Acting Executive Director, Quality, Nursing and Allied Health Professionals
Author:	Caroline Whittaker, Quality Lead, Quality, Nursing and Allied Health Professionals

Approval/Scrutiny route:	Business Executive Team: November 2018

Purpose:

The purpose of this paper is to provide the Quality, Safety and Improvement Committee with interim progress on the 2018/19 Annual Quality and Clinical Audit Plan. The Plan contains both National (UK and Welsh) Audits (externally determined) and Local audits (internally determined) including the interim findings and recommendations listed within the full document.

Recommendation:

APPROVE	CONSIDER	RECOMMEND	ADOPT	ASSURANCE
☐	☐	☐	☐	☒

The Executive is asked to:

- Receive assurance on the progress of the Annual Quality and Clinical Audit Plan for 2018/19

Link to Public Health Wales Strategic Plan Public Health Wales has an agreed strategic plan, which has identified seven strategic priorities and well-being objectives. This report contributes to the following:	
Strategic Priority/Well-being Objective	6 - Supporting the development of a sustainable health and care system focused on prevention and early intervention

Summary impact analysis	
Equality and Health Impact Assessment	An equality and health impact assessment is not required as there is no impact on policy or decisions relevant to Race, Disability and Gender duties
Risk and Assurance	Welsh Government expects that all NHS organisations in Wales participate in clinical audit and requires healthcare organisations to have a cycle of continuous quality improvement that includes clinical audit
Health and Care Standards	This report supports the Health and Care Standards for NHS Wales Theme 3 Effective Care Standard 3.3 Quality Improvement, Research and Innovation
Financial implications	None
People implications	There is no anticipated impact on the workforce of Public Health Wales NHS Trust

1 Introduction

The purpose of this paper is to provide the Quality, Safety and Improvement Committee with an interim update from the 2018/19 Annual Quality and Clinical Audit Plan ('the Plan').

The Plan contains both National UK and Welsh audits (externally determined) and Local audits (internally determined) with the main findings and recommendations listed within the document.

2 Background

The aim of the plan is to ensure that all quality and clinical audit data, for a given financial year, is collated in one document and to make certain that actions resulting from recommendations are completed in a timely manner.

3 Description

The audits detailed in the attached report include two externally generated National (UK) and 12 Local audits (generated by the organisation).

The two National (UK) Audits are on track to deliver, as and when the data is requested nationally.

Three out of the 12 local audits have been completed.

A further three have had the start date rescheduled due to service demands, with two are still expected to be completed on time. The outcome of one local audit will not be delivered within the original timeframe identified.

3.1 Well-being of Future Generations (Wales) Act 2015

The report contributes to Goal 3 "Support the NHS to deliver high quality, equitable and sustainable services" This below information follows the five ways of working, as defined within the sustainable development principle in the Act, in the following ways:

An annual audit plan is conducted to support services to engage in activities to continuously improve by evaluating, developing and implementing innovative ways of working. The plan demonstrates the organisations commitment of continuous improvement

Where possible Public Health Wales seeks to validate the efficacy of its practice and to make continuous improvements. The annual audit plan is integral to supporting this work.

The audit plan impacts a number of the wellbeing goals, including "A Resilient Wales" and "A More Equal Wales"

The annual audit plan contains work across UK and Wales and includes other NHS bodies working together with Public Health Wales NHS Trust to provide the best outcomes

The audit plan is an important aspect of the organisation's governance arrangements, and, as such, helps the organisation to improve the quality and safeguard the high standards of the services provided by Public Health Wales

4 Recommendation(s)

The Quality, Safety and Improvement Committee is asked to gain assurance on progress against the Annual Quality and Clinical Audit Plan 2018/19.

Interim Report: 2018/19 Annual Quality and Clinical Audit Plan

November 2018

Index

Page

Section 1: National Audits UK / Wales (externally generated) 7

List of audits, interim outcomes and recommendations

Section 2: Local Audits 8-10

List of audits, interim outcomes and recommendations

Section 1: National Audits UK / Wales (2018/19)

	National Audits (UK) 2018/19	
	Abbreviations	
	BSW – Bowel Screening Wales	**NBHSW** – New Born Hearing Services Wales
	BTW – Breast Test Wales	**WAAASP** – Wales Abdominal Aortic Aneurysm Screening Programme Wales
	CSW – Cervical Screening Wales	**AHP –** Allied Health Professionals
	DESW – Diabetic Eye Screening Wales	**QNAHP –** Quality Nursing and Allied Health Professionals

No.	Directorate	Division	Lead	Audit Title	Scope/Aim	Start Date	End Date	Interim Update
1	Public Health Services	BTW	Director of Screening	Association of Breast Surgery annual audit of screening detected breast cancers	To examine NHS Breast Screening Programme surgical activity. Public Health Wales is requested to provide data to support the National Cancer Data UK programme (ongoing annual audit)	Apr 18	Mar 19	This is an ongoing audit and data is submitted upon request
2	Public Health Services	BSW	Director of Screening	The National Bowel Cancer Audit (NBOCAP) (ongoing annual audit)	Public Health Wales is requested to provide data to assist the National UK programme. PHW has the national cancer data and analysis expertise and support the Wales Cancer Network (hosted by PHW) and by extension the health boards (who have a duty to participate) with advice and some data and interpretation where necessary.	Apr 18	Mar 18	This is an ongoing audit and data is submitted upon request

Section 2: Locally Generated Audits (2018/19)

	Local Audits 2018/19							
	Abbreviations							
	BSW – Bowel Screening Wales				**NBHSW** – New Born Hearing Services Wales			
	BTW – Breast Test Wales				**WAAASP** – Wales Abdominal Aortic Aneurysm Screening Programme Wales			
	CSW – Cervical Screening Wales				**AHP –** Allied Health Professionals			
	DESW – Diabetic Eye Screening Wales				**QNAHP –** Quality Nursing and Allied Health Professionals			
No.	**Directorate**	**Division**	**Lead**	**Audit Title**	**Scope/Aim**	**Start Date**	**End Date**	**Interim Update**
1	Public Health Services	Microbiology (Mid and West)	Consultant Microbiologist and Clinical Service Lead	Clinical report authorisation for Hywel Dda UHB	To develop audit methodologies to assess variability of approach to authorisation	Sept 18	Mar 19	Two rounds of audits were undertaken with all authorisers, with an amendment following the first cycle. Further learning cycles are to be undertaken, with a view to further standardise reporting practice. On track to be

								completed on time.
2	Public Health Services	Microbiology (CRU)	Consultant Clinical Scientist and Head of Cryptosporidium Unit	Laboratory practice for diagnosis of Cryptosporidium in the UK	To understand variation in Cryptosporidium ascertainment and reporting; to support a research project into household transmission	Sept 18	Mar 19	Postponed due to work priorities being realigned. Start date now November 2018. On track to be completed on time.
3	Public Health Services	DESW	Head of Programme, DESW	DESW audit of patient record	To review the quality of patient records within the DESW clinical system	Nov 18	Nov 18	Postponed due to service pressures. Start date now January 2019
4	Public Health Services	BTW	Head of Programme, BTW	Annual record keeping audit	To review the quality of the nursing record keeping across the three BTW centres, identify issues and make improvements based on the finding	Nov 18	Mar 19	Senior breast care nurses have been given an objective to audit 30 records in respective centres, between November 2018 and January 2019. The results will be analysed in January 2019. On track to be completed on time.
5	Public Health Services	BSW	Head of Programme, BSW	BSW – Central Administration Audit	Listen to 10 calls made to helpline for each team member (10x10=100) Check 10 participant records on each suspend code (18x10=180)	Oct 18	Mar 19	Postponed. This audit was carried forward from a previous year and had not progressed due to service demands. Whilst the start time has been delayed, the work is anticipated to be

								completed on time
6	Public Health Services	WAAASP	Head of Programme, WAASP	2nd cycle of elective vascular network Quality Assurance Review	To monitor Elective Vascular Networks (EVN) compliance with WAAASP and Vascular Society for Great Britain and Ireland (VSGBI) standards	Jun 18	Feb 19	On track to be completed on time.
7	Public Health Services	CSW	Head of Programme, CSW	Abnormal predicted value v Positive predictive value	To review the performance of individual Pathologists; is discussed at the Pathologist group meetings across Wales	Dec 17	Mar 19	This is part of a continual internal review process cycle and will continue as part of the normal process of ensuring quality. These are produced quarterly and reports back to individuals involved, who also receive peer stats anonymously for comparison. A copy goes to the Laboratory Clinical Lead for Magden Park Lab and to the CSW programme QA Laboratory Advisor. Each round is reviewed and flagged with an individual pathologist's clinical manager if any action is required. This forms part of

								the Cytology Laboratory's internal QA processes which are assessed by UKAS as part of our ISO15189 laboratory accreditation
8	Public Health Services	CSW	Head of Programme, CSW	Zed Scan Service Evaluation	Adjunctive colposcopy technology evaluation. Possibly to be worked up as Research project in view of NICE recommendations 9	Jul/Aug 18	Aug 19	This work has now been confirmed as a Research study and will include the identification of quality outcomes. ZedScan is being developed into a feasibility study and a grant application for research at 3 clinic sites is underway. On track to be completed on time.
9	Public Health Services	CSW	Head of Programme, CSW	Dysis Service Evaluation	Adjunctive colposcopy technology evaluation of 3 year follow up data	2015 (over 3 years)	Dec 18	This audit has been completed. The paper will included in the end of year Quality and Clinical Audit Plan report.
10	Public Health Services	CSW	Head of Programme, CSW	Audit of Human papillomavirus (HPV) Vaccinated cohort follow up study	A follow up study with the vaccinated cohort who received the Human papillomavirus (HPV)	Aug 18	Aug 19	Ongoing capture of statistics. On track to be completed on time.

11	Public Health Services	CSW	Head of Programme, CSW	Cytology reporting bias amongst Cytoscreeners when HPV test result is already know	To establish if cytology is over called when HPV positive result is known. Training to be given and re-audit	Dec 17	Dec 18	This audit has been completed and Has been reported to the Cervical Screening Audit and Research Group. The findings were not statistically significant so there is no further action to be taken.
12	Public Health Services	NBHSW	Head of Programme, NBHSW	Quality Assurance of Newborn hearing screening diagnostic assessment and early support	To audit health board provision of assessment, early support for babies referred from screening against standards defined in Children's Audiology V2	Apr 18	Oct 18	Completed. Each Health Board has received a summary of their individual performance. NBHSW will receive feedback on planned actions via Regional meeting structures.

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales	**Name of Meeting** Quality, Safety and Improvement Committee **Date of Meeting** 15 January 2019 **Agenda item:** 6.1.2.QSIC.150119

Putting Things Right
Quarter 2 Report
(1 July 2018 – 30 September 2018)

Executive lead:	Sian Bolton, Acting Executive Director, Quality, Nursing and Allied Health Professionals
Author:	Gay Reynolds, Governance and General Manager, Quality, Nursing and Allied Health Professionals

Approval/Scrutiny route:	Business Executive Team The Health and Safety and Information Governance sections have been reviewed by the leads for these functions.

Purpose

This report provides an aggregated analysis of concerns and compliments and also outlines instances of lessons learnt within the Trust that underline our commitment to continuous improvement; providing assurance of the effectiveness of the management of concerns (incidents, complaints and claims).

Recommendation:

APPROVE	CONSIDER	RECOMMEND	ADOPT	ASSURANCE
☐	☐	☐	☐	☒

The Committee is asked to:

- **Assurance**

Link to Public Health Wales Strategic Plan Public Health Wales has an agreed strategic plan, which has identified seven strategic priorities and well-being objectives. This report contributes to the following: **All**	
Strategic Priority/Well-being Objective	Choose an item.
Strategic Priority/Well-being Objective	Choose an item.
Strategic Priority/Well-being Objective	Choose an item.

Summary impact analysis	
Equality and Health Impact Assessment	No decision is required
Risk and Assurance	
Health and Care Standards	This report supports and/or takes into account the Health and Care Standards for NHS Wales Quality Themes Governance, Leadership and Accountability Choose an item. Choose an item.
Financial implications	The financial implications relate to claims and redress.
People implications	There is any no potential impact on workforce

1. Purpose / situation

Public Health Wales is committed to identifying, reporting and investigating concerns (incidents, complaints and claim) to ensure that learning is shared and actions are taken to reduce the risk of recurrence.

This report is presented to the Quality, Safety and Improvement Committee on a quarterly basis to provide an overview of trends, and analysis of concerns. The report demonstrates the organisation's commitment to continuous improvement in relation to minimising recurrence.

2. Background

Where possible Public Health Wales seeks to prevent the occurrence of concerns by taking a proactive approach to the reporting and management of risk to ensure safe services, functions and programmes are delivered, through the promotion of a positive reporting and investigation culture via the Datix system.

The proactive analysis of the data being reported on Datix helps to identify early warning signs of failure and helps manage and identify appropriate risks. This provides assurance to the Executive Team and Quality, Safety and Improvement Committee regarding the governance arrangements.

3. Assessment

3.1 Incidents

During quarter 2 a total of 406 incidents were reported which is an increase compared to previous quarters.

The increase relates mainly to Cervical Screening Wales and the number of out dated vials received by the processing laboratory. Each out dated vial received was initially reported as a separate incident. However, once the scale of the problem was understood a decision was taken to report 1 master incident and to link those incidents that had already been reported to it. This incident has been reported to the Welsh Government as a 'no surprise' and the investigation is ongoing. The Quality, Safety and Improvement Committee will be provided with a detailed report when it meets in January 2019

Of the 406 incidents reported during the period, 380 were graded as no harm demonstrating the overall harm profile for the organisation as being low.

3.2 External Reporting

RIDDOR Report

Two RIDDOR report was submitted to the Health and Safety Executive and further details are annotated on pages 5 and 6 of the PTR report. As part of the organisation's assurance process the report will be reviewed by the People and Organisational Development Committee and Health and Safety Group.

Serious Incident Submitted to Welsh Government

Diabetic Eye Screening Wales

Two clinic lists were sent out to a small number of individuals named on the list, owing to an error in the printing and despatching of letters to participants.

The matter has been referred to the Information Commissioner's Office who has indicated that no further action is required. Diabetic Eye Screening Wales will provide the Quality, Safety and Improvement Committee with a detailed report.

3.3 Complaints

A total of 25 formal complaints were received during the quarter. The number of complaints received by Diabetic Eye Screening Wales has increased since April 2018. This may be due to the improvement work being undertaken by the programme, specifically in relation to the complaints process.

The overall performance for acknowledging and responding to concerns for this period is:

- Acknowledgement within 2 working days: 92% (reasons?)
- Responding within 30 working days: 64% (reasons?)

An analysis of complaints received since the 1 April 2018 is being progressed to understand in more detail the reasons for the delays and identify any areas where improvements can be made.

3.4 Claims

The organisation has 13 open claims (confirmed and potential), 12 of which relate to clinical negligence, 1 relate to personal injury. There are also 3 redress cases being progressed. The total aggregated value for confirmed and potential claims is £4,496,224.

3.5 Compliments

A total of 720 compliments were captured and reported during the quarter. The ratio of compliments to complaints is for the year is 20:1.

3.6 Well-being of Future Generations (Wales) Act 2015

No decision is required.

4. Recommendation

The Quality, Safety and Improvement Committee is asked to consider and note the paper.

Putting Things Right
Quarter 2 Report
(1 June 2018 – 30 September 2018)

1. Quarter 2 reported incidents

Public Health Wales is committed to a high standard of reporting, to learn and change practice when things go wrong.

A total of 406 incidents were reported during quarter 2 which is an increase of 92 compared to the previous quarter. The table below details the number of incidents reported compared to the last 3 quarters:

Organisational Incidents	Q3	Q4	Q1	Q2
Total number of incidents reported	325	297	314	406

Table 1: Incident trends by quarter

The chart below compares the number of quarter 2 incidents reported for each year since the implementation of Datix in April 2013. The chart indicates that there has been an increase in the number of incidents reported. The increase in incidents relate mainly to Screening Services and in particular Cervical Screening Wales and the number of out of date vials received by the processing laboratory. Initially each out dated vial was reported as a separate incident. However, once the scale of the problem was understood a decision was taken to report one master incident and to link those incidents that had already been reported to it. The incident has been reported to Welsh Government as a 'no surprise' and Cervical Screening will provide a detailed report to the Quality, Safety and Improvement Committee in January 2019.

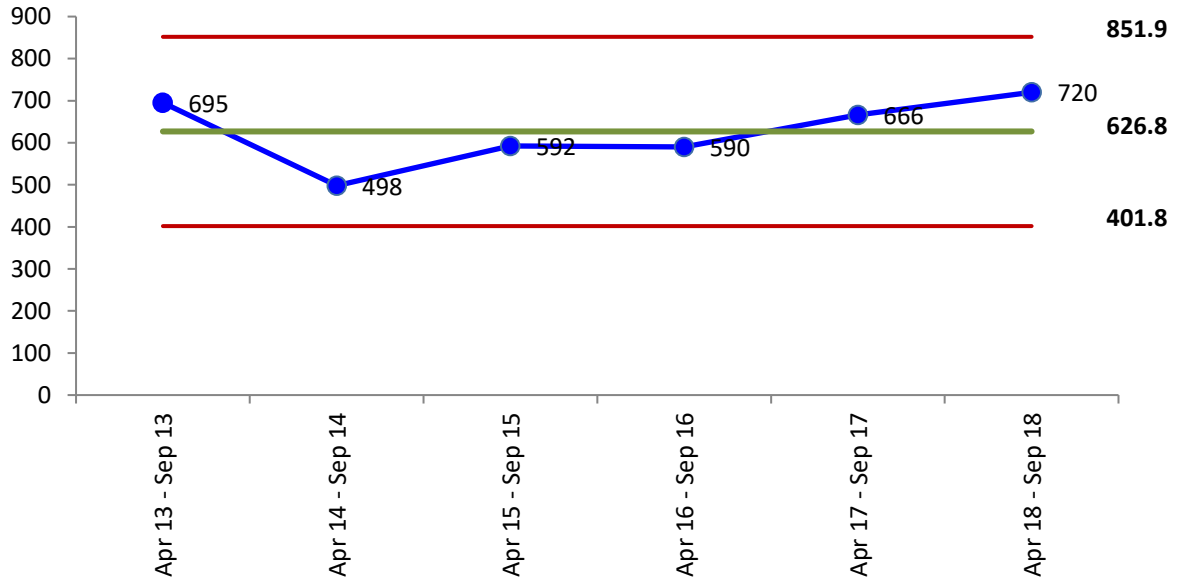


Chart 1: Comparison of the incidents report from 1 April 2013 –30 September 18

The aim is to ensure all incidents have been reviewed and investigated in accordance with the organisation's Incident Reporting Procedure. The table

below details the % of incidents reported / reviewed / closed within the target timescales:

Performance Indicator	Q3 (Oct-Dec 2017)	Q4 (Jan – Mar 18)	Q1 (Apr – Jun 18)	Q2 (Jul – Sep 18)
The % of quarter 2 incidents reported within the 2 day timescale	59%	64%	60%	52%
% of quarter 2incidents reviewed within 2 working days from reporting	39%	71%	64%	60%
% of quarter 2incidents closed within 30 working days	64%	62%	89%	61%

Table 2: % of incidents reported / reviewed / closed within the timescales

The main reasons indicated on Datix for not reporting incidents within 2 working days are as follows:

- Delay in receiving first alert from Health Boards
- Staff shortages
- Laboratory report awaited
- Incident notified from external source after 2 day reporting timescales
- Incident not immediately realised

Some of the reasons detailed for the delays in closing incidents outside of the 30 working day timeframe are as follows:

- Work pressures
- Required further investigation
- Delay with final approval
- The investigation of other incidents were prioritised leading to delays in closure
- Team capacity

During the period 22 incidents reports were rejected for the following reasons:

- Duplication
- Wrong Datix module completed
- Other reasons

1.1 Risk grading of incidents

Incidents are assigned a risk rating based on the severity and likelihood of the incident happing again and to minimise the reoccurrence.

A total of 349 incidents were graded for risk as detailed below:

214	Low
103	Mod

31	Sign
1	Extreme

Table 3: incidents graded for risk

Datix ID: 11765 - The extreme risk relates to an environmental contamination issue observed in the Mycology processing laboratory for study fungi and the Category 3 laboratory which resulted in the processing of patient samples being compromised. As a result of the incident the following actions were taken:

- Operations from the Containment level 3 facility were transferred to the other containment level 3 and the conversion procedure from Containment level 2 to Containment level 3 was implemented
- A deep clean of containment level 3 and the Mycology Laboratory was undertaken by Cardiff and Vale
- The storage of inoculated plates for further testing was reviewed.

The remaining 57 incidents that have not been risk rated remain open on Datix at the time of drafting this report. As this is a mandatory field within Datix the risk rating will need to be completed before the incident can be closed.

1.2 Incident severity

Of the 406 incidents reported during the period, 380 were graded as no harm or no harm at the time of reporting demonstrating the overall harm profile for the organisation as Low.

188	No Harm at time of reporting the incident
192	None (No harm caused)
19	Low (minimal harm caused)
6	Mod (short term harm caused)
1	Severe (permanent or long term harm caused)

Table 4: Incidents by severity

Datix ID: 12051 - The incident graded as severe (permanent or long term harm caused) relates to a Bowel Screening Wales (BSW) participant who was placed on routine recall in instead of intermediate surveillance and has subsequently been diagnosed with symptomatic adenocarcinoma.

1.3 Quarter Trend Analysis

The table below compares the number of incidents reported for the last 4 quarters by type:

Incidents by Type	**Q3**	**Q4**	**Q1**	**Q2**

Patient Safety	149	125	144	244
Health and Safety	44	49	47	46
Information Governance	27	31	21	31
Operational / Organisational	97	82	93	81
Safeguarding	8	10	9	4

Table 5: Incident trends by type for quarters 1, 2 and 3

The highest percentage of incident type reported continues to be Patient/Client. The control charts detailed below provides a trend analysis from 1 April 2018 – 30 September 2018 compared to the same period for previous years.

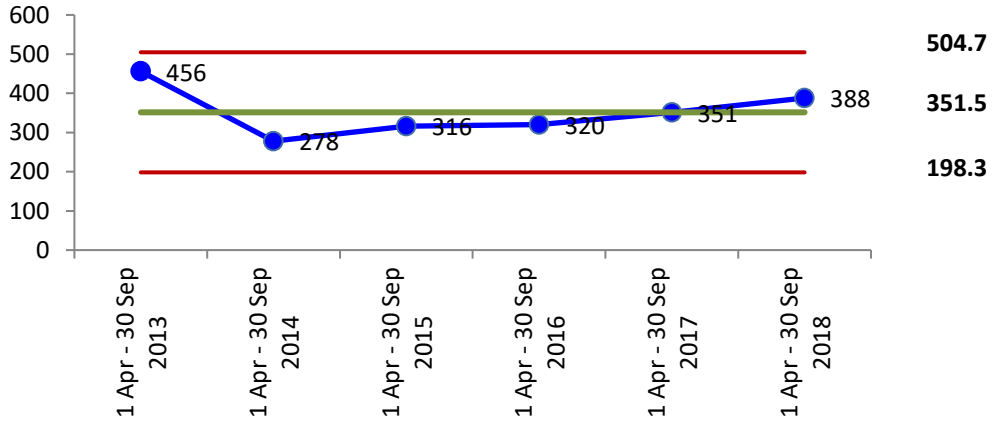


Chart 2: Number of Patient Safety incidents received from 1 Apr 2018 – 30 September 2018 compared to the same period for the previous years

A review of the number of patients and clients suggests that for the period 01 April 2018– 31 October compared to the same period in previous years indicates that there has been an increase in the number of the number of patient and client incidents reported. The increase relates mainly to Cervical Screening Wales and the number of out dated vials received by the processing laboratory.

A further break down of incidents by type is detailed within appendix A.

1.5 Incidents reported externally:

RIDDOR Report (FBC597BF9C) (Datix ID: 11968)

A member of staff tripped and fell in a car park. The member of staff was treated in the Accident and Emergency Department for a fractured elbow and returned to work.

RIDDOR Report (04727394D0) (Datix ID: 11825)

Exposure by aerolisation to Neisseria Meningitidis Due to the severity of the disease and the risks associated with generating aerosols, any manipulation of suspected isolates should always be undertaken in a microbiological safety cabinet until it has been ruled out. An e-alert has been sent to all laboratories to remind them of this.

RIDDOR reports are shared with the Public Health Wales Health and Safety Group and People and Organisational Development Committee as part of the organisation's assurance process.

Serious Incident (SI) Notification to Welsh Government: WG Ref: 347927SEPTEMBER18- Diabetic Eye Screening Wales (Originally submitted as a 'No Surprise'

Owing to an error in the printing and despatching of letters to participants two clinic lists were sent out to a small number of individuals named on the list. The clinic lists would have contained the following personal data from the individuals listed:

- Full name
- NHS number
- Date of Birth
- Full postal address
- Contact telephone number (mobile or landline)

The matter has been referred to the Information Commissioner's Office who has indicated that no further action is required. Diabetic Eye Screening Wales will provide the Quality, Safety and Improvement Committee with a detailed report in January 2019.

No Surprise Notification to Welsh Government - Bowel Screening Wales (WG Ref: 211)

An incident has been identified where participants did not receive appropriate management as a result of incomplete pathways on Bowel Screening Information Management System (BSIMS). Initially 24 participants were identified as not being managed appropriately. This group has now received appropriate management and no apparent harm was caused.

An additional group of over 400 participants who were not invited in the 2 years prior to their 75th birthday has also been identified. The investigation into this cohort is ongoing and the Bowel Screening Wales Clinical Quality Assurance Group has been asked for a decision in relation to the most appropriate management for this group of participants.

