South Eastern Health and Social Care Trust

Paper No. SET 38/18

Annual Report on Information Governance As At 31 March 2018

Policy Profile	
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Lead Director:	Myra Weir, Director Human Resources & Corporate Affairs
Approval Profile	
Information Governance Steering Committee:	Via email Consultation Process,
Trust Board:	21 June 2018

Contents

Appendices

Annual Report on Information Governance as at 31 March 2018

1.0 Introduction

This is a report on the Trust's Information Governance arrangements from the 1 April 2017 to 31 March 2018. It is based on the criteria within the Information Management (IM) Controls Assurance Standard (CAS) issued by the Department of Health (DoH) formerly the Department of Health, Social Services & Public Safety (DHSSPS) in September 2013. The IM CAS was not subject to internal audit in 2017/2018.

The report also outlines the assurance process and criteria which must be assessed to achieve compliance with the IM CAS. The report underpins the DoH Information Management Framework, highlights progress to date in the implementation of the Framework and identifies the Trust's priorities for 2018/2019. Self-assessment confirmed an overall score of 82% in the IM CAS, 2017/2018. This score falls within the substantive compliance range set by the DoH.

The DoH is revising the extant Information Management Controls Assurance standard and the revised model will be effective from 1 April 2018.

2.0 Requirements of the Information Management Controls Assurance Standard

The purpose of the IM CAS is to ensure that all Health & Social Care (HSC) bodies have, "*A systematic and planned approach to Governance of Information is in place within the organisation that ensures the organisation can maintain information in a manner that effectively services its needs and those of its stakeholders in line with appropriate legislation".*

This standard, along with the Risk Management, Governance and Financial Management Standards, provides the basis for statutory reporting for the Governance Statement (previously set out by the Department of Finance and Personnel in DAO (DFP) 05/01).

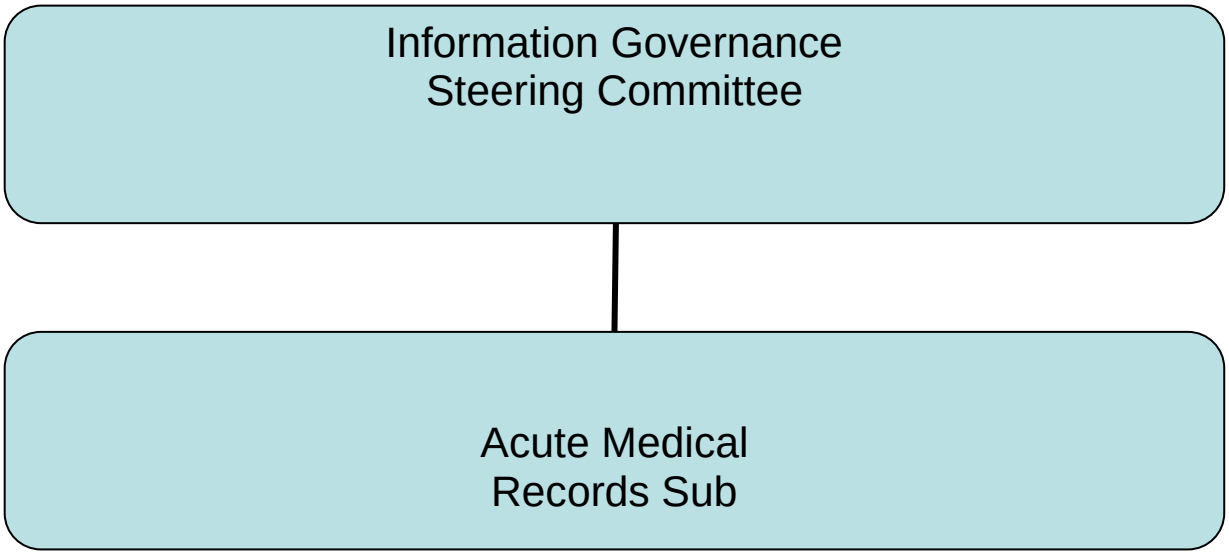
Information Governance (IG) should be recognised within an organisation as an integral part of good practice and embedded in the Trust's culture. It forms a vital part of the Trust's practices and business plans. It should not be viewed or practiced as a separate programme. As an integral corporate function, IG becomes the business of everyone in the organisation.