1.6 Reported errors

The definition of an error (non incident) are events that have had no adverse effect on patients or staff (e.g. logging of errors corrected during the processing of a sample and before reporting) or for incidents where the event is the result of a primary care or a health board incident.

A total of 134 errors were reported during quarter 2 which is a decrease on the compared to the previous 3 quarter:

	Q3	Q4	Q1	Q2
Errors	161	160	152	134

Table 6: Reported error for the last 4 quarters

The errors have been broken down further by Division to compare the number of errors reported during quarters 1 and 2 since the implementation of Datix in April 2013:

Screening	77
Microbiology	57

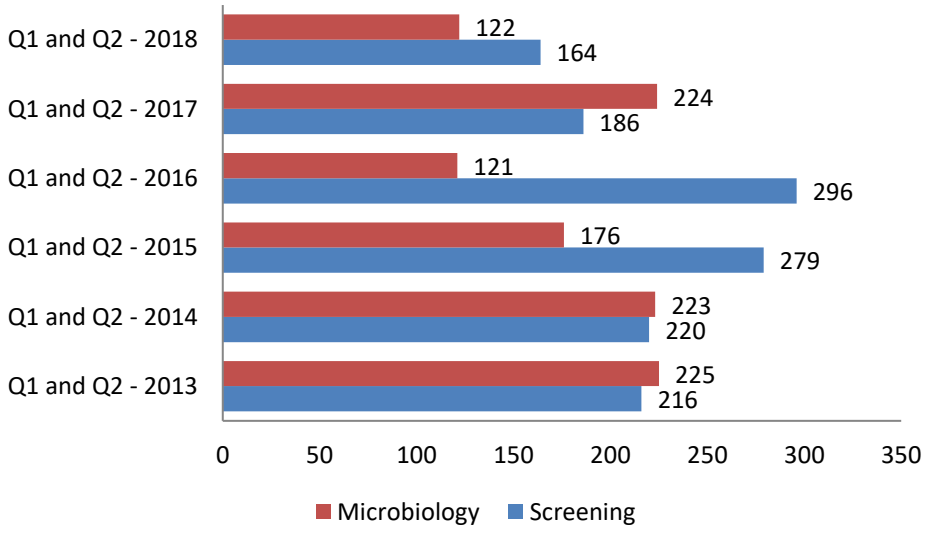


Chart 3: Error by Division

It should also be noted that in some cases the numbers of errors reported may seem high, but when compared to the numbers of samples processed the % of errors is very low. This is confirmed by the number of Cervical Screening Wales samples processed to the nearest 1000, which was 40,000 during quarter 2, compared to the % sample taker errors which is 0.19%. The Microbiology Division process 364,240 samples during the period and the number of laboratory errors relates to 0.015% of samples processed.

2 Performance against tier 1 targets

Performance Target	**Target**	**Q3** (Oct – Dec 17)	**Q4** (Jan – Mar 18)	**Q1** (Apr – Jun 18)	**Q2** (Apr – Sep 18)
Number of formal/written concerns/complaints received	N/A	12	14	11	25
Percentage of written concerns/complaints acknowledged within the 2 day target timescales	100%	83%	71%	100%	92%
Percentage of written concerns/complaints responded to within the 30 working day target timescales	100%	58%%	86%	64%	64%
Number of Serious Untoward Incidents (SUIs) reported	N/A	0	2	0	1
Percentage of SUI investigations completed within target timescales	100%	0	0	0	100%

Table 7: Tier one targets

Holding letters were sent where the 30 working day responses target was breached. The reasons for the delays were due to:

- Interval cancer review taking longer than 30 days.
- Prolonged investigation due to resource issues
- Delays in completing investigations
- Quality assurance taking longer than 10 days.

An analysis of complaints received since the 1 April 2018 is being progressed to understand in more detail the reasons for the delays and identify any areas where improvements can be made.

The complaints have also been broken down by Division:

Division	**Number of Complaints**
Screening	21
Health Protection	1
Microbiology	3

Table 8: Number of complaints by Programme / Service area

The chart below depicts the number of formal complaints received from 1 April 2018 - 30 September 2018 compared to the same period for the previous years. The chart indicates that the number of complaints received has increased compared to same period in previous years.

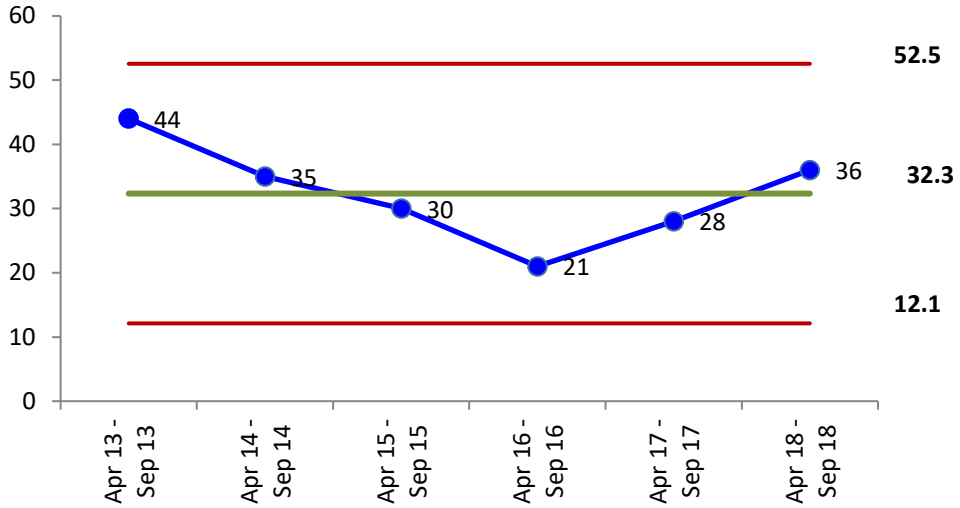


Chart 4: Formal complaints received quarter 1 and 2 from 2013 - 2018

Further analysis indicates number of Diabetic Eye Screening Wales complaints have increased since the start of the calendar year. This may be due to the improvement work being undertaken within the programme and in particular the process for dealing with complaints.

In addition to the above, 17 'on the spot' complaints were reported during quarter 2 for the following categories:

- Appointment process
- Clinical Assessment (including diagnosis, scans, tests, assessments)
- Communication issue
- Treatment / procedure
- Attitude/behaviour of staff
- Consent
- Delays / cancellation
- Documentation
- Welsh Language
- Service Provision

2.2 Lessons learnt:

Programme	Main area of complaint	Lesson Learnt/ what has been changed as a result
Diabetic Eye Screening Wales	Cancellation of appointments on more than one occasion	All future decisions relating to cancelling clinics will be taken centrally, to ensure minimal detrimental impact on patients when appointments are cancelled.
Microbiology	Concern regarding the implementation of the	The importance of following the implementation guidance which

	Cardiff and Vale University Health Board Specimen Labelling Policy in Microbiology and the delay to a child's urine result.	specifies that samples from patients under the age of 5 years should not be rejected has been highlighted to all laboratory staff. In addition all rejected samples are being manually authorised by medical staff.

Table 9: Lessons Learnt

3. Claims

Claims are reported via Datix and managed with advice and support from Legal and Risk Services. All claims are managed and analysed to ensure that lessons are learnt in order to reduce risks of reoccurrence and improve services.

Period covered: 01 April 2018 – 30 June 2018

	Quarter 2
Current number of open claims (confirmed and potential)	14
Current number of redress cases	3
New claims received in Quarter	1
Number of claims closed in Quarter	3
New redress cases received in Quarter	2
Number of redress cases closed in Quarter	0
Number of Settled Claims in this reporting period	2
Aggregate value of **confirmed** claims in progress	£4,496,224
Aggregate value of **potential** claims	£0.00
Aggregate value of **confirmed and potential** claims	£4,496,224
Anticipated Public Health Wales Liability in respect of confirmed claims	£200,000

Table 10: Claims profile

4. Compliments

For the period 1 April 2018 –30 September 2018, a total of 720 compliments were received. The ratio of compliments to complaints for this period is 20:1.

- Positive attitude / behaviour of staff
- Positive comments: service related
- Positive comments: waiting times
- Professionalism of staff

- Timeliness of results
- Flexibility of appointment

For the period 1 April 2018 – 30 September 2018 the ratio of compliments to complaints is	**Compliments**	**Complaints**
	20 	**1** 

Chart 5: Compliments / concerns ratio

Appendix 1

Part 1 – Patient & Client (Clinical)

For the period 1 July 2018 – 30 September 2018 the total number of patient and client incidents reported on the Datix system was 244. The information has been broken down further by Divisions and category:

Division	Number of incidents
Screening	156
Microbiology	87
Health Improvement	1
Total	**244**

Table 11: Incidents by Division

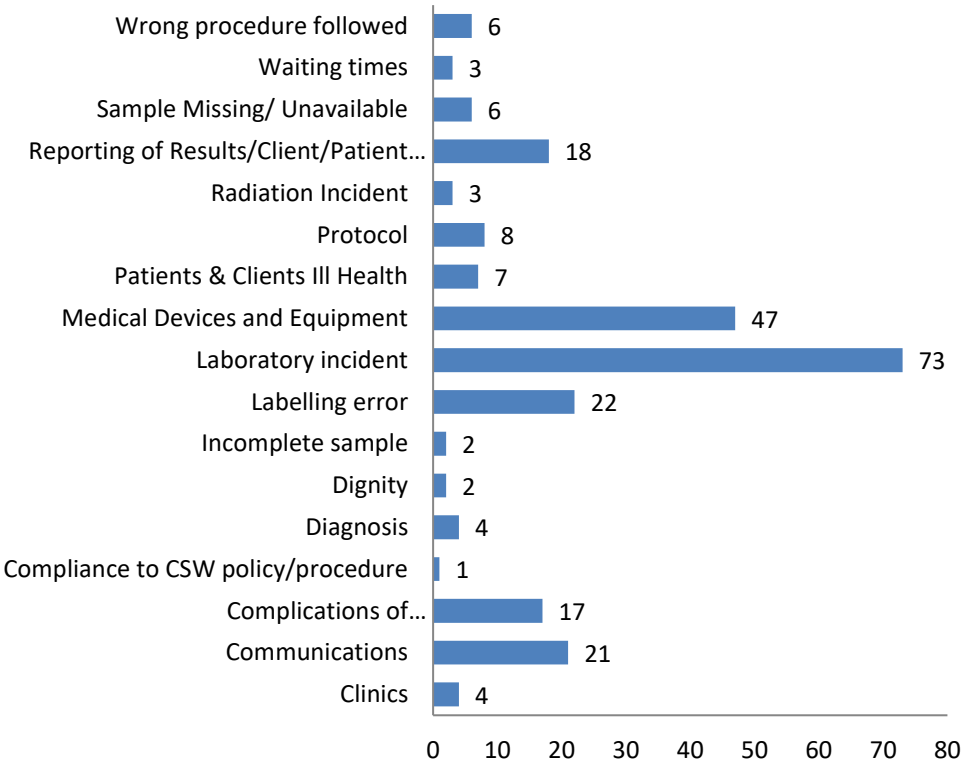


Chart 6: Quarter 2 patient and client incidents by category

Laboratory incidents continue to be the highest reported *patient and client* category and have therefore been broken down further by sub category. Analysis of the data indicates that the sub categories *laboratory lost / delayed specimens* and *laboratory protocol/procedure non compliance* are the highest reported incidents for this period.

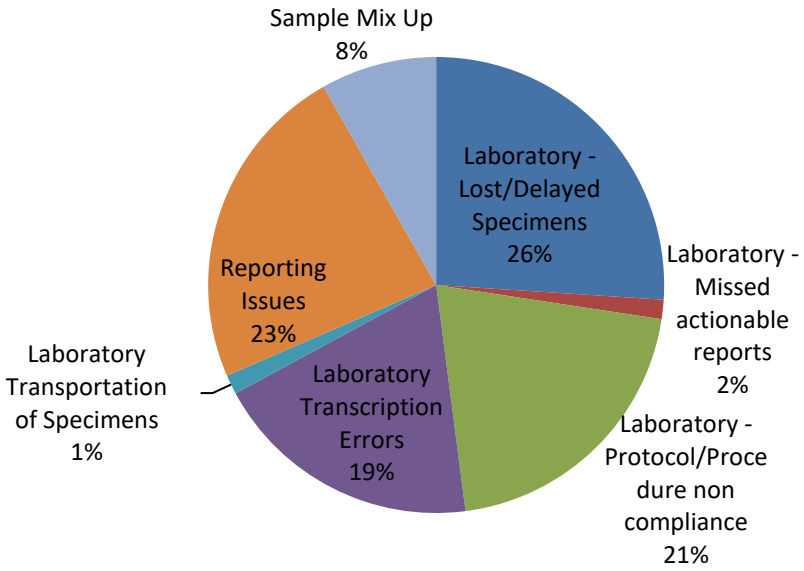


Chart 7: Laboratory incident by sub category

Part 2 - Health and Safety Incident Profile

For the period 1 June 2018 – 30 September 2018 the total number of health and safety incidents reported was 46. The health and safety section of this report will be analysed and reviewed at the Health and Safety Group.

The incidents have been broken down by Division and category:

Division	H&S
Screening	11
Microbiology	30
Workforce and OD	1
Estates and Health and Safety	1
1000 Lives	3
Total	**46**

Table 12: Incidents by Division

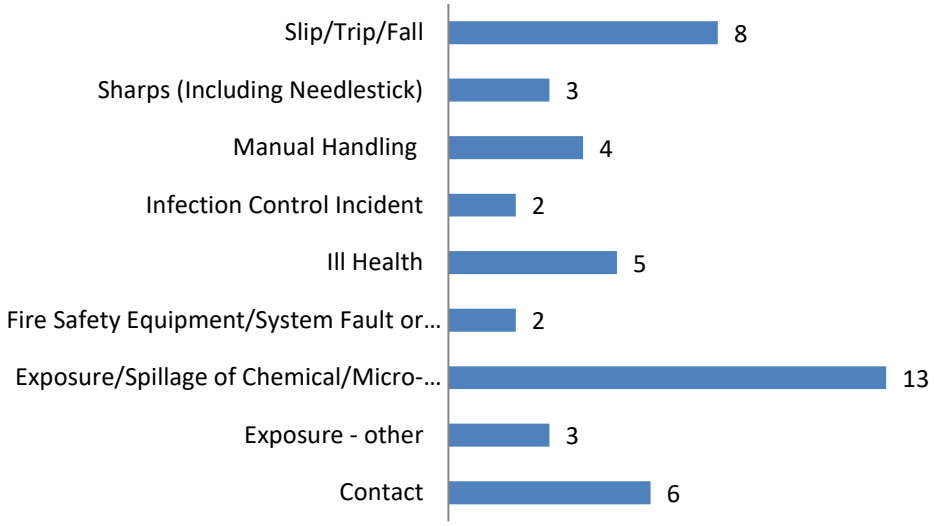


Chart 8: Health and safety Incidents by category

An analysis of the data for health and safety incidents suggests *exposure / spillage of chemical / microorganism* remains the highest reported health and safety incident for this quarter and has therefore been broken down further by sub-category.

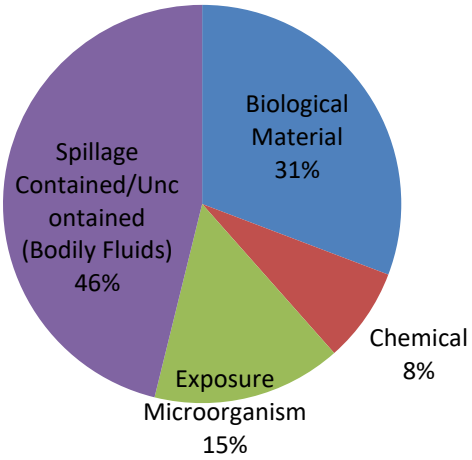


Chart 9: Exposure / spillage of chemical / microorganism by sub-category

Part 3 – Information Governance (IG) Incident Profile

For the period 1 July 2018 – 30 September 2018 the total number of information governance incidents reported is 31**.** The information has been broken down further by Division and category:

Division	
Screening	25
Estates, Health and Safety	1
Health Protection	1
Microbiology	2
Local Public Health Team	2
Total	**31**

Table 13: Incidents by Division

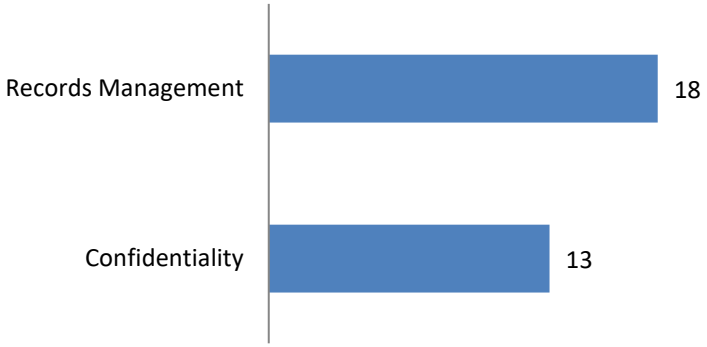


Chart 13: Information governance incidents by category

The chart above indicates that *records management* incidents continue to the highest reported Information Governance incidents and have therefore been broken down by sub category in the chart below:

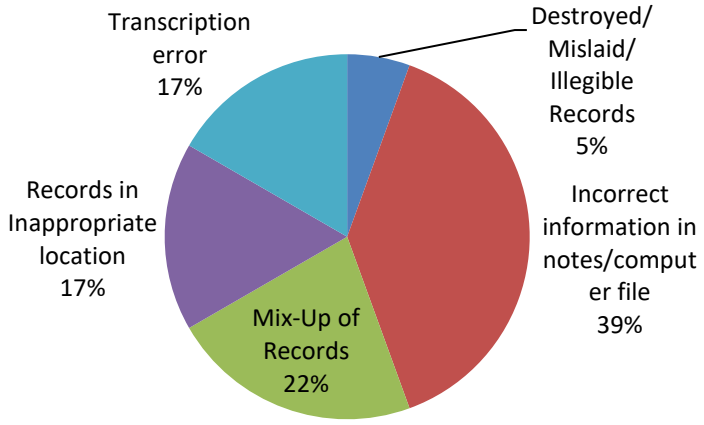


Chart 11: Records management incidents by sub-category**.**

Part 4 – Operational and Organisational Incident Profile

For the period 1 July 2018 – 30 September 2018 the total number of operational and organisational incidents reported was 81. The information has been broken down by Division and category:

Division	Op/Org
Screening	42
Microbiology	37
Health Protection	1
Workforce	1
Total	**81**

Table 14: Incidents by Division

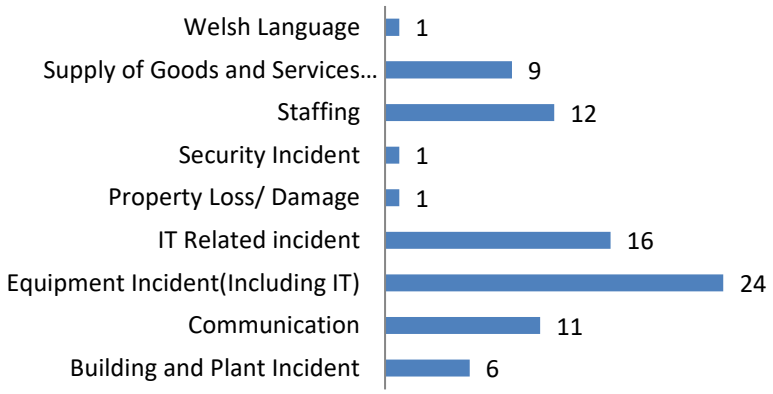


Chart 15: Operational and organisational incidents by category

The highest reported Operational and Organisational type incidents by category for the period relates to *equipment incident* (including IT). This category has been broken down further by sub category in the chart below

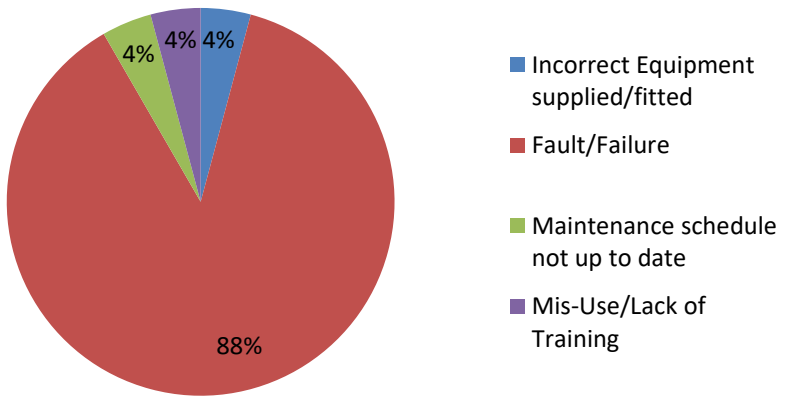


Chart 13: Equipment incident (including IT) by sub category

Part - 5 Safeguarding Incident Profile

A total of 4 safeguarding incidents were record during quarter 2 and are broken down by Division and category:

Division	Safeguarding
Quality Nursing	1
Health Improvement	2
Screening	1
Total	**4**

Table 15: Reported patient and client incidents by Division

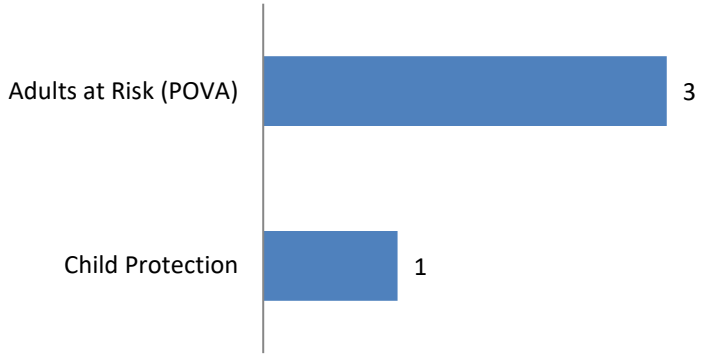


Chart 14: Safeguarding incidents by sub category

The highest reported Safeguarding incidents for the period relate to Adults at Risk (POVA) and these have been broken down further by sub category in the chart detailed below:

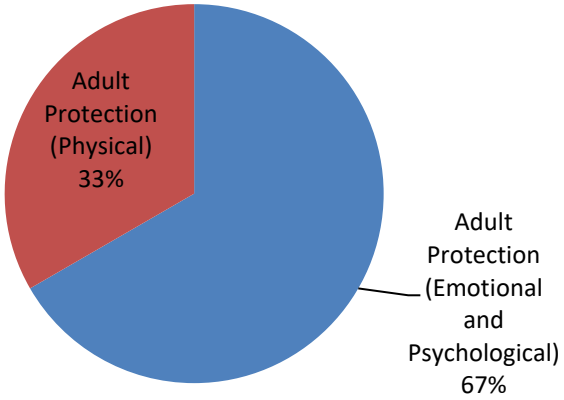


Chart 15: Adults at Risk (POVA) by sub category

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales	**Name of Meeting** Quality, Safety and Improvement Committee **Date of Meeting** 15 January 2019 **Agenda item:** *6.2.1.QSIC.15.01.19*

Public Health Wales Information Governance Performance Report

Executive lead:	Sian Bolton, Acting Executive Director of Quality, Nursing and Allied Health Professionals
Author:	John Lawson, Chief Risk Officer

Approval/Scrutiny route:	Executive Team

Purpose
Receive the new format Information Governance Performance Report, note the contents and approve the format

Recommendation:				
APPROVE ☒	CONSIDER ☒	RECOMMEND ☐	ADOPT ☐	ASSURANCE ☒

The Committee is asked to:

- **Receive assurance** that the Information Governance Management System is working effectively.
- **Approve** the new format for the report.

Link to Public Health Wales Strategic Plan Public Health Wales has an agreed strategic plan, which has identified seven strategic priorities. This report contributes to all Strategic Priorities	
Strategic Priority	Choose an item.
Strategic Priority	Choose an item.

Summary impact analysis	
Equality and Health Impact Assessment	This report has been presented many times previously but is now presented in a new format. There is no significant change in content and therefore no Equality and Health Impact Assessment is required.
Risk and Assurance	This report will provide assurance that the Information Governance Management System is operating effectively. The performance report includes the latest version of the Information Governance Risk Register.
Health and Care Standards	This report supports and/or takes into account the Health and Care Standards for NHS Wales Quality Themes Governance, Leadership and Accountability
Financial implications	No financial implications.
People implications	No people implications.

1. Purpose / situation

The purpose of this paper is to introduce the Information Governance Performance Report.

2. Background

In order to discharge its responsibilities with regards to ensuring the security and appropriate use of personal information, together with being able to demonstrate compliance with data protection legislation, Public Health Wales maintains an Information Governance Management System. As well as being able to report that the organisation is compliant or otherwise, it is essential to be able to report on whether the system is achieving its intended purpose or not. The Information Governance Performance Report fulfils this requirement.

The report also includes the Information Governance Risk Register, which includes the high level, organisation wide risks in the areas of Information Governance and Information Security.

3. Description/Assessment

The report is presented for the first time in a new format, which is intended to present the salient points graphically.

The areas currently reported on are as follows:

1. Freedom of Information Act compliance

   This section indicates compliance or otherwise with the requirements for releasing information under the Freedom of Information Act 2000

2. Data Protection Act compliance

   This section reports compliance or otherwise with the requirements of the General Data Protection Regulation 2016 (GDPR), in relation to the right of access of data subjects to the information which we hold about them. This may be service users or staff.

3. Personal Data Breaches

   This is a new requirement under the GDPR in which we are required to report certain classes of personal data breaches to the regulator, the Information Commissioner's Office.

4. Mandatory Information Governance Training

This section reports compliance or otherwise with targets for mandatory Information Governance Training. Both the NHS Wales target of 80% compliance, and the higher Public Health Wales target of 95% compliance are reported. Figures are shown for the previous 12 months where available to indicate overall trends in compliance.

5. The Information Governance Working Group (IGWG)

This is a new section, reporting on attendance at IGWG, together with the key points and any outstanding actions from the meetings.

The report also introduces the concept of Key Risk Indicators (KRI) for Information Governance. A KRI is a metric which whilst not necessarily indicating a non-compliance in itself, can provide early warning to an organisation of increasing risk exposure. These are currently in development for points 2 and 5, as indicated on the report.

Finally, the report provides an overview of any assurance reports received over the reporting period.

Once the format of the report has been approved, further work will be carried out to identify appropriate KRIs where needed, and to establish further reporting requirements to provide the Committee with the assurances it seeks.

3.1 Well-being of Future Generations (Wales) Act 2015

The requirement for sound Information Governance is only likely to increase and so there will be a requirement for a management system to deliver it for the foreseeable future.

The manner in which Information Governance performance is now reported is intended to prevent small problems becoming large ones, through compliance reporting and the development of Key Risk Indicators.

The Information Governance Management System brings together a wide range of activities into one system.

An effective Information Governance Management System will ensure that any future collaborative arrangements with regards to data sharing are robust, legally compliant and efficient.

The Information Governance Working Group was fully involved in the development of the Management System

4. Recommendation

The Committee is asked to:

- **Receive assurance** that the Information Governance Management System is working effectively.
- **Approve** the new format for the report.

Information Governance Management System
Performance and Assurance Report Quarter 2 – 2018/2019

Compliance

	Freedom of Information	DPA (Subject Access)	Mandatory Training	Data breaches
This quarter				
Prev.quarter				**N/A**

(For explanation of colour coding please refer to the subject specific pages)

Key risk indicators (KRI)

	Freedom of Information	DPA (Subject Access)	Data Breaches	Mandatory Training	IGWG	TBC	TBC
KRI1							
KRI2							
KRI3							

Headlines

This paper reports on Information Governance performance over the period – Quarter 2 2018/2019. Compliance is green with the exception of the new criteria, Data Breaches. The amber rating is due to the late reporting of one data breach which itself was attributed to misunderstanding of the new reporting requirements, and the complexities and uncertainties over the incident itself. For further details, please refer to the relevant section of the report.

There are two new sections in this quarter's report:

- Information Governance Working Group
- Assurance Reporting

Mandatory IG training shows an improving trend for the organisation over the previous 12 months.

Contents

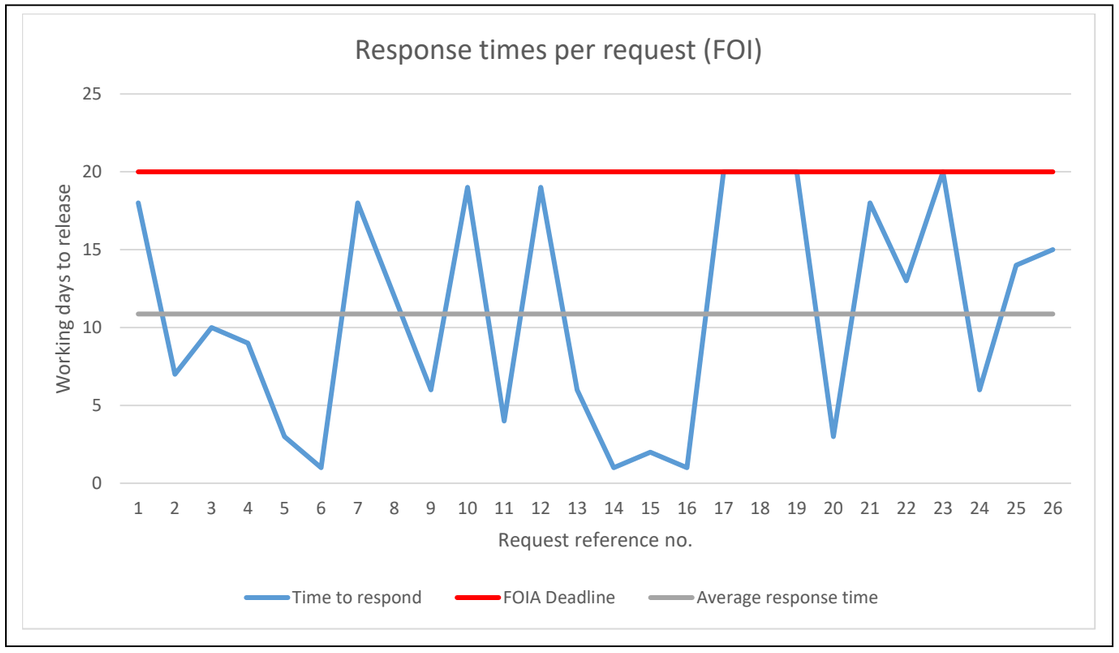
Subject	Page no
Freedom of Information	3
Data Protection (Subject Access) Requests	5
Data Breaches	7
Mandatory Information Governance Training	9
Information Governance Working Group	11
Assurance Report	12

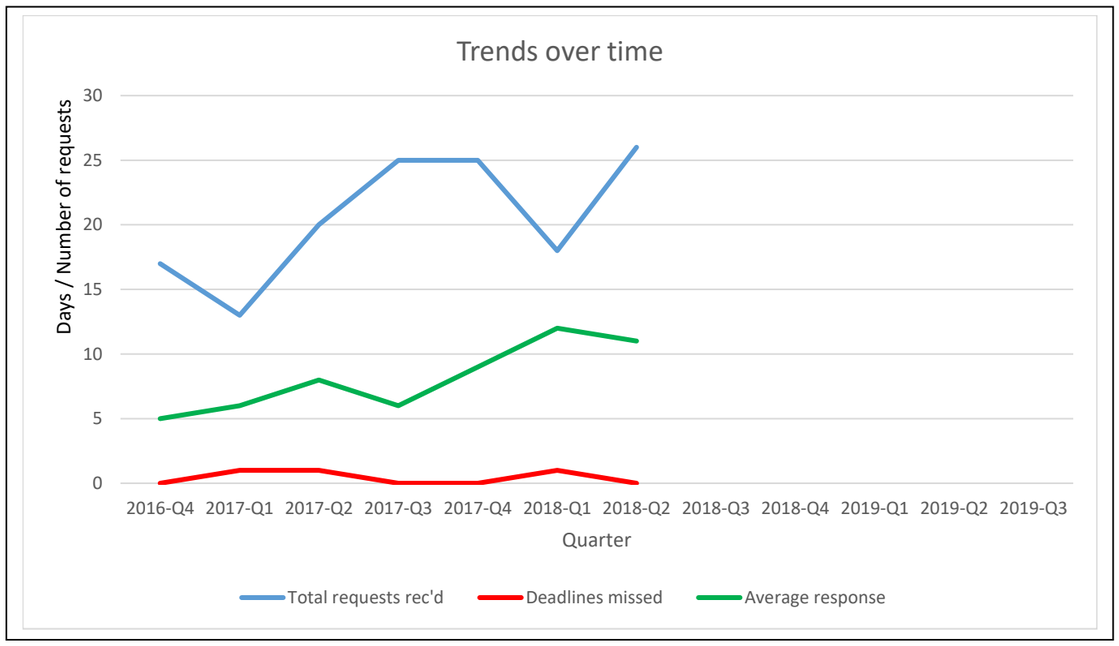
Glossary

DPA	Data Protection Act 2018	KRI	Key Risk Indicator		
DPO	Data Protection Officer	RIGM	Risk and Information Governance Manager		
FOIA	Freedom of Information Act 2000	SAR	Subject Access Request		
GDPR	General Data Protection Regulation 2016	SIRO	Senior Information Risk Officer		
ICO	Information Commissioner’s Office				
IGWG	Information Governance Working Group				
KPI	Key Performance Indicator				

Freedom of Information Requests

Compliance Status		
	2 or more legislative non-compliances	
	Single legislative non-compliance	
	Fully compliant	**X**





Narrative

Performance this quarter has been acceptable with all requests being serviced within the deadline, with an average response time to respond of 10.87 days.

Public Health Wales continues to receive a large number of requests for which we do not hold the information, however these usually take as much time to respond as a release as the same amount of work needs to be done to clarify the information that we hold. The average response time remains well below the KRI threshold of 15 days.

One request was refused on the basis that it was vexacious. This related to highly detailed information requested on all contracts related to telephony contracts.

Missed deadlines shown on the 'Trends over time' chart have been reported to Committee previously.

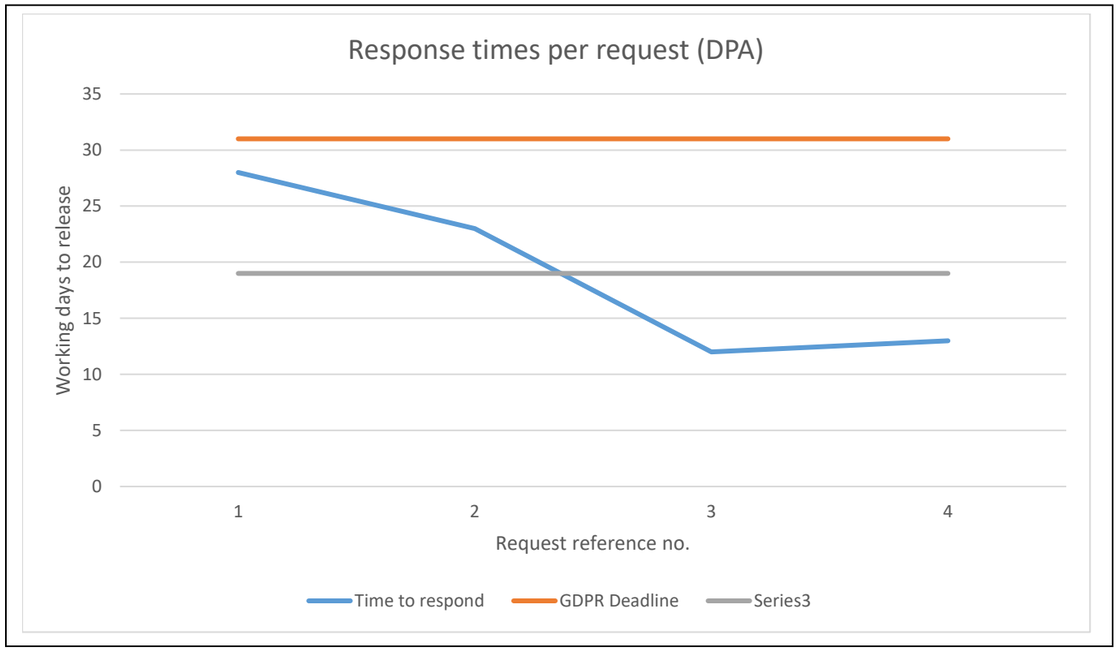
Performance Indicator	No	Target	Remarks
Total Requests Received	24	N/A	
Full Release		N/A	
Partial release with exemptions	0	N/A	
Release declined – Exemptions engaged	1	N/A	Release was declined on the basis of being vexacious.
Release declined – Information not held	17	N/A	
Deadline not met*	0	0%	

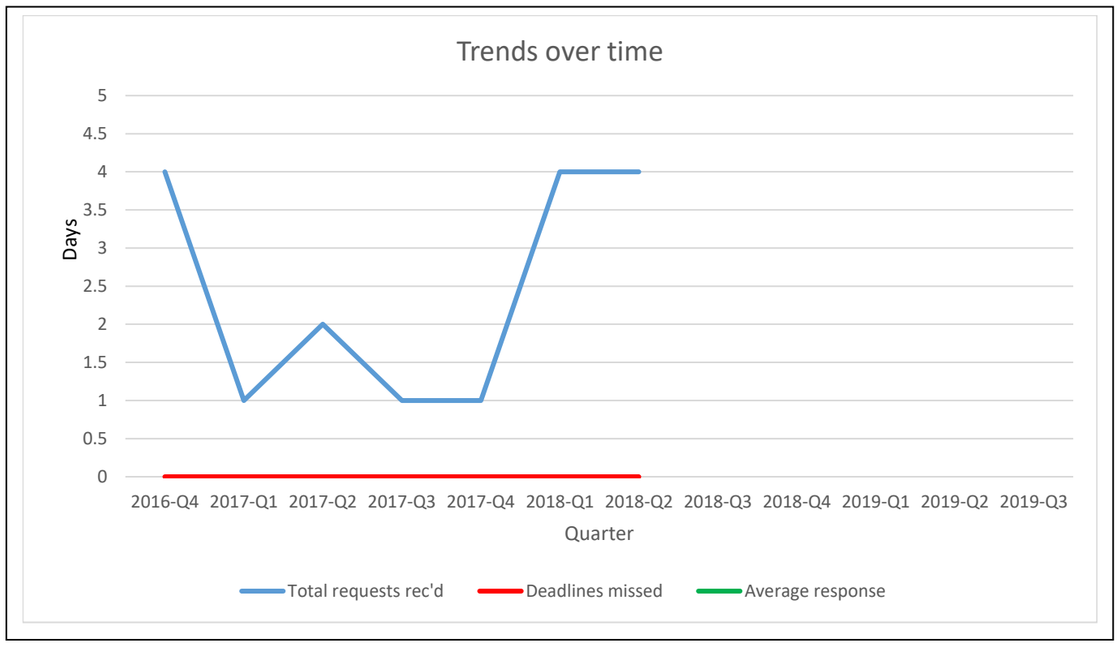
Key Risk Indicators		Status
KRI1	Average time to release information >15 days for three consecutive months	
KRI2	Increase in requests for three consecutive months	
KRI3	Requests remain above 50 for three consecutive months	

*indicates legislative non-compliance

Data Protection (Subject Access) Requests

Compliance Status		
	2 or more legislative non-compliances	
	Single legislative non-compliance	
	Fully compliant	**X**





Narrative

Four Subject Access Requests were received in the reporting period and all were met within the deadlines imposed by GDPR. It should be noted that the report for trends over time does not yet show average response times as these have never previously been collected. This information will be available at the next reporting period.

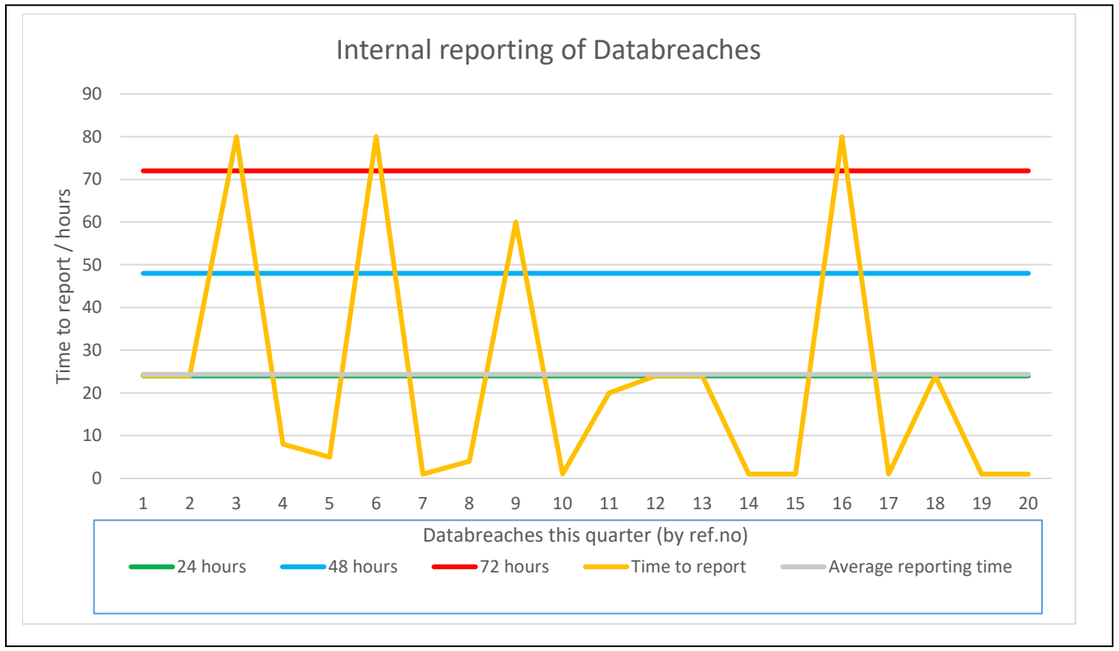
Performance Indicator	No		Remarks
Total Requests Received	4		
Full Release	4		
Release declined – Exemptions engaged	0		
Deadline not met*	0		

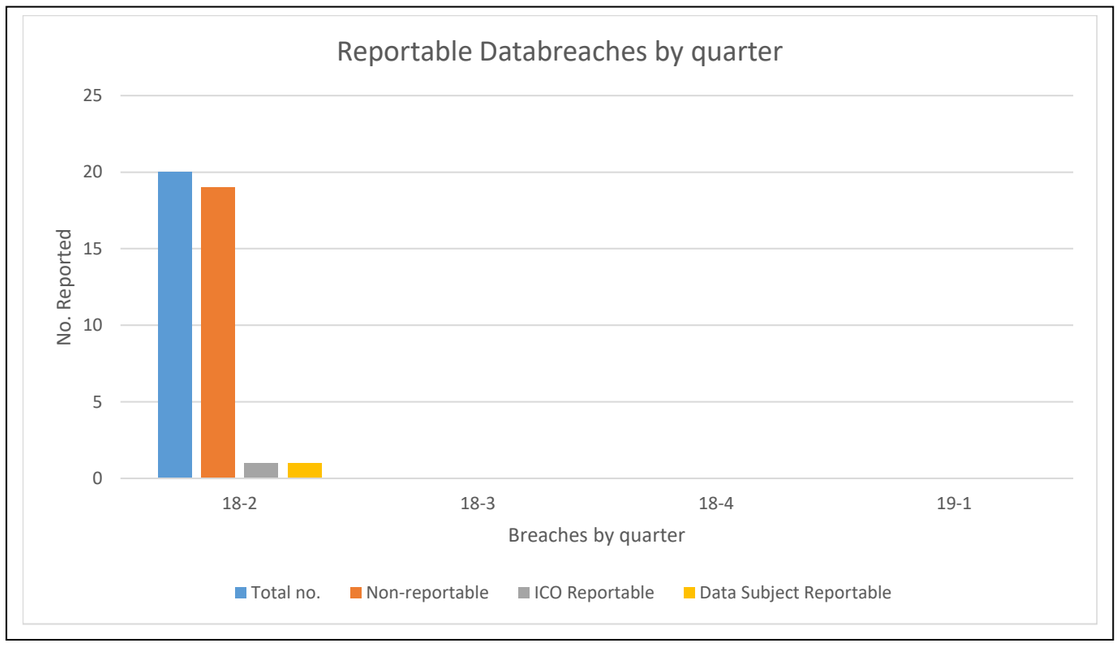
Key Risk Indicators		**Status**
KRI1	Average time to release information >25 days for three consecutive months	
KRI2	Increase in requests for three consecutive months	
KRI3	Requests remain above 10 for three consecutive months	

*indicates legislative non-compliance

Reported Data Breaches

Compliance Status		
	2 or more legislative non-compliances	
	Single legislative non-compliance	**X**
	Fully compliant	





Narrative

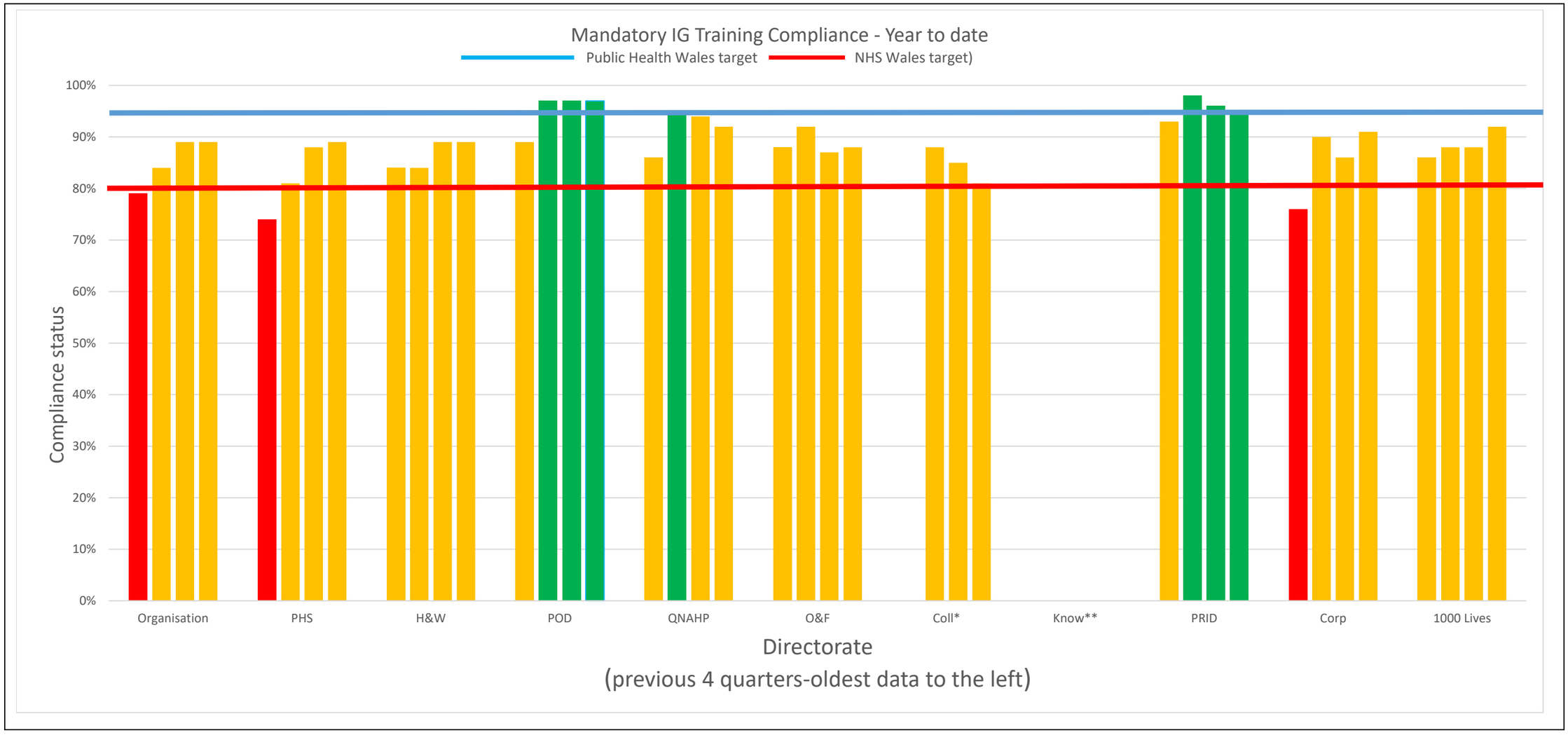
This is the first quarter on which data breaches have been reported and so no historic data are available. All breaches are risk assessed by the Risk and Information Governance Team and a decision taken by the Data Protection Officer on whether or not to report to the Information Commissioner based on the requirements of the General Data Protection Regulation (GDPR). The majority of breaches are very low risk including emails being sent to the wrong recipient within the NHS environment, or errors on a service users record which is picked up through a failsafe system and corrected. High risk breaches must be reported to the ICO within 72 hours of the organisation becoming aware of it. Three breaches were reported outside of the 72 hour window, meaning that if they had needed to be reported this deadline could not have been met. Investigations show that this has been down to the lack of understanding of new reporting requirements, which is being addressed through the new Incident Management Policy and Procedure. One breach was reported to the Information Commissioner, which was an incident within Diabetic Eye Screening Wales, which has been reported to this committee. This was reported late for the reasons previously mentioned. It is important to note that there was no delay to the management or investigation of the incident, only the reporting to the Information Commissioner (ICO). The ICO has notified us that they are satisfied with our investigation and intend taking no further action either on the breach or the late reporting.

Performance Indicator	No		Remarks
Total no. of databreaches reported*	20		
Databreaches reported internally after > 48hours*	4		
Databreaches reported to ICO <72hours	0		
Databreaches reported to ICO >72hours*	1		See narrative above
Databreaches reported to Data Subject	1		

Key Risk Indicators		Status
KRI1	Increase in reported databreaches for three consecutive months	
KRI2	Increase in databreaches reported >48hrs for three consecutive months	
KRI3	Databreaches reported to the ICO for three consecutive months	

*indicates legislative non-compliance

Mandatory Training Compliance



*Collaborative data only available from Q4-2017
**Knowledge Directorate not yet established

Narrative

Performance has improved over the last year, with all Directorates now reporting compliance with the NHS Wales target of 80%, however there remains only two Directorates (POD and PRID) which are also compliant with the higher Public Health Wales target of 95%. All Directorates are showing a generally upward trend on the year with the exception of Operations and Finance and NHS Wales Health Collaborative.

Performance Indicator	No	Remarks
Directorates compliant with Public Health Wales target	2	
Directorates compliant with NHS Wales target	10	
Directorates below 80% compliance	0	

Key Risk Indicators		Status
KRI1	3 or more Directorates below 80% compliance for 1 reporting period	
KRI2	2 or more Directorates below 80% compliance for 2 reporting periods	
KRI3	1 or more Directorates below 80% compliance for 3 reporting periods	

Information Governance Working Group

Date of last meeting –

Attendance

Key		Attended		Deputy attended		No attendance

Role	Name	Attendance (Current quarter)	Attendance (Previous quarter)	Attendance (Anti-penultimate quarter)
Senior Information Risk Owner	Sian Bolton			
Caldicott Guardian				
Head of Information Governance	John Lawson			
Risk and IG Team	Katie Donelon			
Risk and IG Team	Jane Evans			
Risk and IG Team	Lisa Partridge			
Head of IM&T				
Office of Board Secretary	*Eleanor Higgins*			
Health and Wellbeing				
NHS Wales Quality Improvement				
NHS Wales Health Collaborative				
Operations and Finance				
People and Organisational Development				
Policy, Research and International Development	Benjamin Grey			

Note –

(Representatives shown in grey denote attendance is a new requirement with effect from next quarter. Names in *italics* denote deputy.)