The IG and Information Communication & Technology (ICT) and Information & Systems (I&S) Departments work closely together to implement measures to address information governance risk and to monitor compliance. This improves IG across the Trust, particularly in relation to protecting personal information and data accessibility.

3.0 Governance Reporting Arrangements within the South Eastern Health & Social Care Trust

The IGSC is a sub-committee of the Corporate Control Committee. It has one sub-committee. The IGSC sub-committees (listed in Diagram 1, below) have identified programmes of work, agreed on an annual basis by the IGSC.

Diagram 1 – Sub-Committees Aligned to the Information Governance Steering Committee (IGSC)



The IGSC reviewed its supporting sub-committee structure during 2017/2018 and has reduced its supporting sub-committees to one namely, the Acute Services Sub-Committee. The Data Quality Sub-committee was aligned to the new E-Health Strategy Committee following a review of the Governance Framework which resulted in the standing down of the Informatics Programme Board and the establishment of the new Electronic Health Programme Board. All other Operational areas have subsumed their information governance work into their Directorate Governance Committee structure and report back to the IGSC quarterly on an exceptions basis. The off-site storage group was de-commissioned by the IGSC on 13 March 2018 with the proviso that any issues with the contract are raised with the Head of Information Governance and/or the Procurement & Logistics Service as appropriate.

3.1 Managerial Accountability

The Director of Human Resources and Corporate Affairs is the designated Director with lead responsibility for IG, accountable to the Chief Executive and Trust Board for the performance and quality of this function.

The Director of Human Resources and Corporate Affairs is also the appointed Senior Information Risk Owner (SIRO) for the Trust.

The Director of Planning, Performance & Informatics acts as deputy SIRO. These appointments were implemented in line with the DoH, Information Governance Framework.

The Assistant Director, Risk Management & Governance is responsible for ensuring that robust systems and processes are in place to ensure Trust compliance with legislation and best practice in terms of systems and processes, and that adequate expertise, advice and guidance in relation to IG is available to Trust staff. Within the Risk Management & Governance structure, the Head of Information Governance provides expertise within the Trust and ensures that appropriate monitoring and audit arrangements are in place to provide assurance of the quality of this function within the Trust.

The Medical Director and Director of Children's' Services & Social Work are the appointed Personal Data Guardians for the Trust, and have responsibility for approving access to sensitive information held on Trust's service users.

A Chief Clinical Information Officer was appointed and is responsible for supporting the clinical information needs and the implementation/review of clinical information systems which enhance and compliment clinical workflows to improve patient outcomes.

Directors and Managers are responsible for ensuring that they and their staff are properly managing information/records within their areas of responsibility, and for ensuring that all staff have the necessary knowledge of Trust policies, guidelines and systems. Each Assistant Director also fulfils the role of Information Asset Owner (IAO). The appointments of IAOs were implemented in line with the DoH (formerly DHSSPS) Information Governance Framework.

Individual members of staff are responsible for the proper management of records, and for ensuring that they are aware and knowledgeable of the IG policies, procedures and systems.

4.0 Information Governance Policy and Procedures – 2017/2018

The Trust has a suite of IG policies and procedures all of which are available via the IG intranet page. The status of all IG policies and procedures is reviewed by the IGSC quarterly.

A list of IG Policies/Procedures which have been endorsed and agreed through the Trust consultation process is attached at Appendix 1.

5.0 Information Governance Risk Register

The IGSC Risk Register is incorporated into the Risk & Governance Directorate's Risk Register as the implementation of the action plans primarily fell within the remit of this Directorate. During 2017/2018 these risks focussed on the management of the off-site storage contract and loss of records. Cyber security was listed on the Corporate Risk Register and was managed by the Information Communications & Telecommunications Department.

Quarterly progress reports are submitted to the Corporate Control Committee. Other IG risks are also included in individual operational Directorate Risk Registers, as appropriate.

6.0 Information Governance Programme of Work – 2017/2018

The programme of work for 2017/2018 was primarily focused on achieving substantive compliance in the IM CAS and preparation for the implementation of the General Data Protection Regulation (GDPR) summarised as follows:-

- Achieve substantive compliance in the IM CAS and undertake programme of work to ensure continued embedding of the CAS throughout the Trust;
- Participate in the regional HSC GDPR Working Group and associated workflows;
- Development, review and monitor the Trust's GDPR Action Plan;
- Annual review of Directorate Information Asset Registers;
- Continued participation in the DoH Information Governance Advisory Group.

A copy of the IGSC programme of work for 2017/18, including progress report as at 31 March 2018, is attached at Appendix 2, for information.

7.0 Baseline Assessment of the Information Management Controls Assurance Standard – 2017/2018

Results of Baseline Assessment – 2 March 2018

The assessment was completed by self-assessment and a score of 82% was achieved.

The Trust's final score was 82% and this was submitted to the DoH in May 2018.

A summary of the IM CAS criterion, compliance, required level of compliance and actual compliance ranking is listed in Appendix 3, for information.

8.0 Requests for Information

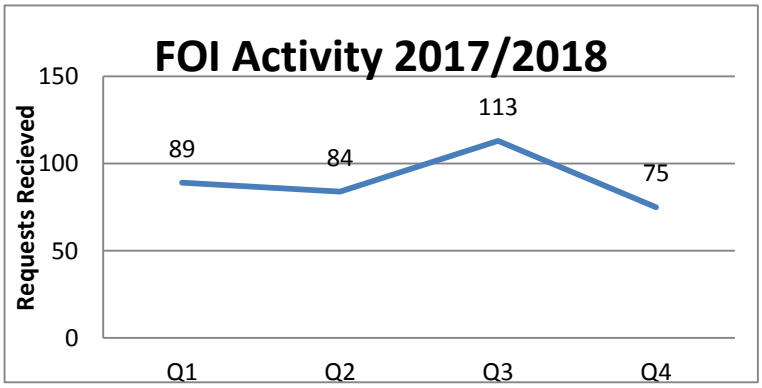
8.1 Freedom of Information Requests & Environmental Information Regulations

Freedom of Information (FOI) and Environmental Information (EIR) requests are co-ordinated and processed centrally via the IG team. During the period 01/04/17 - 31/03/18, 361 requests for information were handled by the IG team under the Freedom of Information Act 2000 and Environmental Health Regulations 2004.

FOI Activity & Compliance by Quarters 2017/2018

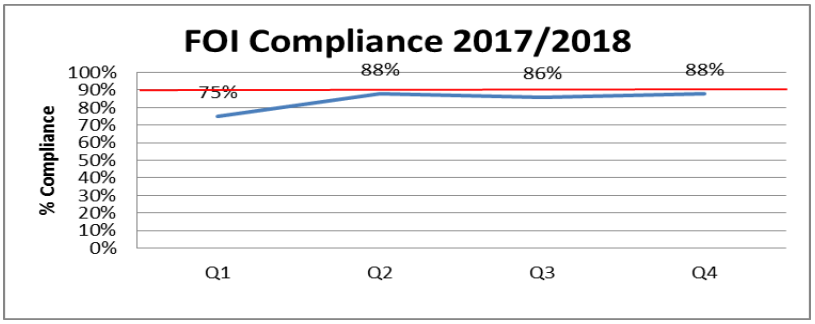
Graph 1A illustrates volume of FOI requests received per quarter.