Actions overdue

None

Key points

The format of the new performance report was discussed and approved by the group

The issue of timely reporting of data breaches was again discussed and members asked to re-inforce the requirement within their Directorates

The group approved the revised Terms of Reference which will now go to the Executive Team for approval.

The group approved the use of a new GDPR compliant photograph consent form

Key Risk Indicators		Status
KRI1	TBC	
KRI2		
KRI3		

Assurance report

Internal audit reports

None received during the reporting period

External audit reports

None received during the reporting period

Self-inspection reports

None received during the reporting period

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Summary of Experience - 'Framework for Assuring Service User Experience'

Executive lead:	Sian Bolton, Acting Executive Director of Nursing Quality and Allied Health Professionals
Author:	Junaid Iqbal – Service User Lead

Approval/Scrutiny route:	Lead Executive

Purpose

The purpose of this paper is to provide the Quality, Safety and Improvement Committee with a report on service user feedback for 2017/18, as set out in the 'Framework for Assuring Service User Experience' (2016).

In addition it is to inform members of a recent Welsh Health Circular containing a revised 'Framework for Assuring Service User Experience 2018' and the implications for Public Health Wales.

Recommendation: (note - to mark an x in the grey box below right click on the mouse, then select "properties", and then select "checked")

APPROVE	CONSIDER	RECOMMEND	ADOPT	ASSURANCE
☐	☒	☐	☐	☒

The Committee is asked to:

- **Receive assurance** that the 'Framework for Assuring Service User Experience 2016' is being utilised across the organisation for gathering feedback and experiences and is being utilised as a tool for quality improvement
- **Consider** the implications for Public Health Wales following the recent publication of the revised 'Framework for Assuring Service User Experience 2018'

Link to Public Health Wales Strategic Plan Public Health Wales has an agreed strategic plan, which has identified seven strategic priorities and well-being objectives. This report contributes to the following:	
Strategic Priority/Well-being Objective	All Strategic Priorities/Well-being Objectives

Summary impact analysis	
Equality and Health Impact Assessment	Not required
Risk and Assurance	The importance of listening and learning to users of our services is recognised.
Health and Care Standards	This report supports and/or takes into account the Health and Care Standards for NHS Wales Quality Themes Governance, Leadership and Accountability Person Centred Care Theme 3 - Effective Care
Financial implications	There are no financial implications
People implications	Feedback from individuals provides us with the opportunity to learn how to improve the services, functions and programmes we offer.

1. Purpose / situation

The purpose of this paper is to provide the Quality, Safety and Improvement Committee with a report on service user feedback for 2017/18, as set out in the 'Framework for Assuring Service User Experience' (2016).

In addition it is to inform members of a recent Welsh Health Circular containing a revised 'Framework for Assuring Service User Experience 2018' and the implications for Public Health Wales.

2. Description/Assessment

In January 2018 an initial draft report collating feedback from individuals who use our services, functions and programmes for 2016/17, was presented to the Quality Safety and Improvement Committee. Comments were provided by members and work commenced on amending templates to collect feedback for 2017/18. However, in early 2018 the Welsh Government informed NHS Wales that they were planning to revise the 2016 Framework to include a new set of core questions which would be published during 2018. To prevent duplication of work a decision was made to continue collecting feedback against the three agreed core questions (from the 2016 Framework) until the revised Framework was published.

This paper provides the Committee with feedback for 2017/18. It should be noted that not all services, programmes and functions report against the Framework, as the focus of the Framework is on front facing services. All front facing services including Help Me Quit and Screening (with the exception of Diabetic Eye Screening Wales - DESW) collect service user feedback. DESW plan to commence collecting feedback during 2019/20. Public Health Wales also collects additional feedback off services, functions and programmes that are not front facing as they have adopted the principle that collecting feedback supports a culture of quality improvement and listening and learning. This includes obtaining feedback from staff or other stakeholders e.g. Health Boards using our microbiology services.

During 2018 Public Health Wales has continued to work closely with Welsh Government, via its Service User Lead and Putting Things Right Lead, on revising its Framework. It was important that any revision of the Framework allowed feedback to be sought, not only from individuals seeking healthcare provision for an illness or condition but also from all users of services who were predominately well (i.e. those attending screening and wellbeing services). In October 2018 the Welsh

Government issued a Welsh Health Circular containing the revised Framework. The changes to the document includes a move away from the use of the term patient to Service User and a new set of 11 core questions. The Welsh Health Circular stipulates that 'These validated core questions are to be used in all NHS Wales organisations'.

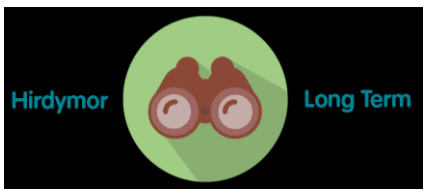
The change to the core questions potentially poses a challenge to Public Health Wales as a number of these do not apply easily to a public health organisation. The Welsh Health Circular implies that use of the 11 core questions are a requirement. However in a follow up meeting with Welsh Government it was confirmed that these are not mandated but rather it is expected that organisations comply. Further work is planned with the members of the Service User Experience and Learning Panel, Screening and Help me Quit to determine how and if these core questions can be utilised.

Listening to the experiences of our users is a fundamental part of quality improvement and should therefore be reported to a Board Committee on a regular basis. In 2016, the Wales Audit Office published good practice guidance to support NHS Boards to seek assurance that their organisation is learning from users to improve services, programmes and functions. The attached paper seeks to provide assurance to Committee members that listening and learning is taking place across the organisation.

The attached document provides the Committee with an overall picture in relation to the previously agreed 2016 service user core questions. In light of the revised Framework further detailed work is required, with a view to adopting or amending new/ additional core questions from 1 April 2019.

3.1 Well-being of Future Generations (Wales) Act 2015

This work has been put together following the five ways of working, as defined within the sustainable development principle in the Act, in the following ways:



The 'Framework for Assuring Service User Experience' has been in place for four years. The revised Framework provides an opportunity for Public Health Wales to relook at the core questions with a view to putting in place a strategy which will enable learning and a sustainable approach.

The use of core questions aligned to service specific fields will enable services, programmes and functions to identify needs, makes changes and delivery training to promote quality and good practice.

The current core questions used by services, programmes and functions are integrated into existing surveys.

The rollout of any new core questions is being taken forward in a whole organisational collaborative manner. With opportunities for service programmes to tailor the questions and timing of any survey to suit service delivery.

The 'Framework for Assuring Service User Experience 2016' was developed in partnership with NHS Wales and tested with patients. Welsh Government also held a number of focus groups during the revision of the Framework (2018)

3. Recommendation

The Committee is asked to:

- **Receive assurance** that the 'Framework for Assuring Service User Experience 2016' is being utilised across the organisation for gathering feedback and experiences and is being utilised as a tool for quality improvement
- **Consider** the implications for Public Health Wales following the recent publication of the revised 'Framework for Assuring Service User Experience 2018'

Feedback from Users of our Services

2017-2018

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Public Health Wales

Who provided feedback?

In 2014 the Welsh Government published the 'Framework for Assuring Service User Experience' (the Framework) which aimed at improving the service user's journey through the NHS by identifying areas of good practice and supporting delivery of the tier one NHS target.

The Framework was later revised and republished via a Welsh Health Circular in 2016 to include the need to gain feedback from concerns, complaints, compliments and clinical incidents. It is intended to guide and compliment service user improvements in all NHS Wales organisations. The Framework outlines three domains to support the use and design of feedback methods and recommends a four quadrant model of obtaining feedback to build on existing expertise and resources. The Framework identified 15 Core Questions which could be asked by NHS organisations. Welsh Government require all NHS organisations to report uptake against the Framework.

Public Health Wales recognised the importance of listening to users of our service and the need to implement the Framework to gather feedback and enable shared learning across the organisation. As a result it established a Service User Experience and Learning Panel in 2014. An initial focus of the Panel was to consider the Framework and agree a set of core questions which could be applied across Public Health Wales. After consulting with front facing services such as Screening, a decision was made to focus on initially obtaining feedback against 3 core questions as

many of the 15 core questions identified within the Framework did not directly apply to the work of Public Health Wales as they were predominately written for patients within a care environment. The 3 core questions originally agreed by the Service User Experience and Learning Panel were:

- How would you rate your overall experience?
- Do you feel people were polite to you?
- Do you feel that you were given all the information needed?

Obtaining feedback on these questions focused initially on the Screening

Programmes and Help me Quit. However, as time progressed more Directorates and programmes started collecting feedback and contributing to the Panel. It is proposed that this will continue until all Directorates are providing feedback. Whilst only Screening and Help Me Quit have direct contact with the general public, the organisation, via the Service User Experience and Learning Panel, have adopted the principle that all areas should consider collecting feedback to support a culture of listening and learning. This can include obtaining feedback from staff or other users of our services such as other NHS organisations eg Health Boards using our microbiology services.

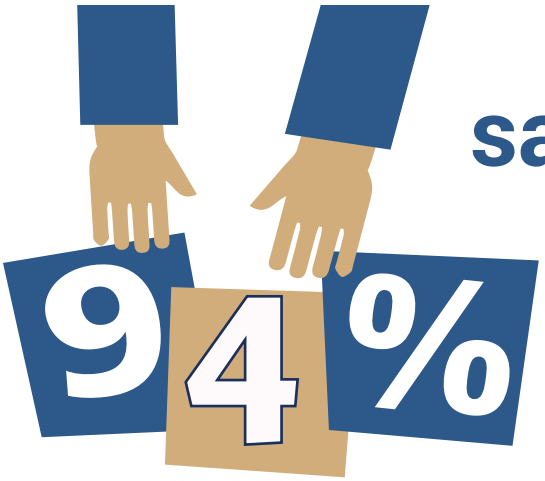
This document relates to the period 1 April 2017 to 31 March 2018 and provides a summary of feedback obtained on a quarterly basis from the following areas within Public Health Wales:

- Breast Test Wales
- Bowel Screening Wales
- Wales Abdominal Aortic Aneurysm Screening Programme
- Maternal and Child Health Screening Wales
- Cervical Screening Wales
- Help Me Quit
- Microbiology
- 1000 Lives

Diabetic Eye Screening Wales piloted the core questions for 1 quarter 2017/2018, but do not currently collect feedback from service users. It is planned to implement collecting feedback in 2019/2020.

From the reports received during 2017/2018 over 7,181 people provided feedback out of a total of 17,909 asked. This includes feedback from both the public and wider stakeholders (effectively anyone who has used a Public Health Wales service or programme). The figures contained in the report are a snap shot of the organisation's total engagement with the feedback captured at periodic times throughout the year.

Results of Core Questions



people asked said they were given all the information they needed

98% of people asked said our staff were

POLITE & CARING

of people asked said they had experience a good

Engagement

During 2017/2018 over 140 engagement activities were reported to the Service User Experience and Learning Panel. It is recognised that as not all areas report, this does not fully reflect the total number of engagement events that occurred during this period.

The events reported included both those aimed at stakeholders, the general public and people who used a Public Health Wales service. A number of examples are provided below which highlight the diverse nature of the work undertaken by the organisation.

Microbiology:

The Public Health Wales Virology team in partnership with Cardiff and Vale University Health Board spent their evenings aboard the Salvation Army bus in Cardiff City Centre, where they carried out liver screening and hepatitis tests for some of the most vulnerable people in society.

The team occupied the upper deck of the Salvation Army bus for 1 week to not only carry out testing but to raise awareness of the virus amongst this population, including how to prevent infection and to make arrangements to deliver treatment when required.

We took part in over 140 engagement activities involving both the public and wider stakeholders over the last year

Reducing the numbers of individuals with Hepatitis C is not only good for the individuals who receive treatment but also decreases demand on NHS resources and reduces the risk of onward transmission.

1000 Lives:

Education Programme for Patients Cymru (EPP Cymru) facilitated 70 self-management courses for 950 members of the public across Wales. These courses are delivered primarily by trained volunteers, healthcare professionals and occasionally Health Board EPP coordinators.

Working in collaboration with the Wales Cancer Network, a cohort of 21 existing EPP tutors successfully completed the Cancer: Thriving and Surviving Programme (CTS), enabling them to deliver this course to people who have survived cancer.

Concerns (Complaints)

We received 52 complaints from the public during 2017/2018. Out of these complaints 87% (45) were acknowledged within two working days and 73% (38) were acknowledged within 30 working days.

The Screening Division attracts the highest number of concerns as they deal directly with the public. It should also be noted that during 2017/2018 the national population based screening programmes screened over 578,000 participants. The percentage of concerns received by the Screening Division in comparison to the number of individuals screened is approximately 1 per 15,220 screened and represents less than 0.006% of screening activity.

All concerns were investigated and actions identified to reduce the risk of the incident occurring again.

A number of examples of learning from concerns and actions are included below:

Example 1:
Concerns were raised in relation to communication about the process for follow up testing after a new-born hearing screening test where the result obtained a one ear clear response.

What we did
As a result of the concern the importance of sharing choices with parents, due to a one ear clear response, was reinforced during the Newborn Screeners annual competency checks and their regular training sessions.

We received 52 complaints from the public during 2017/2018

> “87% were acknowledged within 2 working days”

> “The accident and initial attitude of Public Health Wales had negatively affected all our family, but things changed after our second letter and they couldn’t have been more helpful and honest.”

Newborn Hearing Screening Wales also committed to undertaking a review of their letters and literature to determine if the information provided could be improved.

Example 2:
A number of concerns were received relating to customer care in Diabetic Eye Screening Programme.

What we did
It was identified that diabetic eye screeners had not had specific customer care training. This has now been delivered across the programme and there has been a noticeable reduction in concerns relating to this issue.

Compliments

In the period 2017/2018 we received 1,714 compliments, which is an increase from the 1,042 reported in 2016/2017.

Via the collection of data it has become evident that some programmes "batch" their compliments when they record them on Datix. This has meant that when a data search is undertaken the number is under reported. This has now been addressed on Datix. The compliments received mainly relate to the quality of help and support provided by staff, the professionalism demonstrated, the positive attitude displayed and the information provided.

Below are a few examples of compliments received:

We recieved 1,714
COMPLIMENTS
over the last year

Thank you very much for your prompt response. I really appreciate how helpful you have been from the start. Microbiology

I should be grateful if you could pass on my thanks to all those who helped ensure that the awards this year were, once again, a tremendous success. 1000lives

Thank you to all your staff for the hard work yesterday in relation to the difficult situation with systems failure (WLIMS particularly) and your effort in maintaining services for patients. It was recognised at ABMU Health Board today the impact of this and particular recognition was made on the impact on pathology and the hard work your teams did to manage this and the Chair, Chief Execs (outgoing and incoming) and all Board members thank you for keeping the show on the road as best you could. Microbiology

Thank you for all you care and kindness when I came for my appointment. You were very kind and explained everything clearly and I felt that you were concerned for my well-being. An amazing service. Breast Screening

Staff were kind, helpful, understanding, caring, efficient, professional, Good experience/care.
Bowl Screening

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Public Health Wales

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Official Statistics –Terms of Reference for Official Statistics Group

Executive lead:	Sian Bolton – Acting Executive Director of Quality, Nursing and Allied Health Professionals
Author:	Linda Bailey – Consultant in Public Health and interim Lead Officer for Official Statistics for Public Health Wales

Approval route:	Public Health Wales Official Statistics Group

Purpose
This paper asks the committee to receive and approve the attached Terms of Reference for the Public Health Wales Official Statistics Group.

Recommendation:				
APPROVE ☒	CONSIDER ☐	RECOMMEND ☐	ADOPT ☐	ASSURANCE ☐

The Quality, Safety and Improvement Committee is asked to:

- Approve the attached Terms of Reference.

Link to Public Health Wales Strategic Plan Public Health Wales has an agreed strategic plan, which has identified seven strategic priorities and well-being objectives. This report contributes to the following:	
Strategic Priority/Well-being Objective	7 - Building and mobilising knowledge and skills to improve health and well-being across Wales

Summary impact analysis

Equality and Health Impact Assessment	No Equality or Health Impact Assessment is required. The Committee is asked to approve the attached papers which have been considered at the Official Statistics Group which reports into this Committee and approval of these does not carry with it any significant changes to services or structures.
Risk and Assurance	There is a risk that Public Health Wales produces information that is not robust or reliable. If producers of data within the organisation are following the UK Statistics Authority Code of Practice for Official Statistics this risk will be mitigated.
Health and Care Standards	This report supports and/or takes into account the Health and Care Standards for NHS Wales Quality Themes Governance, Leadership and Accountability Theme 7 - Staff and Resources Choose an item.
Financial implications	No financial implications have been identified
People implications	No potential impact on workforce have been identified

1. Purpose / situation

This paper accompanies the new Public Health Wales (PHW) Terms of Reference for the Official Statistics Group, which the Committee are asked to approve. The attached Terms of Reference state that the Official Statistics Group is a sub-group of the Quality, Safety and Improvement Committee. This is on advice from the Board Secretary.

The Official Statistics group first met in January 2018, to support the robust production and dissemination of Official Statistics within Public Health Wales, and the work of the interim Lead Officer for Official Statistics for Public Health Wales, who was identified in January 2018, following a request from the Executive team.

2. Background

Criteria for production of Official Statistics are set out in the Code of Practice for Official Statistics[1]. The majority of Official Statistics produced in the UK are produced by Government departments and the Office for National Statistics (ONS). Non-Crown bodies who are producers of Official Statistics must identify a 'Lead Official for Statistics' (LO), to work across their organisation and in liaison with the Chief Statistician in Welsh Government (in Wales).

The Board of Public Health Wales agreed that the organisation should become a producer of Official Statistics on 27thSeptember 2012. Subsequently PHW was listed as a non-Crown producer of Official Statistics in Wales under a statutory instrument[2] in 2013.

3. Description / Assessment

The first Official Statistics released by PHW were released in 2014. The Director of Health Intelligence at that time took on the role of Lead Officer and Chief Statistician, however there has been a gap between her retirement in 2015, and identification of a new Lead Official.

The current arrangements are interim. Ideally this post would be at Board level, because of the pan-organisational remit. The current lead has a link with the Executive Director of Quality, Nursing and Allied Health Professionals in her role as Senior Information Risk Officer (SIRO). It is anticipated that the new Director for the Knowledge / Intelligence Directorate will take on the LO role as part of their remit.

The interim Lead Official has worked with staff from across the organisation to introduce governance arrangements for the production of Official Statistics, through the establishment of the Official Statistics

[1] The UK Statistics Authority Code of Practice was updated in February 2018
[2] Welsh Statutory Instruments – 2013 No. 649 (W.73) : Official Statistics, Wales. The Official Statistics (Wales) Order 2013

Group. The Terms of Reference for the Official Statistics Group are included at appendix 1.

No equality, health impact or finance issues have been identified. However there is a reputational risk to the organisation if the production of Official Statistics is not supported by adequate governance and oversight at Committee / Board Level.

It is proposed that future assurance for the Committee could be provided through receipt of meeting minutes and an annual report from the Lead Officer.

3.1 Well-being of Future Generations (Wales) Act 2015

Under the sustainable development principle of the Well-being of Future Generations (Wales) Act 2015, Public bodies need to make sure that when making their decisions they take into account the impact they could have on people living their lives in Wales in the future.

Ensuring that data and information that is produced by a public body is robust, reliable, trustworthy and adheres to the national Code of Practice for Official Statistics meets the five considerations required under the Act.

Having a uniform process agreed, and oversight that is pan-organisational:-

- meets longer-term needs
- future-proofs against issues arising around reliability of data and use of that data, going forward
- ensures that all directorates and divisions within Public Health Wales are working to the same standards, which are set nationally by the UK Statistics Authority
- brings together stakeholders in data from across the organisation

4. Recommendation

- The Committee is asked to **receive** and **approve** the Terms of Reference for the Official Statistics Group which was established in January 2018 (appendix 1).
- The Committee is also asked to **note** the delegated powers of the Official Statistics Group.
- The Committee is asked to **consider** what further information they would want to provide continued assurance about Official Statistics Production. It is initially proposed that minutes of the Official Statistics Group meetings and an Annual Report from the LO are provided.

Public Health Wales Official Statistics Group Terms of Reference & operating arrangements	
Author: Linda Bailey – Consultant in Public Health	
Date: September 2018	**Version:** 2
Purpose and Summary of Document: These are the terms of reference for the Public Health Wales Official Statistics Group	
Committee/Groups that have received or considered this paper: Official Statistics Group	
Please State if the Paper is for:	
Discussion	
Decision	
Information	**X**
Publication / Distribution: • Intranet	

Version Number	Status	Explanation
0a, b, c	First three drafts work in progress	Author's first draft. Comments received and incorporated
1	Approved	Document for final approval by Official Statistics Group.
2	For approval by Quality, Safety and Improvement committee	The document should now be published to the intended audience.

1.1 Introduction

A group will be convened to oversee Official Statistics preparation and release within Public Health Wales. This group will be known as the Public Health Wales Official Statistics Group. The Lead Officer for Official Statistics for Public Health Wales shall be the Chair of the group.

1.2 Purpose

The purpose of the group is to:

- Develop advice, guidance and assurance for producers of Official Statistics within Public Health Wales, supporting sharing of good practice
- Provide assurance to the Quality, Safety and Improvement Committee (prior to January 2019) and through that Committee to the Public Health Wales Board that Official Statistics are being prepared in line with national guidance from the UK Statistics Authority
- Provide support and advice to the Lead Officer for Official Statistics for Public Health Wales, in the execution of their role
- Dissemination of information about Official Statistics within Public Health Wales

1.3 Delegated Powers

The group will develop guidance for the production of Official Statistics from across all divisions and directorates, ensuring coherence in all aspects of production and release, including:

- compliance with national guidance and legislation
- analysis, production and dissemination
- pre-release access
- release

This guidance will be made available through a web page on the intranet. An external webpage will also be developed and maintained.

The group will also provide advice and support to divisions and individuals within Public Health Wales who are producing Official Statistics for the first time. The group will have delegated powers if concerns are raised about any aspect of production, acting through the Lead Officer for Official Statistics.

1.4 Access

The Lead Officer for Official Statistics will have unrestricted access, on behalf of the group, to:

- the Executive Director of Quality, Nursing and Allied Health Professionals, in their role as the organisation Senior Information Risk Owner (SIRO)
- The Chief Statistician for Welsh Government

They will also have reasonable access to other Directors and senior staff as appropriate.

2. Membership, attendees and quorum

2.1 Members

There shall be representation at senior level from across the organisation, including all directorates or divisions responsible for Official Statistics releases. Membership at April 2018 shall include the post-holders below or their nominated deputies:

- Lead Officer for Official Statistics (Chair of Group)
- Consultant in Public Health lead for Welsh Cancer Information and Surveillance Unit
- Consultant in Public Health – Screening Division
- Chief Risk Officer
- Lead Informatics and Data Services Manager, Informatics
- Communications Co-ordinator
- Head of Surveillance, Health Protection
- Director of Health Intelligence
- Senior Public Health Information Analyst, Observatory Analytical Team
- Web Officer, communications
- Secretariat provided by Lead Officer's Division Business Support Team

2.2 Attendees

External and internal stakeholders may be invited to attend all or parts of meetings of the group.

2.3 Quorum

At least three members must be present to ensure the quorum of the Group, one of whom should be the Group Chair.

3 Frequency of meetings

Frequency of meetings shall be no less than every six months and otherwise as the Chair of the Group deems necessary.

4 Reporting and assurance arrangements

The Official Statistics Group for Public Health Wales shall be a sub-group of the Quality, Safety and Improvement Committee. Minutes shall be available to that Committee and the Board to provide assurance around arrangements for Official Statistics release.

5 Applicability of Standing Orders to Group Business

The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the Group, except in the following areas:

- Quorum
- Meetings will not normally be held in public.
- Agendas and routine reports will be published following each meeting where appropriate

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales	**Name of Meeting** Quality, Safety and Improvement Committee **Date of Meeting** 15 January 2019 **Agenda item:** 10.1.QSIC.150119

Quality, Safety and Improvement Committee Self-Assessment

Executive lead:	Cathie Steele, Acting Board Secretary
Author:	Eleanor Higgins, Corporate Governance Manager

Approval/Scrutiny route:	N/A

Purpose
This report presents the results of the self-assessment of the Quality, Safety and Improvement Committee undertaken in October 2018.

Recommendation:				
APPROVE ☐	CONSIDER ☒	RECOMMEND ☐	ADOPT ☐	ASSURANCE ☐

The Committee is asked to:

- **Consider** the results of the Committee self-assessment

Link to Public Health Wales Strategic Plan Public Health Wales has an agreed strategic plan, which has identified seven strategic priorities and well-being objectives. This report contributes to all 7 strategic priorities:

Summary impact analysis	
Equality and Health Impact Assessment	An equality and health impact assessment is not required as there is no impact on policy or decisions relevant to Race, Disability and Gender duties.
Risk and Assurance	Undertaking an annual self-assessment provides assurance to the Board that the Committee is discharging its duties effectively.
Health and Care Standards	This report supports and/or takes into account the Health and Care Standards for NHS Wales Quality Themes Governance, Leadership and Accountability Choose an item. Choose an item.
Financial implications	Not applicable
People implications	Not applicable

1. Purpose / situation

This report presents the results of the self-assessment of the Quality, Safety and Improvement Committee undertaken in October 2018.