Graph 1A



Graph 1B illustrates FOI % Compliance per quarter.

Graph 1B



The Information Governance team has an excellent working relationship with Directorates in co-ordinating and managing the FOI/EIR requests.

Requests throughout the year have remained steady with a large volume of requests coming from the media, FOI Website, 'whatdotheyknow.com' and commercial organisations. This is consistent with previous years.

Q1 compliance at 75% is the lowest in the reporting period. Following a review of IG workflows, compliance increased significantly fluctuating between 86%-88%.

With regard to information request trends a significant number of requests relate to contract expiry dates, incident management and reporting, services provided in the community, activity management across acute services and staffing levels/locum use across all disciplines.

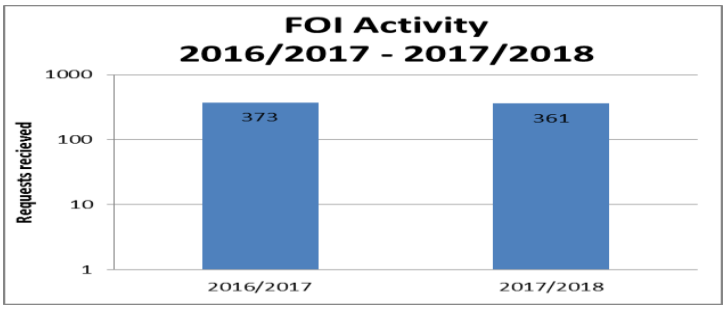
In comparison with 2016/2017 statistics this year has seen a decrease (-12) of FOI requests. This represents a 3% decrease in activity. Compliance rates in activity have improved significantly (2016/2017 = 51%, 2017/2018 = 84%).

Quarterly compliance reports are provided to the IGSC and are also included in the Trust's reporting cycle through Directorate Performance Accountability Reviews, Mid-Year Reviews and the Balanced Scored Card.

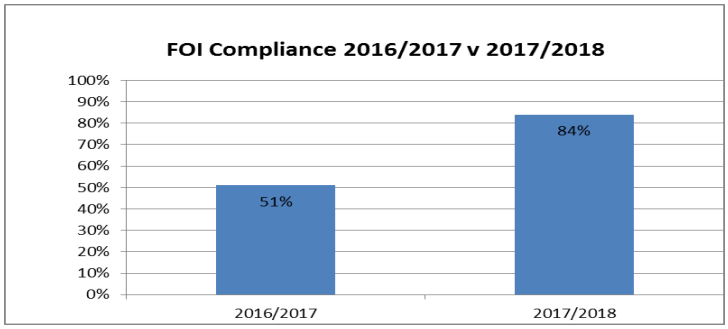
FOI Totals and % Compliance for 2016/2017 & 2017/2018

Graphs 2A & 2B illustrate comparison volume and % compliance data in respect of FOI requests received 2016/2017 & 2017/2018.

Graph 2A



Graph 2B



A total of 32 FOI requests were re-opened during this period as the requestor was dissatisfied with the response or sought further clarification in respect of the initial request(s). During the previous year 43 requests were re-opened. The volume of re-opened cases processed this year represents an 11% decrease on the previous year.

The Information Governance Department continues to publish FOI responses on to the Disclosure log available via the Trust's internet address. This is in line with guidance issued by the Information Commissioner's Office (ICO).

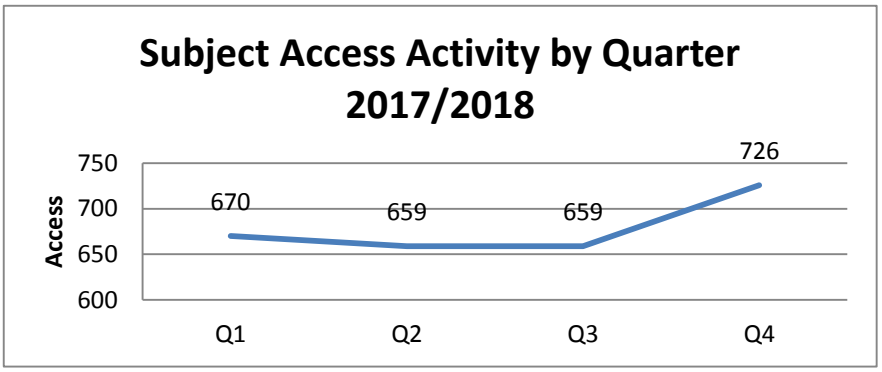
8.2 Subject Access

Subject access requests (SARs) are input by the IG, Mental Health, Prison Healthcare & the Medical Records Departments. A total of 2,714 requests were received. SAR volumes per quarter and compliance per quarter are illustrated in Graphs 3A & 3B below.

DPA Activity & Compliance by Quarters 2017/2018

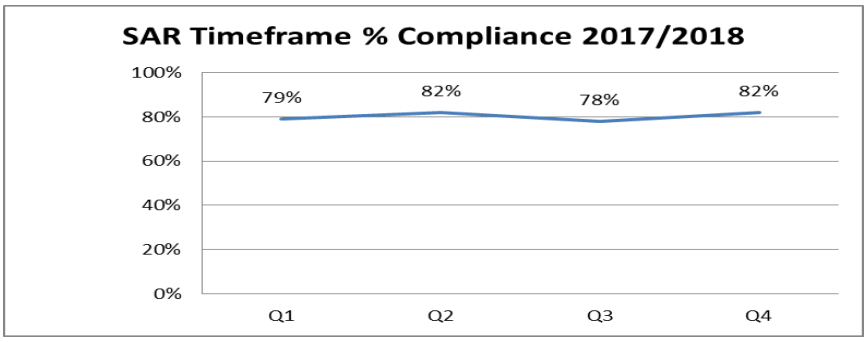
Graph 3A illustrates volume of SARs received per quarter.

Graph 3A



Graph 3B illustrates SAR % Compliance per quarter

Graph 3B



The volume of requests throughout the year has remained steady across all services processing these requests. It is important to note that not all SARs are recorded on Datix (AE and Medical Records at the Downe Hospital do not currently use this system) as the reporting module is not available in these areas. Plans are in place to roll Datix out to these areas and to train staff in Q1 2018/2019.

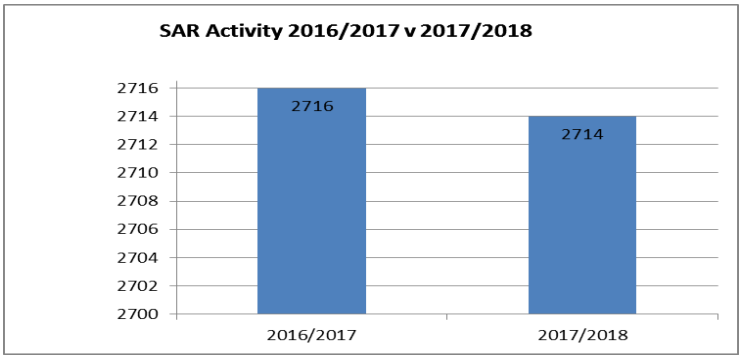
Requests received by the Trust particularly requests relating to family and child care, social work records are considered complex. These records require review and redaction and due to the complexities of the work involved, delays in issuing the records have incurred**.** Regular contain is maintained with the applicant either by the Information Governance Department and/or the relevant Social Work Department.

In comparison with 2016/2017 statistics, the volume of requests processed and recorded on Datix for 2017/2018 remains static.