2. Background

It is good governance practice for all Committees to assess their performance and effectiveness on an annual basis. Based on good governance best practice, an online questionnaire was developed and circulated to members and attendees. 11 out of 12 members/attendees completed the questionnaire. However, three respondents skipped all questions except the first question and one respondent answered the first two questions and skipped the rest. For the purposes of this report, the total number of respondents will be considered as 8 out of 12 for question 2 and 7 out of 12 for the remaining questions. The relatively high number of 'skipped' respondents could be explained by the way the questionnaire system works. If a respondent clicks on the response link but does not complete the questionnaire, it will appear on the survey results as a respondent that has skipped all the questions. Therefore, this number is not indicative of the number of people who completed the questionnaire.

The results of the self-assessment are provided in **Appendix 1**. This paper outlines the key areas/themes identified.

A review of Board Committees was completed in July 2018. The review took into account the development of the new Strategy 2018-2030 and the capacity of the Committees to discharge their Terms of Reference. Following the review, it was agreed there should a significant change to the Committee's remit. The Official Statistics Group will now report formally to the Committee. The role of this group is to ensure the organisation fulfils its responsibilities as a producer of Official Statistics. Public Health Wales is listed as a non-Crown producer of Official Statistics in Wales under Official Statistics (Wales) Order 2013 and it has to ensure that it complies with the requirements of the Code of Practice for Statistics (February 2018). Under these requirements a Lead Officer must be appointed who is responsible for providing assurance to the board and the Chief Statistician (Welsh Government). Due the direct relationship with the Chief Statistician it seems appropriate that assurance is provided directly to a Committee of the Board and not via the Executive. This arrangement will be reviewed on the establishment of the Knowledge, Research and Information Committee.

The review considered whether there were any gaps in the Board mechanism that could enable the Board to be fit for purpose in its strategic decision-making in relation to embracing new innovation and technologies.

As a result, the review identified the need to establish a new Board Committee to focus on Knowledge, Research and Information. The purpose of this Committee will be to provide advice and assurance to the Board in relation to the quality and impact of our knowledge, health intelligence and research activities and also the data quality and information governance arrangements in the organisation. This will therefore take over the scrutiny and assurance of the information governance aspects that have previously been received in the Quality, Safety and Improvement Committee.

3. Strengths

A number of strengths have been identified from the responses to the questionnaire as follows:

3.1 Effective scrutiny and challenge

All who responded to this question (7 out of 7) indicated that Committee members are able to identify key risk areas and to effectively scrutinise and appropriately challenge on critical and sensitive matters (Q3).

One respondent felt that the Committee is somewhat limited by the information that is presented to the Committee, and often there is a lot of debate and questions raised but not always followed sufficiently. Another response commented that this had improved in the past few months.

3.2 Receipt of timely information

The majority respondents (6 out of 7) agreed that the Committee received timely information in relation to incidents, complaints and concerns (Q16); most respondents (5 out of 7) agreed Information Governance matters were received in a timely manner (Q18). Two respondents made reference to the new Knowledge, Research and Information Committee in response to the question on Information Governance. The new Committee will allow for additional time to consider Information Governance matters.

There was a mixed response to the question on whether timely information was received in relation to data protection matters and incidents (Q20). Four out of seven agreed, two answered 'do not know' and the other answered 'no'.

One of the respondents that replied 'no' to questions 16; 18 and 20 commented that the information received by the Committee is often produced weeks in advance of the Committee meeting so that it can be presented to the Business Executive Team meeting beforehand. The timing of the Business Executive Team meetings do not always fit with the timings of the Committee meetings.

3.3 Clinical audit

The Committee approved the Quality and Clinical Audit Plan 2018/19 at its meeting on in July 2018 and receives bi-annual updates against the plan. This was confirmed by most respondents (5 out of 7) who agreed that the Committee received timely information in relation to monitoring progress against the Clinical Audit Plan (Q17). Two respondents indicated that they did not know.

3.4 Accessibility and transparency

All meetings of the Committee are open to the public. Papers are published in advance of the meeting in addition to a public notice on the website news pages.

All respondents (7 out of 7) agreed that the public reporting of the committee's activity was sufficiently open, accessible and transparent (Q15).

3.5 Oversight and scrutiny of risk

The Committee receives an updated extract of the Board Assurance Framework at each meeting. Responses to the questionnaire indicated that the most respondents (4 out of 7) believe that the extract provides sufficient information and the appropriate level of assurance to the Committee (Q11). The remaining respondents answered 'don't know'. One of the positive respondents commented that this item has now been moved to the top of the agenda to give it more time and attention.

The Board Assurance Framework has recently been revised to fit into the new Strategic Plan and is now considered more relevant to the Committee.

When asked whether reports the Committee receives enable it to discharge its internal control and risk management responsibilities, all respondents agreed (Q10). Two respondents commented that this happens 'generally' which one going further to say the deep dives allow time to scrutinise in more detail.

3.6 Service user and staff stories

The ability to capture feedback and learn from experiences is an essential component in developing Public Health Wales' services, function and programmes. The Quality, Safety and Improvement Committee receives stories and experiences from both service users and staff.

All respondents (7 out of 7) indicated that the Committee receives service user and staff experience stories at sufficient frequency (Q13). However, one respondent suggested that we do not seem to follow up or use the information as best we could.

When asked whether these stories help them to make effective decisions (Q14), the majority of respondents (5 out of 7) agreed. One respondent commented that although they usually only give one person's perspective they allow for members to reflect on actual experiences. Another respondent referred to their comment from Q13 where they felt the committee did not seem to follow up on the information provided. A further commented that the stories sometimes help make effective decisions, but mostly we are an organisation that doesn't deal with individuals.

3.7 Membership

The majority of respondents (7 out of 8) felt the Committee had appropriate membership in terms of skills and expertise (Q2). One respondent replied 'no' to this question and commented that the Committee probably needs more about measuring impact.

3.8 Organisational values

All respondents (7 out of 7) indicated that the organisation values (working together, with trust and respect, to make a difference) (Q4) are demonstrated during meetings. One respondent commented that the Committee works hard to do this whilst discussing difficult matters.

3.9 Frequency of meetings

The Committee currently meets on a quarterly basis. The majority of respondents (6 out of 7) confirmed that the Committee meets at a sufficient frequency to deal with planned matters (Q5). One respondent indicated the agendas are very full but that should improve when the new Knowledge, Research and Information Committee is established. Another respondent commented that there may be a need for more time for deep dives. The remaining respondent answered 'no' and commented that the frequency of the meetings is sufficient to deal with planned matters, however the information received by the Committee is sometimes drafted weeks in advance of the Committee due to the timing of the Business Executive Team meeting, which may have an impact on assurance.

3.10 Role in annual reporting – the Annual Quality Statement

The majority of respondents (6 out of 7) indicated that the Committee had reviewed the robustness and content of the draft Annual Quality Statement

before it is recommended to the Board for approval (Q21). One responded 'don't know'.

It should be noted that the Committee was sighted on the draft Annual Quality Statement as it was being developed by a working and editorial group. However, the timings for its completion did not coincide with committee meeting dates. Committee members were able to comment on the final draft 'out of committee' before it was received by the Board. The timetable for completion of the Annual Quality Statement for 2018/19 has been brought forward which should allow the Committee to receive the final draft prior to its submission to the Board.

The Public Health Wales Annual Report also includes a description of the committee's establishment and activities.

3.10 Quality of reports

Most respondents (5 of 7) agreed that the reports provided to the Committee are clear, robust and of sufficient quality (Q8). One responded 'no' and one replied 'don't know'. The respondent that replied 'no' commented that often the reports are narrative with little attention given to providing a succinct summary of the key issues, risks, action plans and anticipated milestones. One commented that the reports can be a 'bit too process though'.

In response to whether respondents think that data (eg incident statistics) provided to the Committee is robust and of sufficient quality most respondents (6 out of 7) agreed (Q9). One respondent did not agree and commented that they were not convinced that the organisation is reporting consistently/accurately via DATIX.

3.11 Overlap with other committees

There was a mixed response when asked whether there were any overlaps with other committees (Q12). Three confirmed there were no overlaps with other committees, whereas two indicated that overlaps occurred and a further two respondents did not know whether there were overlaps. Two commented that this occurs on occasions, but the recent Board paper from Committee chairs highlighted these areas, which will be helpful in providing an opportunity to ensure all committee members are aware of these overlaps. Another commented that there will always be common issues which are developing a mechanism to track and share.

4. Areas for improvement

A number of areas for improvement have been identified from the responses to the questionniare:

4.1 Committee workplan

An annual workplan of committee business is in place. Six respondents answered the question. One of the respondents chose to skip the question commenting that they did not feel qualified to answer the question (Q7).

Of those that answered this question, all respondents (6 out of 6) confirmed Quality and Safety Standards; and concerns and complaints were sufficiently covered.

Four out of six respondents confirmed Development and delivery of services/programmes; Quality and Safety risks; and information governance were sufficiently covered

Three out of six agreed clinical audit was covered.

Quality Improvement (2 out of 6) and Research and Development (1 out of six) did not seem to be sufficiently covered.

Comments in response to this question included:

- insufficient time was given to Information Governance and Research and Development. This would improve once these items had been transferred to the new Knowledge, Research and Information Committee.
- Additional work needed to be completed in relation to clinical audit.
- the agenda had been amended to better reflect areas which had not been covered sufficiently in the past eg delivery of services.
- Health and Safety is discussed at People and Organisational Development Committee rather than Quality, Safety and Improvement Committee. Committee members may not be sighted on safety issues that may require further scrutiny.

4.2 Committee member induction and training

Non-executive Directors are provided with generic introductory training when joining the organisation. Committee members are not currently provided with formal induction specific to the Committee (Q22). The majority of respondents confirmed this with 6 out of 7 answering 'don't know' and one answering 'no'. Only one responded that they were provided with induction and training.

With regard to areas of development for the Committee either collectively or individually (Q23), most respondents (3 out of 6) indicated there were certainly areas of development which Committee members would benefit from collectively or individually. Suggestions included:

- Some time spent with Executive Leads discussing what type of information should come to the Committee to provide the assurance it needs
- Cyber security and Information Governance – although this is probably best done by the new Committee
- Receive development similar to that of the Board

5. Suggested actions

While it is for the Committee to determine the next steps, the following is suggested for consideration:

5.1 Committee member induction, knowledge and training

New committee members have, in the past, received induction from the Board Secretary and other Executive Directors. If they are appointed members of the Quality, Safety and Improvement Committee this would be included in a broad sense. The results from the self-assessment raise the question as to what level of induction committee members feel is needed for new members. It may be necessary to strengthen induction and training for those that are already within the organisation but moving onto the committee.

As the membership of the committee has been revised following a review of the Public Health Wales board committee structure it might be advisable to develop a committee development plan linked within the wider Board Development Plan.

5.2 Review of Committee workplan coverage

Responses to the questionnaire have indicated that not all areas of the organisation's quality and safety related business receives sufficient scrutiny and consideration.

As part of the review of Public Health Wales Board Committees, the need was identified for a new Knowledge, Research and Information Committee which will start meeting in early 2019. The remit for this new committee will include Information Governance and Research and Development. The Chair and lead Executive of the Quality, Safety and Improvement Committee will work closely with the Chair and lead Executive of the new Knowledge, Research and Innovation to ensure the workplan for the new Committee provides fair coverage of these items.

Once these items have been remitted from the Quality, Safety and Improvement Committee, the workplan should be reviewed and re-focused to enable the committee to have greater scrutiny of the areas outlined in

4.1, and ensure that proportional consideration of quality and safety activity across all directorates within Public Health Wales. This should also help the Committee to identify gaps in scrutiny and assurance or areas of overlap with other Committees and governing fora.

In this consideration, the Committee should also consider the work programmes of the supporting management groups and whether these adequately inform the activity of the Committee.

5.3 Timeliness of information

There was a recurring response to a number of questions from one respondent in relation to the timeliness of the information received by the Committee. The Business Executive Team scrutinises data and information prior to it being submitted to the Committee. The Committee meets on a quarterly basis. The Business Executive Team met on a monthly basis for the first half of the year. However, from November 2018 it started meeting bi-monthly to feed into Board meetings. As a result, there are some occasions in the reporting calendar where reports are produced a number of weeks prior to the Committee meeting. It is recommended that the Lead Executive, together with the Board Secretary look into this further.

6. Conclusion

The results of the questionnaire have indicated that the Committee is broadly operating effectively, with clear strengths. However, areas for improvement have been identified. In considering the outcomes of the questionnaire, the Committee needs to consider how the areas identified can be addressed and agree the next steps.

7. Well-being of Future Generations (Wales) Act 2015

This work has been put together following the five ways of working, as defined within the sustainable development principle in the Act, in the following ways:

The Committee self-assessment will be completed on an annual basis and there will be a rolling programme of improvement and assessment.

The self-assessment reviews whether the Committee is discharging its duties in accordance with the Committee Terms of Reference

The Committee self-assessment is integral to the Governance report included in the organisation's annual report

The action plan will be developed in collaboration with Committee members

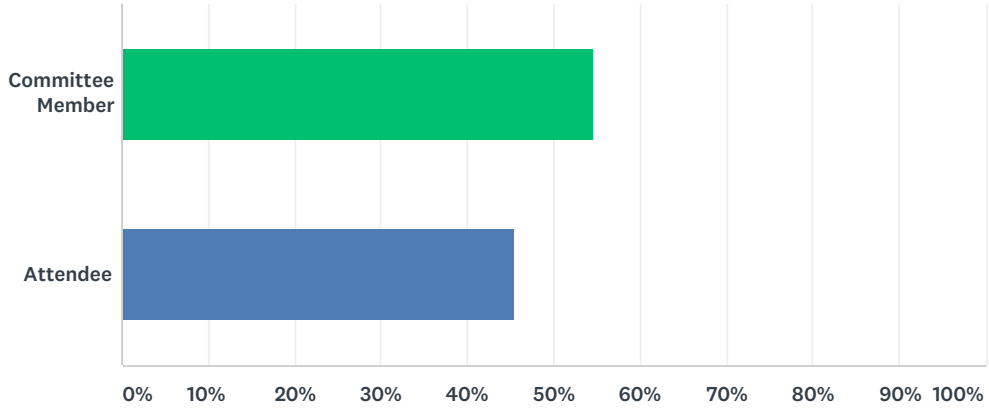
All regular attendees to the Committee were asked to contribute to the self-assessment

8. Recommendation

The Committee is asked to **consider** the proposed action plan.

Q1 What is your role on the Committee?

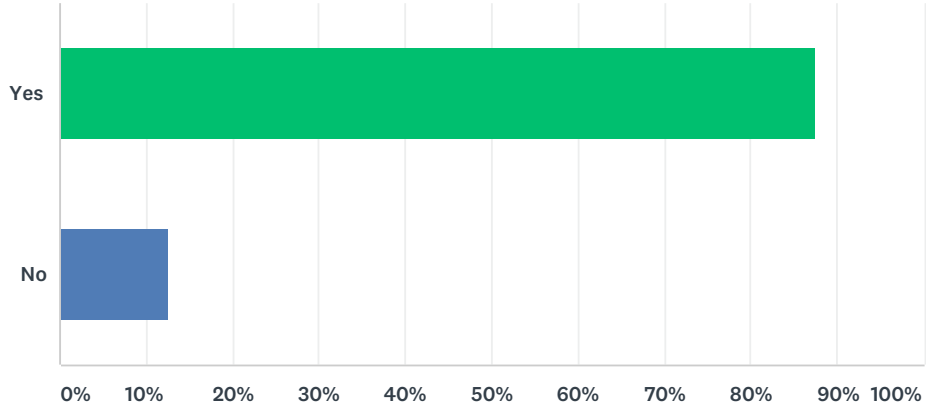
Answered: 11 Skipped: 0



ANSWER CHOICES	RESPONSES	
Committee Member	54.55%	6
Attendee	45.45%	5
TOTAL		11

Q2 Is the committee membership appropriate, in terms of available skills and expertise? If no, please elaborate in the comments section.

Answered: 8 Skipped: 3

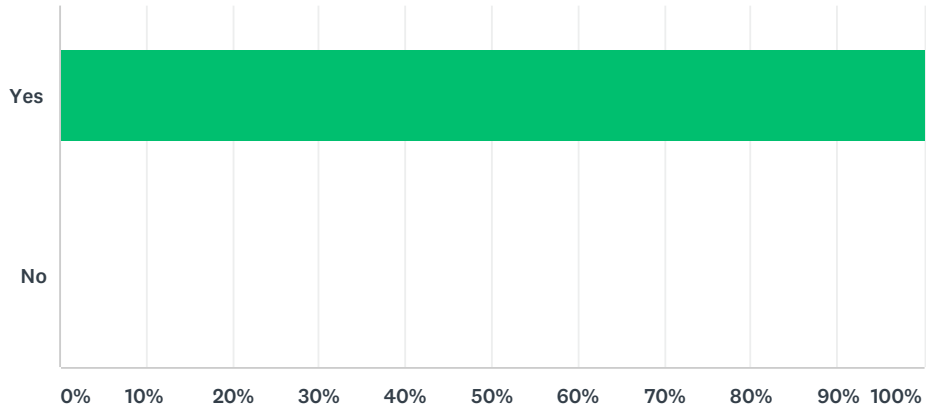


ANSWER CHOICES	RESPONSES	
Yes	87.50%	7
No	12.50%	1
TOTAL		8

#	COMMENTS	DATE
1	Probably need more about measuring impact	12/13/2018 3:47 PM

Q3 Are committee members able to identify key risk areas and to effectively scrutinise and appropriately challenge on critical and sensitive matters?

Answered: 7 Skipped: 4

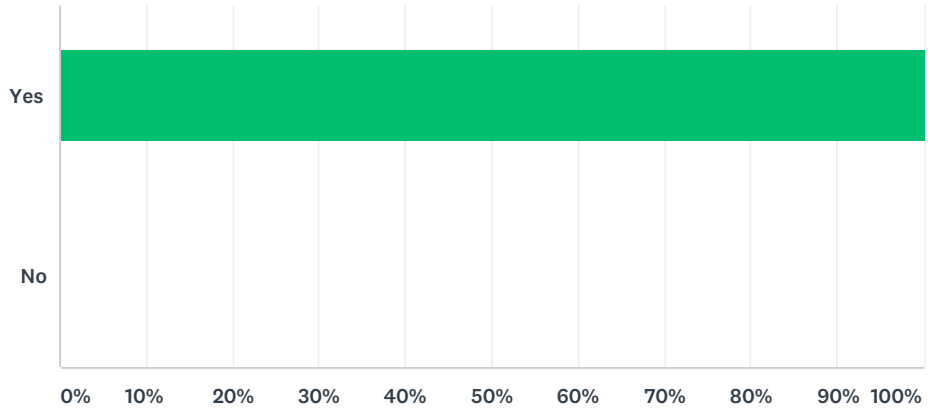


ANSWER CHOICES	RESPONSES	
Yes	100.00%	7
No	0.00%	0
TOTAL		7

#	COMMENTS	DATE
1	Although in general I feel the answer to this question is yes, I feel we are somewhat limited by the information that is presented to committee, and quite often there is a lot of debate and questions raised but this is not always followed sufficiently.	12/3/2018 8:53 AM
2	I also feel that this has improved in the past few months	11/30/2018 8:36 AM

Q4 Do you think that the organisational values (Working Together, Trust and Respect, Make a Difference) are demonstrated during Committee meetings?

Answered: 7 Skipped: 4

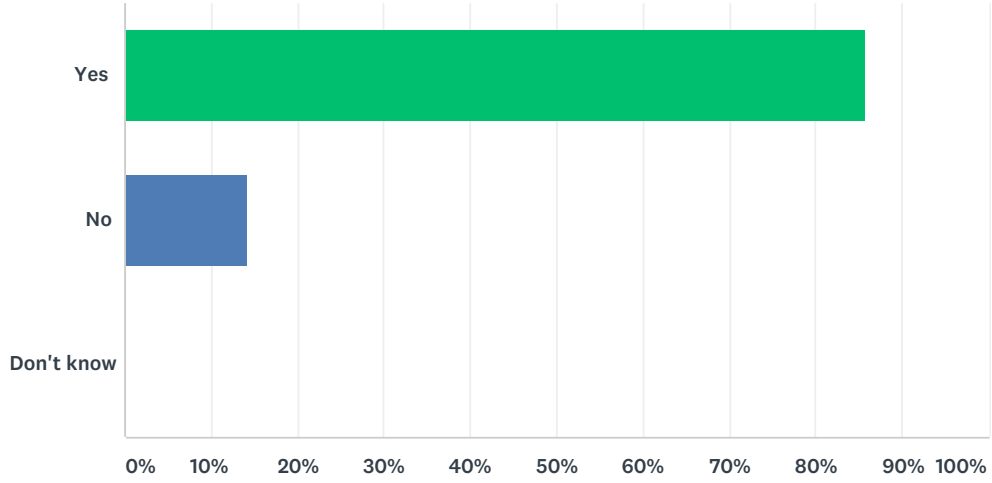


ANSWER CHOICES	RESPONSES	
Yes	100.00%	7
No	0.00%	0
TOTAL		7

#	COMMENTS	DATE
1	The committee works hard to do so while discussing difficult matters.	11/29/2018 3:52 PM

Q5 Does the Committee meet at a sufficient frequency to deal with planned matters and is enough time left for scrutiny and discussion?

Answered: 7 Skipped: 4

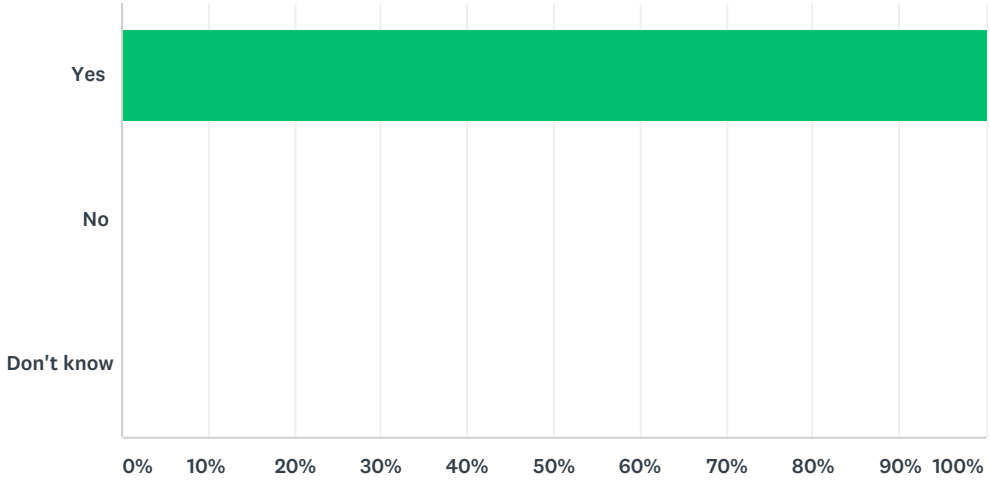


ANSWER CHOICES	RESPONSES	
Yes	85.71%	6
No	14.29%	1
Don't know	0.00%	0
TOTAL		7

#	COMMENTS	DATE
1	Although the frequency of the meetings are sufficient to deal with planned matters the information is drafted weeks in advance of the Committee meeting due to the timing the Business Executive Team which may impact on assurance.	12/7/2018 12:05 PM
2	Alhtough the current agendas are very full - although this shoudl imporve in the new year with the additional committee looking at knowledge etc	11/30/2018 8:39 AM
3	Quarterly	11/29/2018 3:53 PM
4	Maybe more time needed for deep dives.	11/21/2018 1:36 PM

Q6 Are you provided with the opportunity to contribute during the meetings?

Answered: 7 Skipped: 4

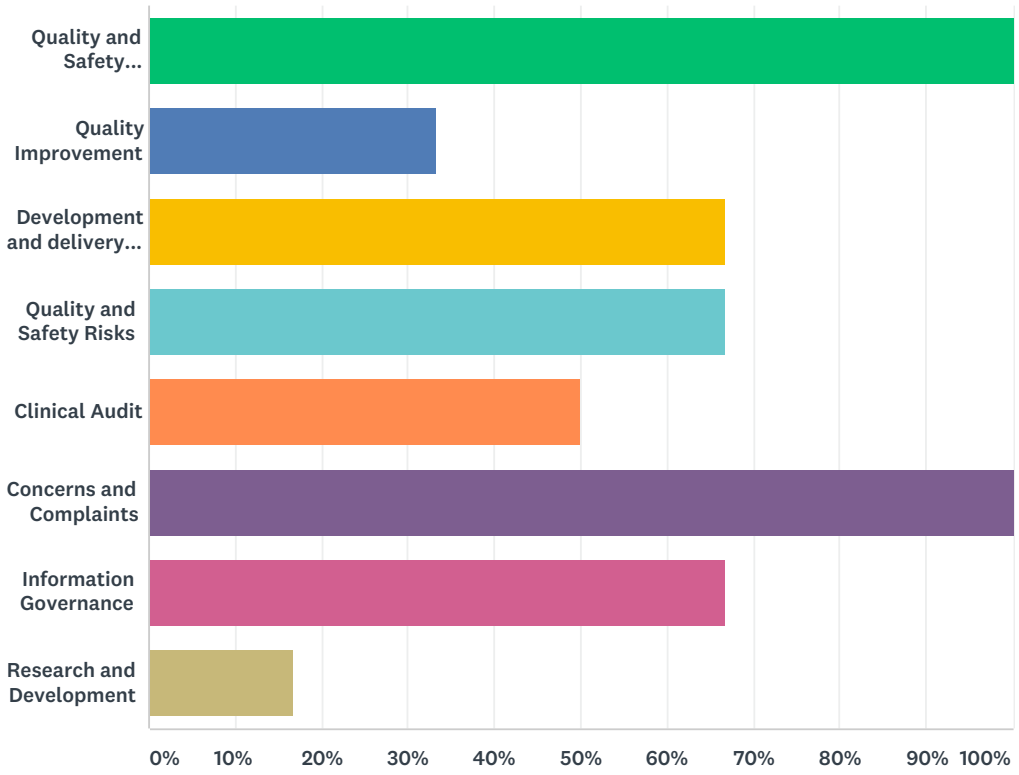


ANSWER CHOICES	RESPONSES	
Yes	100.00%	7
No	0.00%	0
Don't know	0.00%	0
TOTAL		7

#	COMMENTS	DATE
	There are no responses.	

Q7 An annual workplan of committee business is in place. Does the workplan sufficiently cover the following areas (please tick all that apply)?