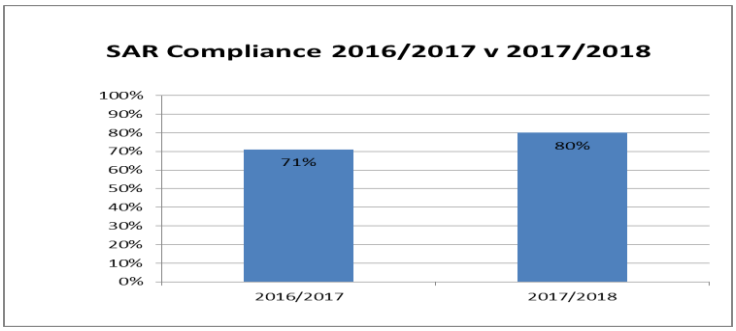
Quarterly compliance reports are provided to the IGSC and are also included in the Trust's reporting cycle through Directorate Performance Reviews, Mid-Year Reviews and the Balanced Scored Card.

SAR comparison data for 2016/2017 & 2017/2018 are represented in graphs 4A & 4B below.

Graph 4A



Graph 4B



A total of 19 DPA requests were re-opened during this period as the requestor was dissatisfied with the response or sought further clarification in respect of the initial request(s).

Overall, totals of FOIs and SARs for 2017/2018 (3075) saw a decrease of 0.45% activity compared with 2016/2017 (3089).

8.3 Internal Reviews & Complaints to the Information Commissioner

Six complaints were referred by applicants to the ICO for investigation. These have been progressed satisfactorily and the ICO has closed all cases.

Five requesters sought internal review following receipt of the initial Trust response. Four related to FOI requests and one related to a Subject Access request. Following internal review, 3 FOI decisions were upheld. One FOI review resulted in the applicant receiving the information in full and one subject access resulted in the applicant receiving further information.

There were no ICO challenges against the Trust in regard to exemptions applied by the Trust under the Freedom of Information Act, 2000.

8.4 Information Governance Incidents

A total of 495 IG incidents (IR1) were reported during 2017/2018. Of these, 29 necessitated further investigation in line with the Trust's Incident Reporting Policy and Procedures (IR2). The IGSC is fully satisfied that reporting procedures are robust and that all breaches are thoroughly investigated and that the necessary actions are taken to minimise future occurrence. In line with the Trust's governance arrangements any learning from IG incidents are shared with the Lessons Learnt Committed, chaired by the Chief Executive. Information is also disseminated via quarterly Lessons Learnt newsletter to all staff.

Staff are trained and encouraged to report all incidents including (Information Governance) incidents to ensure the Trust can investigate the reasons for an incident happening again. The IGSC receives quarterly reports on all information governance incidents. In addition, all reported incidents of data loss or confidentiality breach in 2017/2018 have been assessed. While there were several small scale incidents, the impact was limited and procedures were put in place to address future risk in these areas. The Trust reported 4 incidents to the Information Commissioner's Office (ICO) during this period. The ICO has concluded on 3 of their investigations and has taken no further action based on the prompt remedial works undertaken by the Trust. One incident remains under investigation.

Any issues specifically identified by the IGSC are managed via the Risk Management & Governance Risk Register or are escalated to the Corporate Risk Register, as appropriate.

Following the NHS Wannacry incident (15/5/2017-17/5/2017) which did not affect HSC, the risk to HSC cyber security was escalated and registered as a risk on the Trust's Corporate Risk Register. Plans are in place to hold a table top exercise on 23 April 2018.

8.5 Publication Scheme

The IGSC continues to monitor progress in respect of the publication of Trust information on to the Trust's publication scheme. This has been incorporated into the launch of the regionally formatted Trust internet site which the Communications department is leading on.