Answered: 6 Skipped: 5



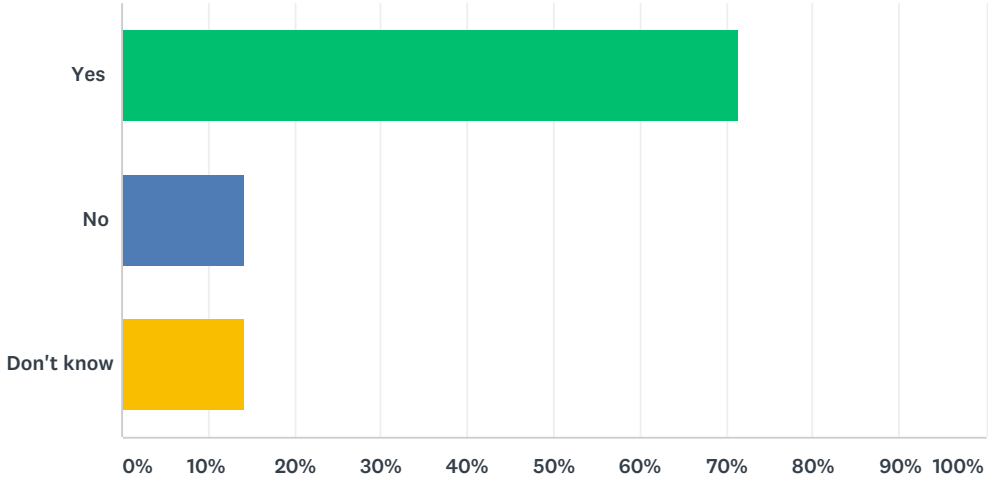
ANSWER CHOICES	RESPONSES	
Quality and Safety Standards	100.00%	6
Quality Improvement	33.33%	2
Development and delivery of services/programmes	66.67%	4
Quality and Safety Risks	66.67%	4
Clinical Audit	50.00%	3
Concerns and Complaints	100.00%	6
Information Governance	66.67%	4
Research and Development	16.67%	1
Total Respondents: 6		

#	OTHER (PLEASE SPECIFY)	DATE
1	Safety issues are discussed at the POD Committee and therefore Committee members may not be sighted on issues that may require further scrutiny.	12/7/2018 12:05 PM
2	- Health and safety does not currenlty report to QSIC - We ackniowldge that there is additional work that needs to be completed re clincial audit - IG and R&D will be better ocvered int he new committee as there will be additonal time	11/30/2018 8:39 AM
3	We've recognised that we can't give IG sufficient attention so it will be moved out. We've made changes to our agenda to better eflect areas we haven't covered well in the past e.g. delivery of services.	11/29/2018 3:53 PM

4	I'm afraid I don't feel qualified to answer that question	11/21/2018 1:36 PM

Q8 Do you think that the reports provided to the Committee are clear, robust and of sufficient quality?

Answered: 7 Skipped: 4

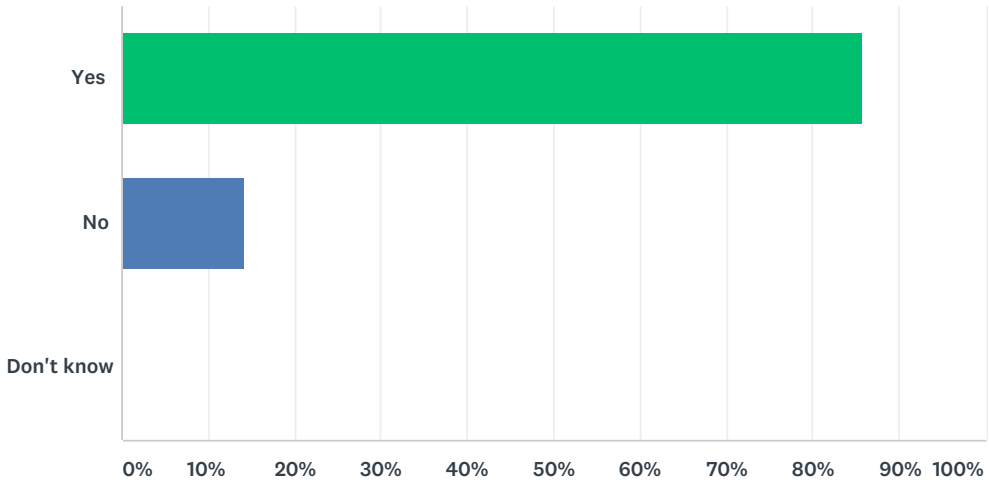


ANSWER CHOICES	RESPONSES	
Yes	71.43%	5
No	14.29%	1
Don't know	14.29%	1
TOTAL		7

#	COMMENTS	DATE
1	Bit too process though	12/13/2018 3:48 PM
2	See previous comment - -often these are narrative with little attention given to providing a succinct summary of the key issues, risks, action plans and anticipated milestones	12/3/2018 8:55 AM
3	Generally	11/30/2018 8:39 AM

Q9 Do you think that data (e.g. incident statistics) provided to the Committee is robust and of sufficient quality?

Answered: 7 Skipped: 4

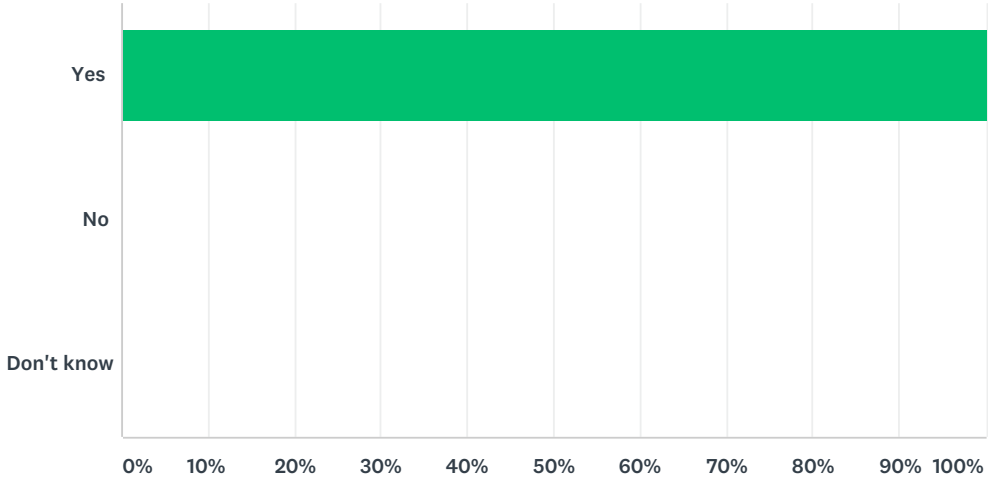


ANSWER CHOICES	RESPONSES	
Yes	85.71%	6
No	14.29%	1
Don't know	0.00%	0
TOTAL		7

#	COMMENTS	DATE
1	I am not convinced that we are reporting via Datix accurately/consistently across the organisation. I have raised this at QISC.	11/21/2018 1:40 PM

Q10 In your view, do the reports the Committee receives enable it to discharge its internal control and risk management responsibilities?

Answered: 7 Skipped: 4

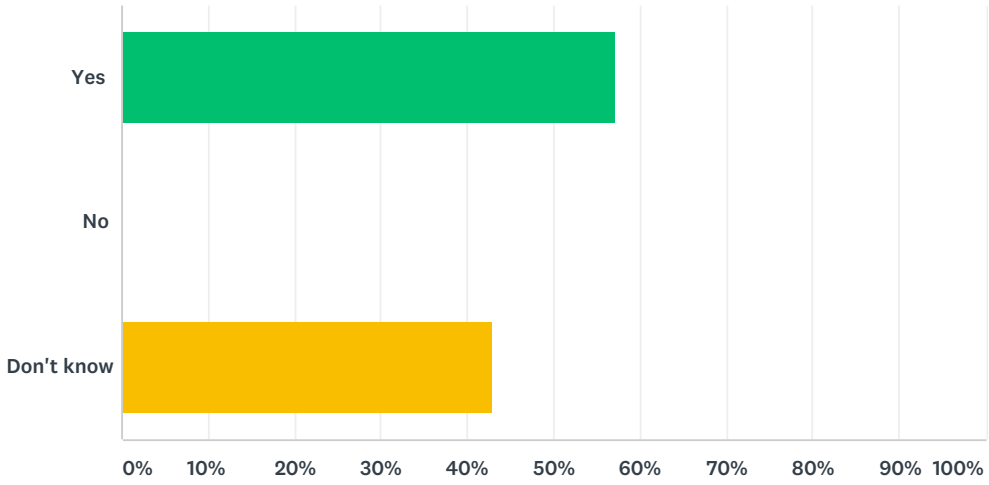


ANSWER CHOICES	RESPONSES	
Yes	100.00%	7
No	0.00%	0
Don't know	0.00%	0
TOTAL		7

#	COMMENTS	DATE
1	Generally although the deep dives allow time to scrutinise in miore detail	11/30/2018 8:42 AM
2	Generally	11/21/2018 1:40 PM

Q11 The Committee receives an updated extract of the Board Assurance Framework at each meeting. Does this provide sufficient information and the appropriate level of assurance to the Committee?

Answered: 7 Skipped: 4

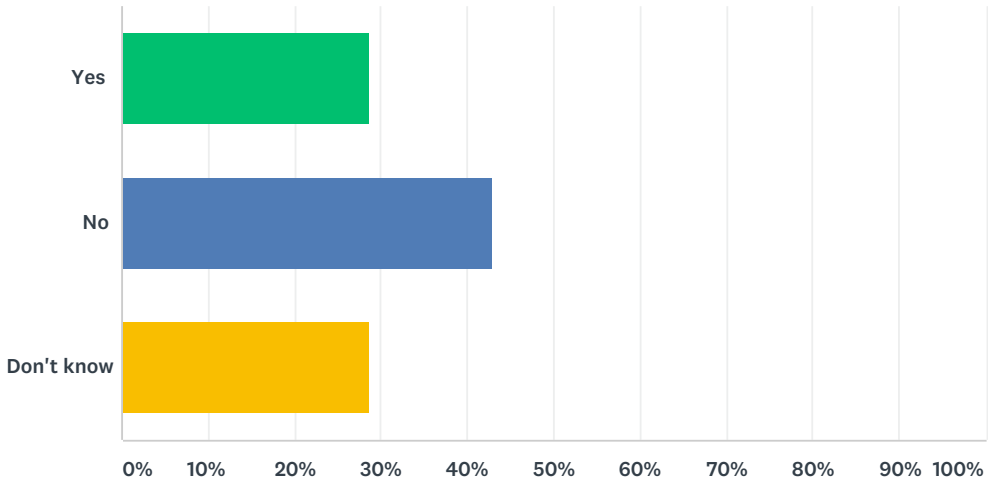


ANSWER CHOICES	RESPONSES	
Yes	57.14%	4
No	0.00%	0
Don't know	42.86%	3
TOTAL		7

#	COMMENTS	DATE
1	We've moved this to the top of the agenda to give it more time and attention.	11/29/2018 3:55 PM

Q12 In your view, are there any unnecessary areas of overlap with other committees?

Answered: 7 Skipped: 4

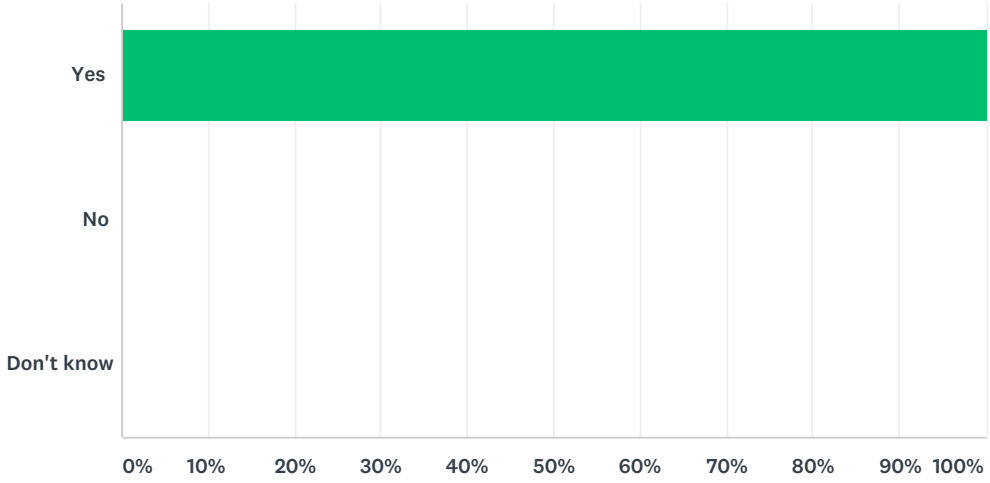


ANSWER CHOICES	RESPONSES	
Yes	28.57%	2
No	42.86%	3
Don't know	28.57%	2
TOTAL		7

#	COMMENTS	DATE
1	Sometimes eg microbiology though the Committee is aware and has indicated its willingness to address this.	12/13/2018 8:46 PM
2	On occations yes but the recent Baord paper highlighted these areas, which will be particualrly helpful in providing an opportunity to ensure all committee members are aware of these overlaps.	11/30/2018 8:42 AM
3	Ot overlap, but there will always be common issues which are developing a mechanism to track and share.	11/29/2018 3:55 PM

Q13 In your view, does the Committee receive staff and/or service-user experience stories at sufficient frequency?

Answered: 7 Skipped: 4

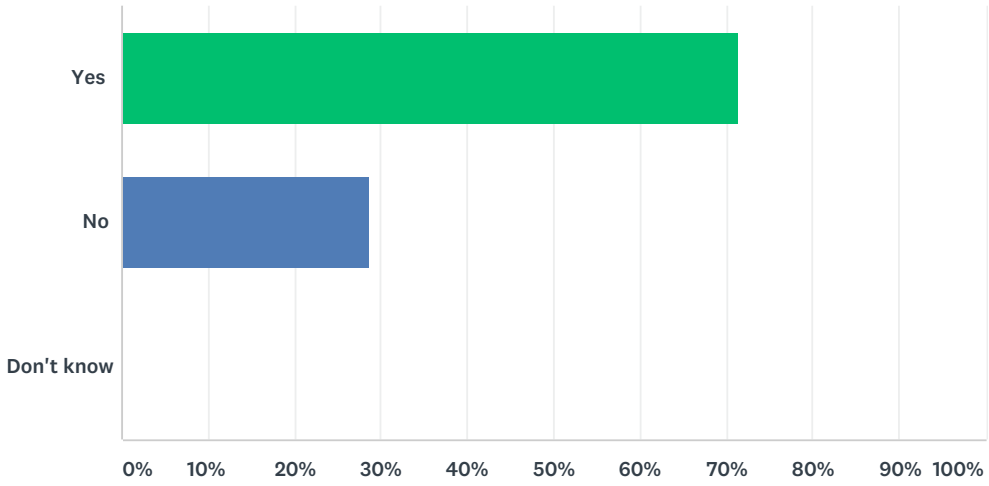


ANSWER CHOICES	RESPONSES	
Yes	100.00%	7
No	0.00%	0
Don't know	0.00%	0
TOTAL		7

#	COMMENTS	DATE
1	...but we don't seem to follow up or use the information as best we could.	11/21/2018 1:43 PM

Q14 Do these stories help you to make effective decisions?

Answered: 7 Skipped: 4

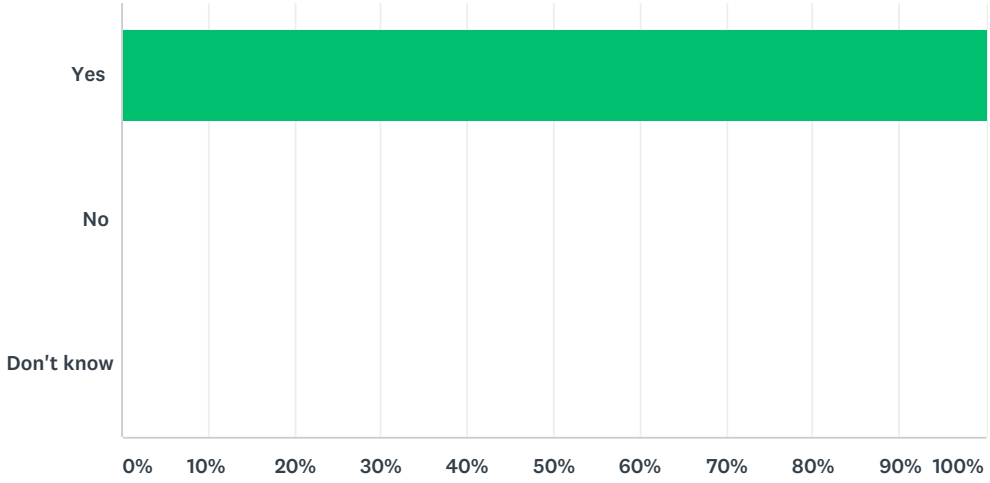


ANSWER CHOICES	RESPONSES	
Yes	71.43%	5
No	28.57%	2
Don't know	0.00%	0
TOTAL		7

#	COMMENTS	DATE
1	Sometimes but mostly we are an organization that doesn't deal with individuals	12/13/2018 3:50 PM
2	More so now that they are linked to agenda items.	12/7/2018 12:34 PM
3	Although they are only usually one person's perspective they allow for members to reflect on actual experiences	11/30/2018 8:42 AM
4	See comment above	11/21/2018 1:43 PM

Q15 Is the public reporting of the Committee's activity sufficiently open, accessible and transparent?

Answered: 7 Skipped: 4

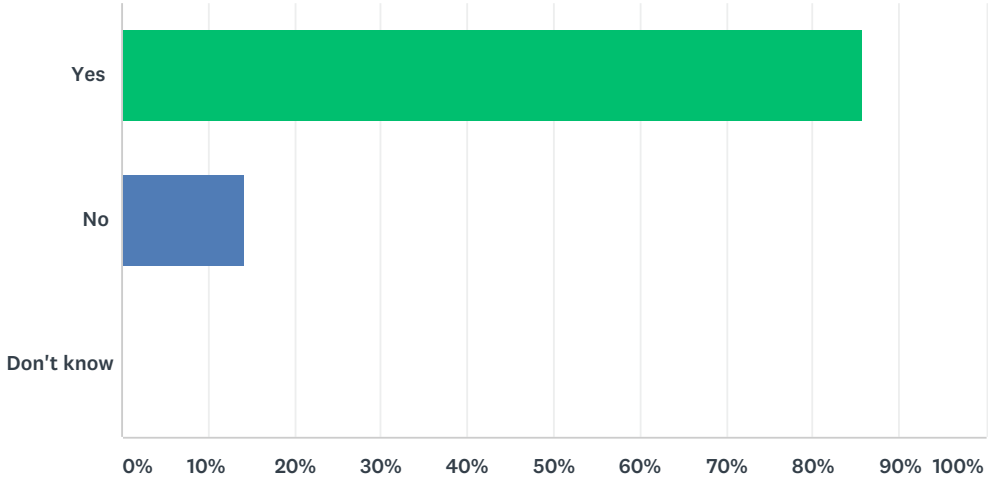


ANSWER CHOICES	RESPONSES	
Yes	100.00%	7
No	0.00%	0
Don't know	0.00%	0
TOTAL		7

#	COMMENTS	DATE
	There are no responses.	

Q16 Does the Committee receive timely and sufficient information on incidents, complaints and concerns?

Answered: 7 Skipped: 4

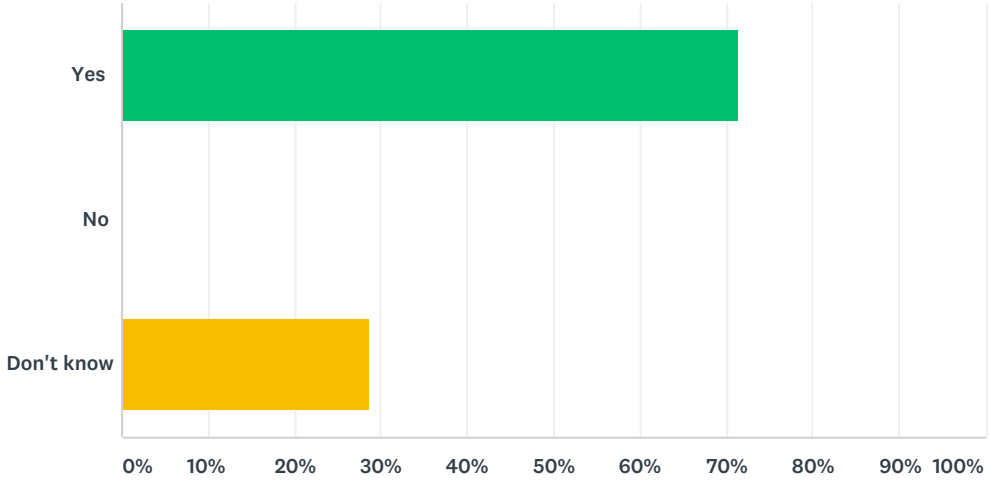


ANSWER CHOICES	RESPONSES	
Yes	85.71%	6
No	14.29%	1
Don't know	0.00%	0
TOTAL		7

#	COMMENTS	DATE
1	The information on incidents, complaints and concerns is produced weeks in advance of the Committee meeting due to the timing of the Business Executive Team and Committee dates.	12/7/2018 12:44 PM

Q17 Does the Committee receive timely and sufficient information to enable it to monitor progress against the Clinical Audit Plan?

Answered: 7 Skipped: 4

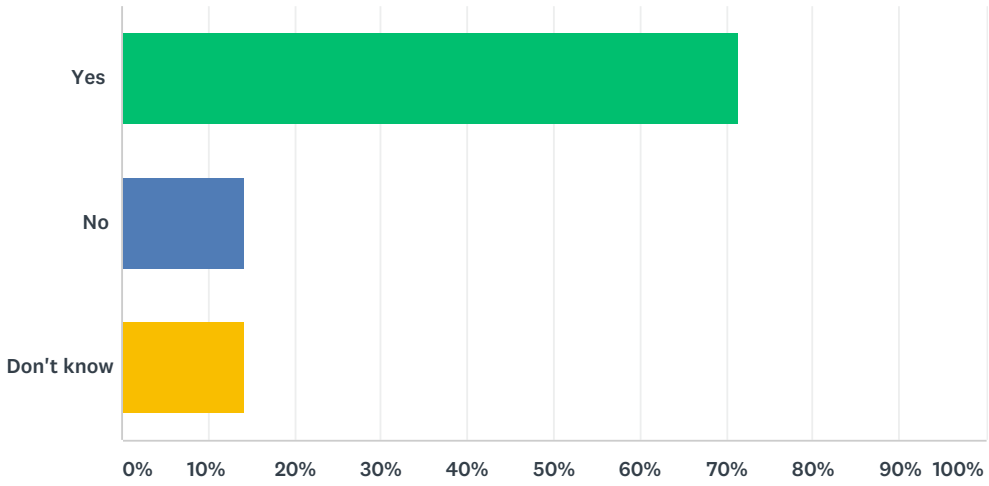


ANSWER CHOICES	RESPONSES	
Yes	71.43%	5
No	0.00%	0
Don't know	28.57%	2
TOTAL		7

#	COMMENTS	DATE
1	This is scheduled in 6 monthly and will be reported on as such this year.	11/30/2018 8:43 AM

Q18 Does the Committee receive sufficient and timely information on information governance matters?

Answered: 7 Skipped: 4

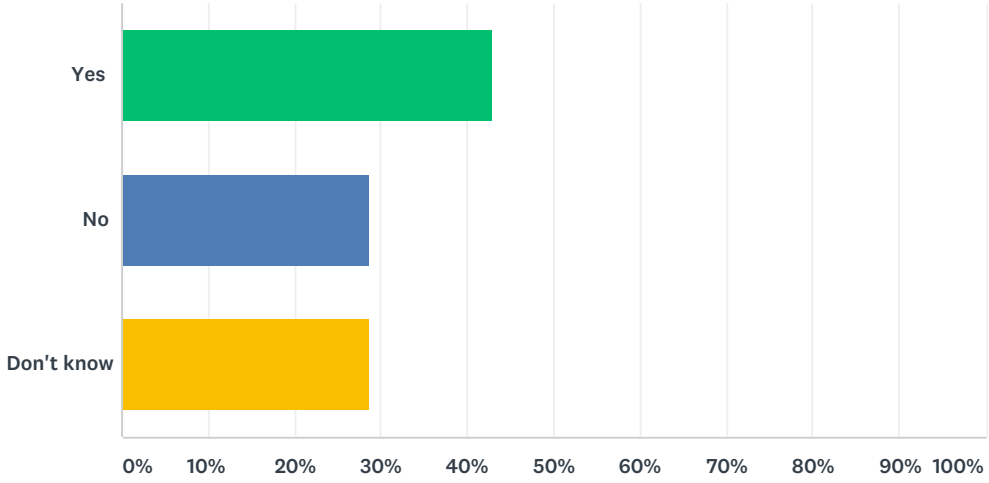


ANSWER CHOICES	RESPONSES	
Yes	71.43%	5
No	14.29%	1
Don't know	14.29%	1
TOTAL		7

#	COMMENTS	DATE
1	This information can also be weeks old when received by the Committee due to the timings of both the Committee and Business Executive Team dates.	12/7/2018 12:46 PM
2	Althoguh the new committee will allow for additional time	11/30/2018 8:44 AM
3	Although see previous answer, to give this requisite time it will be moved 9ut of this Committee.	11/29/2018 3:56 PM

Q19 Does the Committee review progress against the organisation's Caldicott Principles into Practice Action Plan?

Answered: 7 Skipped: 4

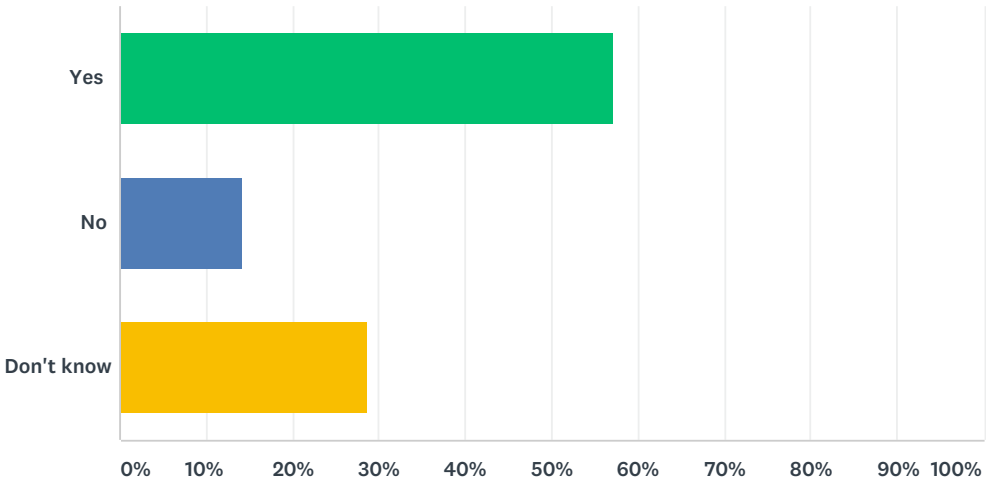


ANSWER CHOICES	RESPONSES	
Yes	42.86%	3
No	28.57%	2
Don't know	28.57%	2
TOTAL		7

#	COMMENTS	DATE
1	Only by exception	12/7/2018 12:46 PM
2	Within IG performance report	11/30/2018 8:44 AM

Q20 Does the Committee receive timely and sufficient information on data protection matters and incidents?

Answered: 7 Skipped: 4

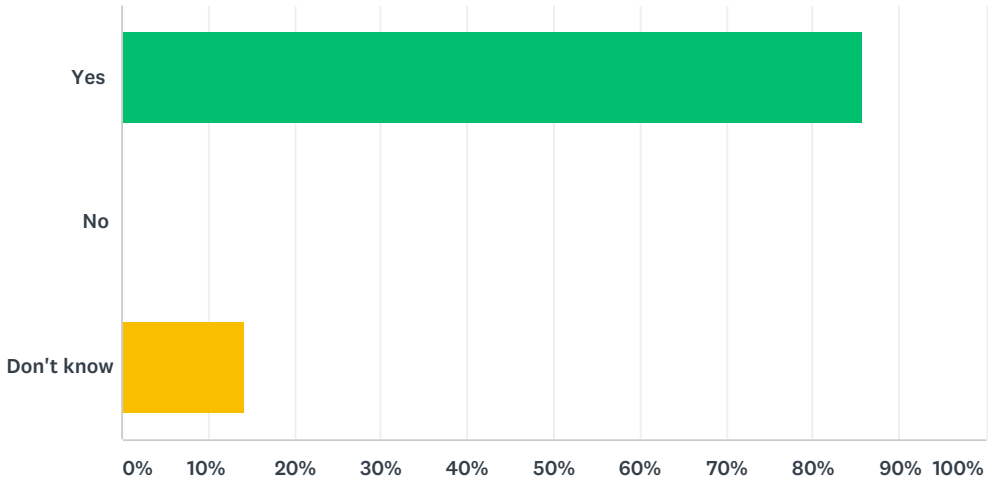


ANSWER CHOICES	RESPONSES	
Yes	57.14%	4
No	14.29%	1
Don't know	28.57%	2
TOTAL		7

#	COMMENTS	DATE
1	This information can also be weeks old when received by the Committee due to the timings of both the Committee and Business Executive Team dates.	12/7/2018 12:46 PM
2	Within IG performance report	11/30/2018 8:44 AM

Q21 Has the Committee reviewed the robustness and content of the draft Annual Quality Statement before it is recommended to the Board for approval?

Answered: 7 Skipped: 4

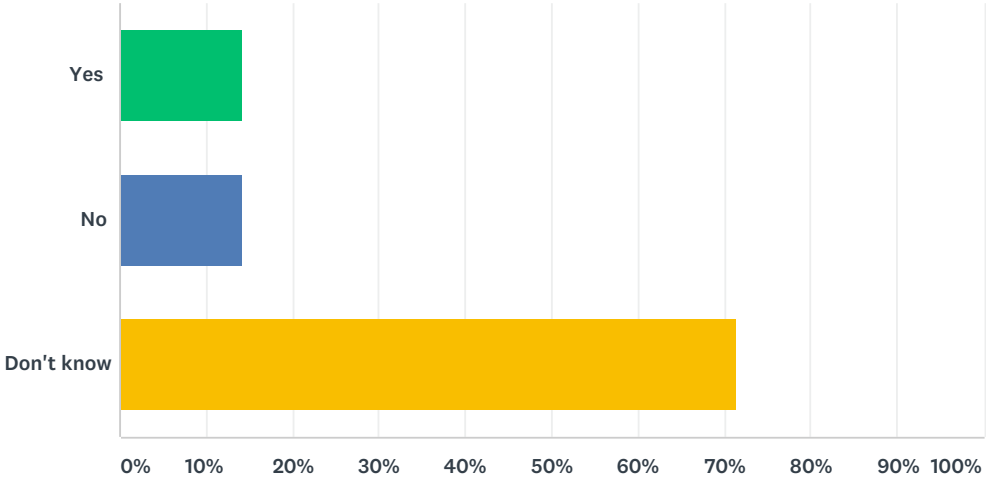


ANSWER CHOICES	RESPONSES	
Yes	85.71%	6
No	0.00%	0
Don't know	14.29%	1
TOTAL		7

#	COMMENTS	DATE
	There are no responses.	

Q22 Are members, particularly those new to the Committee, provided with induction and training?

Answered: 7 Skipped: 4

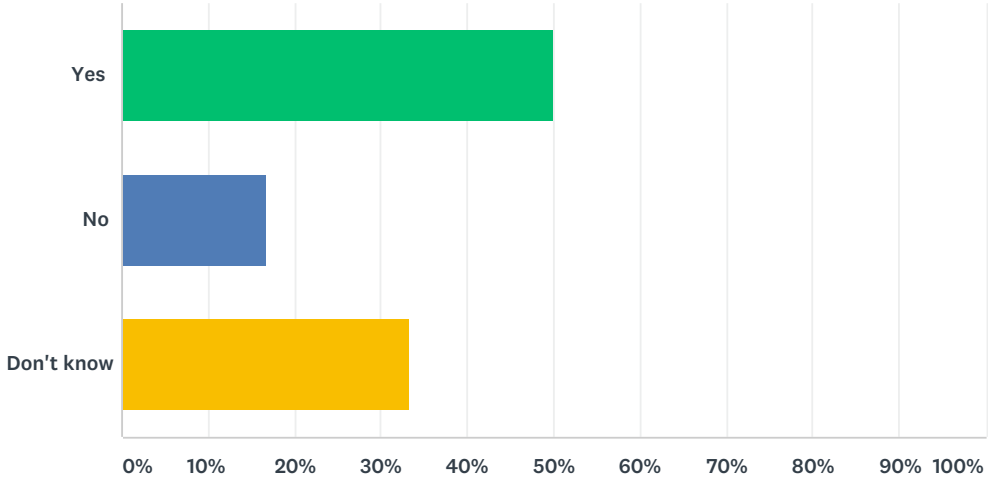


ANSWER CHOICES	RESPONSES	
Yes	14.29%	1
No	14.29%	1
Don't know	71.43%	5
TOTAL		7

#	COMMENTS	DATE
1	I've ticked don't know as i think this is an area we could develop - we've had development sessions in the oast but a more robust development a plan for members could fall out of this feedback.	11/29/2018 3:59 PM

Q23 Are there any areas of development that you feel Committee members would benefit from either collectively or individually?

Answered: 6 Skipped: 5



ANSWER CHOICES	RESPONSES	
Yes	50.00%	3
No	16.67%	1
Don't know	33.33%	2
TOTAL		6

#	COMMENTS	DATE
1	Impact assessment	12/13/2018 3:52 PM
2	I think some time should be spent with exec leads discussing what type of info should come to committee to provide the assurance it needs	12/3/2018 8:57 AM
3	Cyber security and IG - although this is probably best done by the new committee.	11/29/2018 3:59 PM
4	I think committees should receive development similar to that of the board.	11/21/2018 1:45 PM

Q24 This survey is one way of reviewing the effectiveness of the Committee. Do you have any other suggestions for how the Committee can periodically review its effectiveness?Please include any other comments which you feel you have not had the opportunity to include elsewhere in this survey.Once you have finished, please click 'Done' to submit your survey responses.Thank you for completing this survey.

Answered: 0 Skipped: 11

#	RESPONSES	DATE
	There are no responses.	

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales	**Name of Meeting** Quality, Safety and Improvement Committee **Date of Meeting** 15 January 2019 **Agenda item:** 10.2.QSIC.150119

Ratification of Chair's Action

Executive lead:	Cathie Steele, Acting Board Secretary and Head of Corporate Governance
Author:	Eleanor Higgins, Corporate Governance Manager

Approval/Scrutiny route:	Chair's action taken

Purpose
This report details a Chair's Action taken on behalf of the Committee on 31 October 2018.

Recommendation:				
RATIFY ☒	CONSIDER ☐	RECOMMEND ☐	ADOPT ☐	Assurance ☐

The Board is asked to:

- **Ratify** the Chair's Action

Link to Public Health Wales Strategic Plan
Public Health Wales has an agreed strategic plan, which has identified seven strategic priorities and well-being objectives. This report contributes to all 7 of the Strategic Priorities and Well-being Objectives.

Summary impact analysis	
Equality and Health Impact Assessment	An Equality Impact Assessment was completed alongside the policy for which Chair's action was taken. A specific Equality and Health Impact Assessment (EHIA) is not required in support of this Chair's action report.
Risk and Assurance	In line with the Standing Orders this report provides assurance that when Chair's action is taken it is taken in line with the Standing Orders.
Health and Care Standards	This report supports and/or takes into account the Health and Care Standards for NHS Wales Quality Themes Governance, Leadership and Accountability
Financial implications	There are no financial implications as a result of approval of this report.
People implications	There are no people implications as a result of approval of this Chair's action report.

1. Purpose / situation

This report details a Chair's Action taken on behalf of the Committee on 31 October 2018.

2. Background

2.1 Chair's Action

In accordance with Section 2.1 of the Standing Orders there may occasionally be circumstances where decisions that would normally be made by the Board need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Board. In these circumstances, the Chair and the Chief Executive, supported by the Board Secretary as appropriate, may deal with matters on behalf of the board – after first consulting with at least two other Non-Executive Directors.

This provision extends to the Board's committees where the Chair of the Committee can take forward urgent decisions, in consultation with two Committee members and supported by the Board Secretary.

3. Description/Assessment

The Chair of the Quality, Safety and Improvement Committee, supported by two Independent members, approved the:

Medical Devices and Equipment Management Policy and Procedure.

4. Recommendation

The Committee is asked to:

- **Ratify** the Chair's Action

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales	**Name of Meeting** Quality, Safety and Improvement Committee **Date of Meeting** 15 January 2019 **Agenda item:** 10.2.QSIC.150119

Medical Devices and Equipment Management Policy and Procedure	
Executive lead:	Dr Quentin Sandifer, Executive Director of Public Health Services and Medical Director
Author:	Cara Tingle, Compliance Manager, Public Health Services

Approval/Scrutiny route:	Senior Leadership Team – comment (June 2018) Business Executive Team – note (July 2018) Quality, Safety and Improvement Committee – approval (15 January 2019)

Purpose

This report presents the revised Medical Devices and Equipment Management Policy (Annex 1) and Procedure (Annex 2).

Recommendation:

APPROVE	CONSIDER	RECOMMEND	ADOPT	NOTE
☒	☐	☐	☐	☐

The People and Organisational Development Committee is asked to:

- **Approve** the policy and procedure.

Link to Public Health Wales Strategic Plan Public Health Wales has an agreed strategic plan, which has identified seven strategic priorities and well-being objectives. This report contributes to the following:	
Strategic Priority / Well-being Objective	5 - Protecting the public from infection and environmental threats to health

Summary impact analysis	
Equality and Health Impact Assessment	An Equality and Impact Assessment has been completed for this procedure.
Risk and Assurance	There is no specific current risk relating to the policy and procedure on an organisational risk register, however the policy is itemised on the corporate Policy and Control Document register and existing documentation has passed the review date.
Health and Care Standards	This report supports and/or takes into account the Health and Care Standards for NHS Wales Quality Themes Theme 2 - Safe Care
Financial implications	The procedure includes provisions with regard to procurement and contractual costs associated with maintenance, replacement, disposal, servicing and repair of medical devices.
People implications	The policy and procedures ensure that Public Health Wales will use medical devices safely in order to protect the health and wellbeing of patients, service users, staff and others.

1. Purpose

This report presents the revised Medical Devices and Equipment Policy (Annex 1) and associated procedure (Annex 2).

2. Background

This policy applies to all medical devices used in the Trust, associated establishments or supplied to service users for use in their own homes irrespective of whether the equipment has been purchased, loaned or received as a gift.

The purpose of medical device management is to ensure that the right equipment is available when required, in a safe and serviceable condition and at a reasonable cost.

3. Description/Assessment

3.1 Summary of revisions

The Medical Devices Policy was updated in line with legislation and to reflect the revised organisational policy process.

A new procedure has also been developed.

3.2 Consultation

Wide consultation for the updated policy and procedure has taken place to ensure that it meets the needs of our stakeholders and the organisation. The consultation undertaken specific to this documentation was as follows:

- The document was added to the policy consultation pages on the intranet for 28 days between 12 April - 10 May 2018.
- The document was discussed at a meeting of the Local Partnership Forum.

Any comments received were incorporated within the draft document.

An Equality and Health Impact Assessment was also undertaken (Annex 3).

3.3 Publication and dissemination arrangements

The primary source for dissemination of this document (specify) within the organisation will be via the intranet. It will also be made available to the wider community and our partners via the internet site.

3.1 Well-being of Future Generations (Wales) Act 2015

This procedure will contribute to the following Public Health Wales well-being objectives:

Goal 3 - Support the NHS to deliver high quality, equitable and sustainable services
Goal 4 - Minimise public health risks

The policy and associated procedure has been revised to ensure the long-term safety of staff and patients with regard to the use of medical devices.

The policy and procedure ensures an appropriate and safe approach to medical device management.

The policy and procedure are fully integrated and have been developed with due consideration of other related policies and procedures.

The policy and procedure were developed in collaboration with specialists and stakeholders across the organisation.

The policy and procedure were circulated for wide staff consultation.

4. Recommendation

The Committee is asked to:

- **approve** the policy and associated procedure.

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales	**Reference Number:** PHW 69 **Version Number:** 2 **Date of next review:** 27 November 2021

Medical Devices and Equipment Management Policy

Policy Statement

It is the policy of Public Health Wales that all practicable steps should be taken to ensure all risks associated with the acquisition, management and use of medical devices are minimised to protect the public health and safeguard the interest of service users, carers and staff.

The term "medical devices" covers all products, except medicines, used in healthcare for the diagnosis, prevention, monitoring or treatment of illness or disability. The range of products is very wide, it includes airways and equipment used in life support, aids to daily living eg wheelchairs, syringes, needles, thermometers, mattresses, beds, examination gloves, urine testing strips, specimen collection tubes and any of thousands of other items used every day by healthcare providers and users.

Public Health Wales must ensure that the medical devices and equipment meet appropriate standards of safety, quality and performance, complying with all the relevant directives set out by the Medicines and Healthcare Products Regulatory Agency (MHRA).

It is the responsibility of the organisation and all employees to contribute to the provision of safe and secure use of all medical devices for service users, carers and staff.

The aim is to ensure whenever a medical device is used, it should be:

(a) Suitable for its intended purpose;
(b) Properly understood by the user;
(c) Maintained in a safe and reliable condition;
(d) Stored and disposed of appropriately;
(e) Decontaminated in accordance to manufacturers guidance.

Policy Commitment

To provide a clear understanding of the organisation's principles regarding the management and decontamination of medical devices and to set out standards and guidance to ensure systems are in place to provide assurances for the safe use and storage of equipment in Public Health Wales.

This policy aims to prevent and control the spread of infection by the provision of robust decontamination principles, for the safety of patients and staff.

The aim of this policy is to support staff in understanding their responsibilities in relation to the management of medical devices. The knowledge and skills of staff, carers and services users have major implications for safety. Instructions must be clear, concise and readily available. Training should be timely and effective, and include procedures for the routine maintenance of medical devices by staff, carers and service users.

This policy is based on statutory requirements produced by the Health and Safety Commission, Department of Health, Medicines and Healthcare Products Regulatory Agency and the Welsh Government including the:

- The Medical Devices Regulations 2002
- The Medical Devices (Amendment) Regulations 2008 and 2012
- Health and Safety at Work etc. Act 1974
- Electricity at Work Regulations 1989
- Management of Health and Safety at Work Regulations 1999
- Provision and Use of Work Equipment Regulations 1998
- Health and Safety (Sharp Instruments in Healthcare) Regulations 2013

Supporting Procedures and Written Control Documents

Other related documents are:

- Health and Safety Policy
- Incident Reporting Policy
- Radiation Safety Policy
- Risk Management Policy
- Waste Management Policy
- Infection Control Policy
- Decontamination Policy
- Disposal of Obsolete and Surplus Equipment Policy

Scope

This policy applies to all medical devices used in Public Health Wales, associated establishments or supplied to service users for use in their own homes irrespective of whether the equipment has been purchased, loaned or received as a gift. The purpose of medical device management is to ensure that the right equipment is available when required, in a safe and serviceable condition and at a reasonable cost.

This policy applies to all staff (employed or contracted) who use, repair or procure medical devices in the course of their work.

All staff are required to ensure that they work within the boundaries set out by this policy.	
Equality and Health Impact Assessment	Integrated Screening Tool completed.
Approved by	Quality, Safety and Improvement Committee
Approval Date	27 November 2018
Review Date	27 November 2021
Date of Publication:	05 December 2018
Group with authority to approve supporting procedures	Quality, Safety and Improvement Committee
Accountable Executive Director	Dr Quentin Sandifer, Executive Director of Public Health Services and Medical Director
Author	Cara Tingle, Compliance Manager, Public Health Services

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or Corporate Governance.

Summary of reviews/amendments				
Version number	**Date of Review**	**Date of Approval**	**Date published**	**Summary of Amendments**
1	1/4/15	1/10/09	1/10/09	First version of policy.
2	01/02/18	27/11/18	05/12/18	Review undertaken in February/March 2018. Changes made as a result of legislative changes. Documentation currently subject to internal approval processes.

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales	**Reference Number:** PHW 69/TP01 **Version Number:** 1 **Date of Next review:** 27 November 2021

Medical Devices and Equipment Management Procedure

Introduction and aims

Public Health Wales is committed to ensuring the health, safety and welfare of its staff and those who are affected by its activities. This procedure supports the **Medical Devices and Equipment Management Policy** and has been developed in line with the requirements of the *Health and Safety at Work Etc. Act 1974*.

Public Health Wales must ensure that the medical devices and equipment meet appropriate standards of safety, quality and performance, complying with all the relevant directives set out by the Medicines and Healthcare Products Regulatory Agency (MHRA).

The procedure aims to:

- To provide a clear understanding of Public Health Wales' principles regarding the management and decontamination of medical devices and to set out standards and guidance to ensure systems are in place to provide assurances for the safe use and storage of equipment in the organisation.
- To prevent and control the spread of infection by the provision of robust decontamination principles, for the safety of patients and staff.

Linked Policies, Procedures and Written Control Documents

- Public Health Wales Medical Devices and Equipment Management Policy
- Health and Safety Policy
- Incident Reporting Policy
- Radiation Safety Policy
- Risk Management Policy
- Waste Management Policy
- Infection Control Policy
- Decontamination Policy
- Disposal of Obsolete and Surplus Equipment Policy

Scope

This procedure applies to all medical devices used in Public Health Wales, associated establishments or supplied to service users for use in their own homes irrespective of whether the equipment has been purchased, loaned or received as a gift. The purpose of medical device management is to ensure that the right equipment is available when required, in a safe and serviceable condition and at a reasonable cost.

This procedure applies to all staff employed (or contracted) by Public Health Wales who use, repair or procure medical devices in the course of their work.

All staff are required to ensure that they work within the boundaries set out by this procedure.

Equality and Health Impact Assessment	EHIA Completed for the Medical Devices and Equipment Management Policy
Approved by	Quality, Safety and Improvement Committee
Approval Date	27 November 2018
Review Date	27 November 2021
Date of Publication:	05 December 2018
Accountable Executive Director	Dr Quentin Sandifer, Executive Director of Public Health Services/Medical Director
Author	Cara Tingle, Compliance Manager, Public Health Services

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Corporate Governance.

Summary of reviews/amendments				
Version number	**Date of Review**	**Date of Approval**	**Date published**	**Summary of Amendments**
1	01.02.18	27.11.18	05.12.18	First version of procedure. Developed as a result of a review in February/March 2018.

1 Introduction

The aim of this procedure is to support staff in understanding their responsibilities in relation to the management of medical devices, in support of the Medical Devices and Equipment Management Policy.

This procedure aims to prevent and control the spread of infection by the provision of robust decontamination principles and clear standards and guidance to ensure systems are in place to provide assurances for the safe use and storage of equipment in the organisation.

2 Resource Implications

The resource implications of this procedure are primarily related to procurement and contractual costs associated with maintenance, replacement, disposal, servicing and repair of medical devices.

Failure to meet regulatory standards could lead to imposition of financial penalties, patient harm and reputational damage.

3 Definitions

The term *medical device c*overs a wide range of products used every day in primary and secondary healthcare settings.

MHRA defines a *medical device* as,

'... an instrument, apparatus, implant, in vitro reagent, or similar or related article that is used to diagnose, prevent, or treat disease or other conditions, and does not achieve its purposes through chemical action within or on the body'

In simple terms a *medical device is* any instrument, apparatus, appliance material or healthcare product (re-usable or single use), excluding drugs used for, or by, a patient or service user.

Medical devices can vary widely in complexity from simple devices such as a hypodermic needle, an oral thermometer, a disposable glove to more advanced devices such as defibrillators, x-ray machines and biopsy guns (and includes any software applications necessary for the device to function).

Within Public Health Wales, there are many pieces of equipment that fall within the definition of medical device. Usage is commonplace and very often training is part of an employee's induction in order for

them to carry out their role. Public Health Wales expects all staff to adhere to the following principles before using ANY medical device:

- Always visually check the piece of equipment for cleanliness and signs of damage and correct settings before each use
- Ensure equipment has been serviced where appropriate by checking service label
- If the equipment requires disposables, ensure they are correct for the device and for its current settings
- All disposables are within expiry date and any associated packaging is intact before opening
- Do not use the piece of equipment unless you have been trained to do so
- Do not be afraid to ask for advice
- Ensure that all equipment is thoroughly decontaminated in line with cleaning schedules and manufacture instructions before and after use. This information should be logged locally.
- Used within an appropriate environment

Manufacturer's Instructions must be readily available for each piece of equipment and it is essential that they are followed. Any deviation from the instructions may not only invalidate any warranty but could also cause an injury to the employee or service user.

4 Legislation and Best Practice Guidance

5.1 Statutory Requirements

The policy and associated procedure is based on statutory requirements produced by the Health and Safety Commission, Department of Health, Medicines and Healthcare Products Regulatory Agency and the Welsh Government including the:

- The Medical Devices Regulations 2002
- The Medical Devices (Amendment) Regulations 2008 and 2012
- Health and Safety at Work etc Act 1974
- Electricity at Work Regulations 1989
- Management of Health and Safety at Work Regulations 1999
- Provision and Use of Work Equipment Regulations 1998
- Health and Safety (Sharp Instruments in Healthcare) Regulations 2013

5.2 Best Practice Guidance

- MHRA, 2014. *Managing Medical Devices – Guidance for healthcare and social services organisations* [online]. London: MHRA. Available at: www.mhra.gov.uk/Publications/Safetyguidance/DeviceBulletins/CON2025142 [Accessed 14 April 2014]MHRA Safeguarding Public Health Device Bulletin DB2011(01) Reporting Adverse Incidents and Disseminating Medical Device Alerts March 2011
- *MHRA, 2008. Devices in Practice- a guide for professionals in health and social care*
- NHS Wales Governance e-Manual: Medical Devices
- Standard 2.9 Medical Devices, Equipment and Diagnostic Systems
- Device Bulletin Single-use Medical Devices: Implications and Consequences of Reuse Single use medical devices-implication reuse
- NHS Wales Shared Services Partnership - Specialist Estates Services publications

5.3 Mandatory requirements

Department of Health
Medicines and Healthcare Products Regulatory Agency
Decontamination of medical devices: a development plan for healthcare organisations
http://gov.wales/docs/dhss/publications/160107whc050en.pdf

5 Acquiring Equipment – Safety Quality and Performance

Appropriate acquisition and selection of devices should be undertaken in accordance with section 3 of the MHRA's Managing Medical Devices Guidance for healthcare and social services organisations April 2014. In addition, reference should be made to the MHRA's publication Devices in Practice – a guide for professionals in health and social care, which includes a series of checklists that can help in the purchase, use and maintenance of medical devices and training.