9.0 Information Governance Priorities – 2018/2019

The key priorities for 2018/2019 will include the embedding of new Data Protection laws, implementation of the new Information Management Assurance programme (formerly the Controls Assurance Standard) and the restructuring of the Information Governance Department. In addition, priority actions for this period will include:-

- To ensure recommendations from the Information Commissioner's Training Audit (June 2017) are progressed and reported to the IGSC;

- The continued participation on regional fora to progress actions required for implementation and embedding of the General Data Protection Regulations (GDPR);
- To ensure continued implementation of the new Data Protection law (GDPR & Data Protection Act 2018) throughout the Trust;
- To participate on the Cyber Security Programme Board and associated Working Groups;
- The preparation and issue of monitoring reports to senior managers in respect of compliance with both Subject Access requests and FOIs;
- To undertake an audit of the SAR process to ensure that it is sufficiently streamlined to promote compliance with new legislative timeframes (30 calendar days);
- To undertake 3rd Systems Audit in conjunction with ICT colleagues and,
- To achieve necessary assurance in the new Information Management Controls Assurance process.

10.0 Summary and conclusion

This report provides an overview of the developments within Information Governance during 2017-2018 based on the criterion outlined in the Controls Assurance Standard for Information Management. It provides an assurance to the Board that the Information Governance function is recognised as an integral part of good practice and is embedded in the Trust's culture and its governance framework.

A self-assessment of the standard states that the Trust achieved 82% substantive compliance (75-100%) with the standard.

The IGSC endorsed the content of this report via email communication during May 2018 for submission to the Trust Board at their next meeting on 21June 2018.

Mrs M Weir and Mrs R Coulter
Joint Chairpersons of the Information Governance Steering Committee

TRACKING TABLE
DEVELOPMENT OF INFORMATION GOVERNANCE & RECORDS MANAGEMENT POLICIES, PROCEDURES, FORMS & GUIDANCE NOTES

EXTANT POLICIES

	REF NUMBER	PUBLICATION DATE	REVIEW DATE	Updated to Reflect GDPR
Records Management Policy Statement	SET/Gen (108) 2014	July 2015	December 2017	Review postponed due to GDPR and Data Protection Act, 2018 (enacted 25/5/2018) Work in progress
Policy for the Safeguarding, Movement & Transportation of Patient/Client/Staff/Trust Records, Files and other media Between Facilities	SET/Gen/Mge (11) 2009	September 2009	September 2012 Archived – incorporated into SET/Gen(107)2014	NA
Records Management Strategy 2009-2012 – incorporated in IG Framework incorporating Strategy	NA Published by IG Department	November 2012	November 2015 incorporated into SET/Gen (109)2015	NA
Retention & Disposal Schedule (Good Management, Good Records DHSSPSNI)	NA	November 2011	Currently under review by DoH – and awaiting sign off by the NI Assembly	Not a Trust document – Department of Health responsible for this document
Policy on the Use of the Internet	SET/Gen/ (94) 2014 SET/GEN (142)	April 2014 April 2016	April 2016 November 2021	These policies are managed by ICT
ICT Security Policy	SET/Gen/ (115) 2015	January 2016	April 2021	
Print Policy	SET/Gen/ (116) 2015	January 2016	April 2021	
Use of Internet	SET/GEN/(142) 2016	November 2016	November 2021	

Information Governance Policy	SET/Gen (123) 2015	September 2015	September 2018	Review postponed due to GDPR and Data Protection Act, 2018 (enacted 25/5/2018) Work in progress
FOI Policy	SET/Gen (122) 2015	June 2015	July 2018	Work in progress
Policy Code of Practice on Protecting Confidentiality of Service User Information	ST/Gen (145) 2016	May 2016	November 2019	Awaiting guidance from PAC
Data Protection Policy Statement	SET/Gen/Mge (60) 2012 SET/GEN(146) 2016	April 2012 Sept 2015	August 2018	Awaiting further guidance on citizen's rights and publication of DPA 2018 re, exemptions
Policy for Processing Freedom of Information (FOI) Requests	SET/Gen (16) 2017	Sept 2016	September 2020	**Updated to reflect GDPR and republished 10/05/2018**
Policy and Procedure for Redaction of Patient/Client/Service User Records	SET/Gen (15) 2017 V2.1 (published 7/3/18 update post Redaction incident (SET 74.17) SET/Gen (15) 2017	August 2016 November 2016	September 2020 April 2020	New SAR form to be attached as Appendix 1 and 4.1.10 requires change from DPA 1998 to DPA **Amended and republished 10/5/18**