6 Roles and responsibilities

7.1 Chief Executive

The Chief Executive has the overall accountability for the management of medical devices.

7.2 Executive Director

The Executive Director of Public Health Services/Medical Director is the Board's nominated Director responsible for ensuring compliance with the policy and procedure.

This includes overall responsibility for ensuring compliance with all current regulations and approved guidance and best practice, and the implementation of the policy and procedure by:

- Communicating the policy and procedure to everyone who works at Public Health Wales.
- Ensuring the policy and procedure is implemented by everyone who works in Public Health Wales.

Delegating the performance of some of the duties related to medical equipment to Directors, Directorate Managers under his/her control

7.3 Head of Estates and Facilities

The Head of Estates and Facilities is Public Health Wales' nominated Medical Devices Liaison Person and is responsible for ensuring the effective reporting of adverse incidents involving medical devices to the Medicines and Healthcare Regulatory Agency (MHRA), the Health and Safety Executive (HSE) and the Surgical Material Testing Laboratory (SMTL), if appropriate, and the dissemination of advice and recommendations issued by them, including medical device alert notices throughout the organisation. When reporting adverse incidents involving medical devices and equipment the organisation's Incident Reporting Policy should be followed.

7.4 Health and Safety Group

The Health and Safety Group consists of wide ranging representation from each Directorate/ division who will be responsible for co-ordinating the Directorate/ division's responses/actions and communications in respect of medical devices and equipment.

7.5 Divisional Level Responsibilities

Divisional Service Directors should ensure equipment management structures are in place and that systems are developed to ensure all staff are aware and take ownership of their responsibilities concerning the management of equipment in accordance with national guidelines

including MDA DB9801 and Health and Care Standards, Standard 2 Safe Care, 2.9 Medical Devices, Equipment and Diagnostic Systems.

7.6 Departmental Managers should

Identify individuals for specific tasks and responsibilities
Set objectives, standards and timescales and monitor performance in relation to equipment management in their areas of work.

Report problems/areas of concern to senior managers
Implement the policy/procedure for equipment management and monitor compliance with the Medical Devices and Equipment Management policy/procedure in their area.

Take part in the business planning process relating to equipment
Check competence of all staff upon induction and monitor/review competence of all staff as part of appraisal and risk management processes.

Identify training and support for department leads. Ensure all training and competence is documented
Ensure adequate resources are provided for use of Personal Protective Equipment and decontamination methods.

7.7 Professional users should:

Work only within sphere of professional/personal competence
Use equipment in a safe authorised manner, only for its intended or designated purpose, following manufacturers guidelines and local policies.

Work to all organisational policies and procedures relating to the procurement, use and disposal of equipment.
Report any adverse incidents and concerns relating to the use of equipment to line manager.

Equipment must not be used or maintained without appropriate training and staff have a responsibility to identify and report any training needs to their line manager.

Ensure decontamination processes are in accordance to manufacturers guidance.

8 Acquiring Equipment – Safety Quality and Performance

8.1 Acquisition

Appropriate acquisition and selection of devices should be undertaken in accordance with section 3 of the MHRA's *Managing Medical Devices Guidance for healthcare and social services organisations April 2014*. In addition, reference should be made to the MHRA's publication *Devices in Practice – a guide for professionals in health and social care*, which includes a series of checklists that can help in the purchase, use and maintenance of medical devices and training.

9 Procurement

9.1 Process

Public Health Wales has a responsibility to ensure they follow a compliant and robust procurement process. Advice and support can be obtained from our procurement partners in Shared Services:-

Head of Procurement
Velindre / Public Health Wales NHS Trusts
NWSSP Shared Services HQ/ Partneriaeth Cydwasanaethau GIG Cymru
4-5Charnwood Court/ 4-5 Charnwood Court Heol
Billingsley/ Heol Billingsley Parc Nantgarw/ Parc Nantgarw Cardiff/ Caerdydd
CF15 7QZ

Telephone 01443 848606
WHTN 01757 8606

Medical equipment purchased for use within Public Health Wales where appropriate is subjected to Risk Assessment during procurement. All Equipment must comply with infection control requirements. Any Public Health Wales agreed standardisation of brands of equipment is compiled with to ensure staff are familiar with the equipment and equipment is comparable with existing devices and to reduce unwarranted variation. Where possible devices are standardised throughout the organisation unless there is a valid clinical reason for the change. Equipment must represent optimal value for money. All devices carry a CE Mark indicating that the Device has been manufactured to the appropriate standard and that it is fit for purpose when used as instructed.

10 Infection, prevention and control

10.1 Cleaning and Decontamination

Cleaning and decontamination will be carried out in line with the relevant Infection, Prevention and Control of Infection policies. Specialist advice can be sought from the organisation's Infection Control Nurse.

Adherence to manufacturers guidance is required in decontaminating reusable devices. The exact method of the decontamination will vary and the level of decontamination (cleaning, disinfection, and sterilisation) will depend on the level of risk then into decontamination risk assessment Examples listed in **appendix 1.**

Guidance should be sought at the tendering stage of procurement from the manufacturer concerning decontamination (cleaning, disinfection, sterilisation), to ensure the manufacturer's instructions can be met within organisational policies and existing facilities.

Advice should be supplied and verified as suitable at the acceptance stage for new or loaned equipment. Users are to refer to the Public Health Wales infection, prevention and control policies and Divisional Standard

10.2 Operating Policies (SOP's)

A record of decontamination of all medical devices must be held by individual areas in order to provide assurances that equipment has been decontaminated in accordance with legislation and guidance. Decontamination certificates should be issued prior to service maintenance or repair by any department or company. Unless the accepting company has issued written communication to say this is not necessary.

10.3 Single Use Items

Medical devices designated for single use are not re-used under any circumstances. MDA DB 2000 (04) draws attention to the hazards and risks associated with re-processing and re-using single use items – see Infection Prevention Control Policy. Single use means that the manufacturer:

(a) intends the item to be used once, then thrown away;

(b) considers the item unsuitable for use on more than one occasion;

(c) has insufficient evidence to confirm that re-use would be safe.

Single use medical devices should not be re-used as this affects the safety, performance and effectiveness of the device, and exposes staff and service users to unnecessary risk.

There is a European Standard Symbol used on packaging to show which medical devices are intended for single use only. All staff involved in the decontamination process should understand this symbol and its meaning.

There is a European Standard Symbol used on packaging to show which medical devices are intended for single use only. All staff involved in the decontamination process should understand this symbol and its meaning.

Please note:

The Consumer Protection Act 1987 will hold a person liable if a single use item is re-used against the manufacturer's recommendation.
Attempts to decontaminate single use items would render the organisation liable in the event of an adverse outcome.

11 Prescription of Devices

The Prescription of Devices is the selection of the most appropriate device to use for a given situation and will only be made by staff with the appropriate professional qualifications. Competency to prescribe must be assessed, recorded and audited to ensure consistency and accuracy of prescribing procedures.

Technical support and advice is available from relevant Maintenance Departments, Infection Control Nurse and Procurement together with relevant external agencies i.e. MHRA, WHE.

12 Device Acceptance Procedures

Each Division will need to have acceptance testing arrangements in place and these should be in accordance with the guidelines contained in section 5 of MHRA DB9801 and DB2003.

For portable equipment, a variety of acceptance testing procedures may be necessary – electrical safety tests, for example.

12.1 Planned Preventative Maintenance (PPM)

Divisions should have arrangements in place for planned preventative maintenance of medical devices and equipment and relevant staff should be aware of maintenance procedures including timescales for maintenance checks based on the manufacturer's recommendations. How the device is used and how often must also be considered when determining service intervals.

12.2 Storage of Devices

It is important that adequate storage arrangements are in place for safely storing equipment including accessories.

12.3 Maintenance and Repair of Medical Devices

Medical devices must be kept safe and effective, through both routine maintenance procedures, supervised by professional users, and planned preventative maintenance by suitably trained technical staff. All maintenance and equipment management will be undertaken using the guidelines contained in MHRA guidance DB9801 and any other relevant publications.

Each Division must ensure that maintenance is carried out by suitably qualified staff whether internal or external.

12.4 Routine Maintenance by Users

Routine maintenance by users should ensure that the device continues to function correctly. It entails regular inspection and care, as recommended by the manufacturer or within local procedures. This should clearly show the routine tasks and how they should be carried out. Instructions for the user maintenance of medical devices should be provided to the user, which should include: -

- Checking that it is working correctly before use
- Regular cleaning
- Specific daily / weekly checks

- Noting when it has stopped working properly or when obvious damage has occurred, and then discontinuing use
- Reporting or arranging for servicing as per local procedures.

Users may need to be trained to carry out routine maintenance.

13 Use of Medical Equipment for Non-designated Purpose

It should be noted that modification of equipment or use of any equipment for other than its intended purpose is a clear breach of the terms of the manufacturer's warranty. If a service user, carer or staff suffers harm in the process.

14 Loan Equipment Procedures

- Equipment Loaned from Others for Trials or other purpose (internal / external)
- Loaned from a manufacturer or supplier
- Loaned from another organisation
- Loaned for research purposes

All borrowed devices must go through the same acceptance procedure/acceptance tests as new equipment. The same standards of training, competence, maintenance, repair and calibration apply to loaned, trial or purchased equipment.

In all cases, a Loan Indemnity agreement must be completed as a record for Public Health Wales or check if a blanket agreement has been signed by the supplier which may need to be used against any incident resulting from faulty equipment.

It is important that at the end of its loan period the equipment is removed from use or accepted as part of the inventory of equipment. Should it cease to be on loan but still in use, full responsibility must be assumed for the equipment and its acquisition treated as if it were new equipment.

14.1 Internal Loans

When a piece of equipment is loaned to another department, it is the responsibility of the borrower to ensure that they have been trained and are competent to use the equipment. The borrower will be responsible for and be aware of the maintenance/care requirements whilst in their possession and must ensure the device is returned in safe working order having been cleaned/decontaminated/sterilised as appropriate.

14.2 External Loans to Carers / Patients

In exceptional circumstances only equipment may be loaned to patients/carers as part of their on-going care needs or as part of their treatment.

It is important to assess whether those being loaned the equipment are capable of taking responsibility for it, i.e. that they are competent to use and maintain the equipment and will return it in good condition.

15 Adverse Incidents (Device Related)

Should there be any Incidents then the Incident Reporting Policy should be followed.

16 Decommissioning and disposal of devices

16.1 Replacement Criteria

In consideration of fiscal circumstances medical devices/equipment will be replaced, following consideration, by the users and where appropriate if appointed Divisional Medical Device Co-ordinator, on the following criteria:

- Worn out beyond economic repair
- Damaged beyond economic repair
- Unreliability (Service History)
- Clinically or technically obsolete
- Spare parts (manufacturers support) no longer available
- More cost-effective or clinically effective devices have become available
- Unable to be cleaned effectively prior to disinfection and/or sterilisation
- Medicines and Healthcare products Regulatory Agency (MHRA) notification-Hazards etc.

16.2 Disposal / Transfer of Ownership of Equipment

The purpose of this section is to ensure that all equipment is disposed of with due regard to safety and to ensure managers consider appropriate legal implications.

16.2.1 Financial Considerations

All equipment sold or disposed of must be done so in accordance with relevant Welsh Government circulars and Public Health Wales' financial corporate governance policy to ensure financial probity and in consideration of any capital charges which may be relevant.

Failure to follow appropriate guidance or legislation when selling medical devices and other equipment could lead to prosecution or liability for damages.

All equipment should be disposed of or sold/donated in accordance with:
Department of Health Guidance HN89(22) and
MHRA Guidance DB9801 supplement Two

16.0.2 Public Health Wales' Liabilities When Ownership is transferred

In the event of a sale or donation all new owners must sign a disclaimer to limit any future legal liabilities of the organisation. It should be noted however that this disclaimer does not absolve the organisation of all legal liabilities and could still be left liable to prosecution e.g. where negligence *can* be proven. In general the more comprehensive the information supplied to the new owner the more the organisation's liability is reduced.

16.0.3 Information to be supplied to New Owner

Manufacturer's instructions and any other information needed to verify whether the medical device can operate correctly and safely, plus details of the nature and frequency of the maintenance and calibration needed to ensure that the device operates properly and safely should be provided to the new owners.

The new owner should also be furnished with any safety information provided by the Medicines and Healthcare products Regulatory Agency (MHRA) such as product safety updates. The new owner should also be advised to regularly check if there are any future product updates.

As a minimum, the following information should be provided: -

- Record of any reconditioning work carried out, including a record of replacement parts
- Copy of all maintenance and servicing that has been carried out including the name of maintenance / servicing organisation
- Record of usage

- Fault log
- Decontamination status

17 Confidentiality

Some equipment may have the capacity to hold electronic information which may compromise a patient's confidentiality. Any such equipment will have memories fully erased or data storage / retrieval capacity destroyed before disposal or transfer of ownership in accordance with IT policies.

Computer system hard drives must be wiped/erased to a recognised standard to ensure no Personal Identifiable Information (PII) or organisational information is retained within the system.

18 Training requirements

18.1 Training of Staff in the Use of Clinical Equipment

Training of staff in the use of medical devices equipment is essential if the organisation is to ensure that the health care workers it employs are competent to undertake the duties for which they are employed and to ensure that the potential risk of harm to patients is reduced to a minimum.

This section applies to all grades and disciplines of staff that are employed directly or indirectly within relevant divisions.

18.2 Identification of Training Need

All departments will identify equipment within their areas for which staff will require specialist training; Department managers will identify which staff are able to use each device following successful completion of a programme of training. This may include setting up a device, preparing for its use, checking the device and decontamination where appropriate.

Consideration must be given to the possible need to develop new Standard Operating Procedures.

19 Training

Training for *medical devices* will be available via several mechanisms

- staff induction

- device specific training from the device manufacturers
- device specific training local lead clinicians/educators

Competence should be measured, documentation maintained and training recorded and reviewed as part of staff's individual My Contribution. An appropriate designated storage place for manufacturer's instruction manuals must be specified (this may be electronic or paper)

Review training plans and organise regular refresher training when necessary
Ensure training / induction includes an understanding of relationships with other departments (e.g. Maintenance Department, Prevention and Control of Infection etc)

Individuals are responsible for ensuring they are competent for any equipment they use. Anyone who does not feel competent must not use equipment until they have undertaken the appropriate training and assessment.

Competence will be monitored and reviewed through staff appraisal and risk management processes or when staff have not used a piece of equipment for 12 months or earlier if indicated by clinical practice

20 Monitoring compliance

20.1 Maintenance

Service Divisions must ensure that there is adequate maintenance and repair provision for medical devices and equipment and appropriate maintenance and repair schedules are put in place. This should include planned preventative maintenance programmes.

The following should be considered where appropriate: -

- Ensure service contracts are in place and establish follow-up systems to ensure contracts are reviewed well before renewal date to ensure best value is achieved.
- Devise and monitor systems to ensure equipment which is loaned to patients / other departments etc., is regularly tested for safety and appropriately maintained.
- Set up and monitor systems to ensure that maintenance contracts are carried out to the required standard.
- A suitable anti-virus product must be installed to any associated computer system and maintained to a current level to protect against all identified vulnerabilities.

20.2 Audit

Random audits should be carried out locally on all elements of appropriate use, decontamination, maintenance, repair, record generation and storage to ensure that the correct procedures are in place and being adhered to. Audits should be carried out by staff with appropriate knowledge and experience of managing medical devices.

The application of the policy/procedure should be regularly reviewed to ensure that, whenever a medical device is used, it is:

- Suitable for its intended purpose
- Used in line with the manufacturer's instructions

Traceable, where possible

- Maintained in a safe and reliable condition, with associated records kept
- Disposed of appropriately at the end of its useful life

21 References

MDA DB9801-February 1999- Medical Device and Equipment Management for Hospital and Community-based Organisations
MDA DB9801-December 1999- Supplement 1- Checks and Tests for Newly Delivered Medical Devices
MDA DB9801-October 2001- Supplement 2-Guidance on the Sale, Transfer of Ownership and Disposal of Used Medical Devices
MDA DB2000(02)-June 2000- Medical Devices and Equipment Management: Repair and Maintenance Provision
MDA DB2002(02)-March 2002- Management of In-Vitro Diagnostic Medical Devices
MDA DB2002(03)-March 2002- Management and Use of IVD Point of Care Test Devices
MDA DB2000(04)-August 2000- Single-Use Medical Devices: Implications and Consequences of Re-use
National Audit Office Report HC475: -June 1999- The Management of Medical Equipment in NHS Acute Trusts in England
MDA-The Report of the Expert Working Group on Alarms on Clinical Monitors:-February 1995- In response to Recommendation 11 of the Clothier report: The Allitt Inquiry
NHS Executive-December 2001- Controls Assurance Standard-Medical Devices Management
NHS Executive HSC 1999/178. 1999 Variant Creutzfeldt-Jacob Disease (vCJD): Minimising the Risk of Transmission

DB2003(05) HSG(93)26-June 1993-Decontamination of Equipment Prior to Inspection, service or repair
Medical Devices Agency-Devices in Practice-a guide for health and social care professionals

Appendix 1

Decontamination Methods

Cleaning

This is the most basic form of disinfection, it is a process that physically removes contamination by micro-organisms, but it does not necessarily destroy the germs themselves. Thorough cleaning with detergents and hot water will remove large numbers of micro-organisms. It is essential that cleaning takes place to remove organic matter prior to disinfecting. Inadequate cleaning means that solutions used to achieve disinfection may not be effective as deposits of organic materials may inactivate the disinfectant and may prevent the disinfectant from reaching all surfaces of the item. This means that disinfection may not be achieved. An item that is not first cleaned must not be disinfected.

Disinfection

This is the destruction of bacteria and viruses. Spores may not destroyed. The aim is to reduce contamination to safe levels which are unlikely to be a danger to health. Chemicals that achieve this result are known as disinfectants. Disinfectants that are applied to skin and mucous membranes are called antiseptics.

Sterilisation

Is a treatment which achieves the complete killing or removal of all types of micro-organisms including spores and bacteria, usually by the use of heat, eg autoclave. Equipment and materials which come in contact with broken skin or mucous membranes should be sterile, eg instruments, dressings, and injection/irrigation fluids. Sterilisation is best achieved by moist heat under pressure (autoclaving), or by dry heat.

Choice of Decontamination Method

This will depend on many factors, including the nature of the contamination, the time required for processing and the risks associated with the decontamination method:

(a) Decontamination – Assessment of Risk

High Risk

These items penetrate skin or mucous membrane and enter the vascular system or sterile spaces.

(b) Intermediate Risk

These items come into contact with intact mucous membranes or may be contaminated with particularly virulent or readily transmissible organisms.

High Risk and Intermediate Risk items require high level disinfection to remove vegetative bacteria:

(a) Low Risk

These items either contact only intact skin or do not come into contact with the service user. It is equally applicable to decontaminate lower risk devices after every use.

(b) Grey Areas

Some devices in the "low risk" category are difficult to clean eg sphygmomanometers. It is good practice to have an individualised cuff for service users with infections such as MRSA to prevent cross infection

Equality and Health Impact Assessment for

Medical Devices and Equipment Management Policy and Procedure

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	Medical Devices and Equipment Management Policy/Procedure
2.	Name of Corporate Directorate and title of lead member of staff, including contact details	Public Health Services Cara Tingle, Compliance Manager Email: Cara.tingle@wales.nhs.uk Tel: 02920104398
3.	Objectives of strategy/ policy/ plan/ procedure/ service	To prevent and control the spread of infection by the provision of robust decontamination principles, for the safety of patients and staff, and to support staff in understanding their responsibilities in relation to the management of medical devices.
4.	Evidence and background information considered. For example • population data • staff and service users data, as applicable • needs assessment • engagement and involvement findings • research • good practice guidelines • participant knowledge • list of stakeholders and how stakeholders have engaged in the development stages • comments from those involved in the	• Developed inline with statutory requirements • Good practice guidance sought from other NHS bodies / NHS standards/Welsh Government/Medicines and healthcare products regulatory agency • Health and Safety Executive guidance (www.hse.gov.uk)

	designing and development stages Population pyramids are available from Public Health Wales Observatory and the 'Shaping Our Future Wellbeing' Strategy provides an overview of health need.	
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	This policy applies to all staff employed (or contracted) by Public Health Wales who use, repair or procure medical devices in the course of their work.

6. EQIA / How will the strategy, policy, plan, procedure and/or service impact on people?

Questions in this section relate to the impact on people on the basis of their 'protected characteristics'. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Directorate / Division.** Make reference to where the mitigation is included in the document, as appropriate
6.1 Age For most purposes, the main categories are: • under 18; • between 18 and 65; and • over 65	No impact		
6.2 Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes	Employees with impairments/disabilities will be affected in different ways. Task based risk assessments will need to be developed for individual circumstances.		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Directorate / Division. Make reference to where the mitigation is included in the document, as appropriate
6.3 People of different genders: Consider men, women, people undergoing gender reassignment **NB** Gender-reassignment is anyone who proposes to, starts, is going through or who has completed a process to change his or her gender with or without going through any medical procedures. Sometimes referred to as Trans or Transgender	Individuals undergoing Gender reassignment are advised during treatment/post surgery against lifting heavy items. There is a potential impact on an individual that may be required to carry equipment as part of their role. Each case will need to be considered on an individual basis with task based risk assessments and safe ways of working developed.		
6.4 People who are married or who have a civil partner.	No impact		
6.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are breastfeeding.	There is an impact on pregnant individuals that may be required to carry equipment as part of their role. Pregnancy risk		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Directorate / Division. Make reference to where the mitigation is included in the document, as appropriate
They are protected for 26 weeks after having a baby whether or not they are on maternity leave.	assessments must be conducted and safe ways of working developed.		
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	No impact		
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	No impact		
6.8 People who are attracted to other people of: • the opposite sex (heterosexual); • the same sex (lesbian or gay);	No impact		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Directorate / Division. Make reference to where the mitigation is included in the document, as appropriate
• both sexes (bisexual)			
6.9 People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design Well-being Goal – A Wales of vibrant culture and thriving Welsh language	No impact	Policy is currently available in English format only.	Ensure that the Policy and supporting procedure are also available in Welsh.
6.10 People according to their income related group: Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health	No impact		
6.11 People according to where they live: Consider people living in areas known	No impact		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Directorate / Division. Make reference to where the mitigation is included in the document, as appropriate
to exhibit poor economic and/or health indicators, people unable to access services and facilities			
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	No impact		

7. HIA / How will the strategy, policy, plan, procedure and/or service impact on the health and well-being of our population and help address inequalities in health?

Questions in this section relate to the impact on the overall health of individual people and on the impact on our population. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Directorate / Division** Make reference to where the mitigation is included in the document, as appropriate
7.1 People being able to access the service offered: Consider access for those living in areas of deprivation and/or those experiencing health inequalities Well-being Goal - A more equal Wales	No impact		
7.2 People being able to improve /maintain healthy lifestyles: Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking cessation, reducing the	No impact		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Directorate / Division Make reference to where the mitigation is included in the document, as appropriate
harm caused by alcohol and /or non-prescribed drugs plus access to services that support disease prevention (eg immunisation and vaccination, falls prevention). Also consider impact on access to supportive services including smoking cessation services, weight management services etc Well-being Goal – A healthier Wales			
7.3 People in terms of their income and employment status: Consider the impact on the availability and accessibility of work, paid/ unpaid employment, wage levels, job security, working conditions	No impact		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Directorate / Division Make reference to where the mitigation is included in the document, as appropriate
Well-being Goal – A prosperous Wales			
7.4 People in terms of their use of the physical environment: Consider the impact on the availability and accessibility of transport, healthy food, leisure activities, green spaces; of the design of the built environment on the physical and mental health of patients, staff and visitors; on air quality, exposure to pollutants; safety of neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces Well-being Goal – A resilient Wales	No impact		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Directorate / Division Make reference to where the mitigation is included in the document, as appropriate
7.5 People in terms of social and community influences on their health: Consider the impact on family organisation and roles; social support and social networks; neighbourliness and sense of belonging; social isolation; peer pressure; community identity; cultural and spiritual ethos Well-being Goal – A Wales of cohesive communities	No impact		
7.6 People in terms of macro-economic, environmental and sustainability factors: Consider the impact of government policies; gross domestic product; economic development; biological diversity; climate	No impact		

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Directorate / Division** Make reference to where the mitigation is included in the document, as appropriate
Well-being Goal – A globally responsible Wales			

Please answer question 8.1 following the completion of the EHIA and complete the action plan

8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service	To ensure that Public Health Wales comply with statutory requirements produced by the Health and Safety Commission, Department of Health, Medicines and Healthcare Products Regulatory Agency and the Welsh Government.

Action Plan for Mitigation / Improvement and Implementation

	Action	Lead	Timescale	Action taken by Directorate / Division
8.2 What are the key actions identified as a result of completing the EHIA?	Ensure that the Policy and supporting Protocols are also available in Welsh format.			

	Action	Lead	Timescale	Action taken by Directorate / Division
8.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment required? This means thinking about relevance and proportionality to the Equality Act and asking: is the impact significant enough that a more formal and full consultation is required?	No			

	Action	Lead	Timescale	Action taken by Directorate / Division
8.4 What are the next steps? Some suggestions:- • Decide whether the strategy policy, plan, procedure and/ service proposal: ○ continues unchanged as there are no significant negative impacts ○ adjusts to account for the negative impacts ○ continues despite potential for adverse impact or missed opportunities to advance equality (set out the justifications for doing so) ○ stops. • Have your strategy, policy, plan, procedure and/or service proposal approved • Publish your report of this impact assessment • Monitor and review	• Take policy through consultation process • Gain approval for Policy • Publish on intranet • Liaise with Welsh Language Lead - Caren Jones to determine the process required for translation of documentation. • Publish Welsh version on intranet. • Review annually or upon any changes to Legislation			