EXTANT PROCEDURES			
Records Management Procedures	SET/Prot (33) 2014	July 2014	December 2017

FORMS			
Application for Access to HSC Records Form		December 2015	January 2018 **Updated May 2018 to reflect changes**

			re, GDPR
Data Access Agreement V 3		February 2018	February 2019 – GDPR compliant
Release of Records Authorisation Form		December 2015	January 2018 – GDPR compliant

INFORMATION GOVERNANCE GUIDELINES			
Sharing of Information	Guidelines issued by Information Governance Department	June 2009	June 2012 Updated March 2012
Staff Guide on Confidentiality	Guidelines issued by Information Governance Department	January 2009	January 2012 Updated February 2012
Handling Vexatious and Repeated Requests under the FOI Act 2000 & DPA 1998	SET/Guide (03) 2017	August 2016	December 2020 **Minor amendments identified and made to this document – title and section 4.14 – issued to Karen Fay Brannigan 04/05/2018 Republished 08/05/2018**

ITEMS CURRENTLY UNDER REVIEW & TO BE CONSIDERED IN LINE WITH NEW INFORMATION MANAGEMENT CONTROLS ASSURANCE			
Policy to support Protocol for Sharing Service User	Develop Policy to support DHSSPS Protocol once ratified for circulation by	25 April 2012- advice provided to all Assistant Directors	DHSSPSNI currently consulting on the introduction of Secondary

Information for Secondary Uses (DHSSPS Guidance)	DHSSPS		Purposes Legislation (September 2014)
Social Media Policy	Approved awaiting publication	May 2017	
Transfer of Personal Information Policy	SET/GEN(107) 2014	February 2013	February 2017 Issued to SAEC for consultation 8/5/17
Policy on Email Management	SET/Gen/ (88) 2014	January 2014 September 2016 approved by CAB and sent for publication (awaiting publication)	October 2016 October 2022
Mobile Phone Device Policy	SET/Gen (82) 2013	October 2014 September 2016 approved by CAB and sent for publication (awaiting publication)	October 2016
ICT Policy	SET/Gen/ (80) 2013	September 2013 March 2016 approved by CAB and sent for publication	September 2015 September 2021
Freedom of Information Act Internal Review Guidance & Procedure	NEW - Currently in draft – comments received from Irene and forwarded to ICO for comments by 31 March 2017. Consultation completed and policy returned to SAEC along with Equality Forms and nominated Scrutiny panel – 10/5/17. **04/05/2018 – email to Karen Fay Brannigan to check status (sent in 2017 but does not appear to have been published) – very minor amendments identified and on file.**		
Information Governance Framework incorporating Strategy	SET/Gen(109) 2015		

Appendix 2

South Eastern Health & Social Care Trust

Information Governance Steering Committee Action Plan 01/04/2017
Updated 30/06/2017
Updated30/09/2017
Updated 07/12/2017
Updated 31/12/2017
Updated 31/03/2018

ACTION PLAN FOR THE INFORMATION GOVERANCE STEERING COMMITTEE 2017/2018

No.	Topic Area/ Objective	Baseline Position as at 1 April 2017	Action Planned	Action Achieved/Outcome As at 31/03/2018	Target Date By whom	Status
1.	IGSC Terms of Reference	Terms of Reference and Programme of work for IGSC in place and subject to annual review.	Review TOR and POW for IGSC on annual basis and amend as appropriate. Review the performance of the committee against the TOR using agreed template	PoW agreed at SMT 30/06/2017 ToR updated at 30/06/2017	IGSC 30 June 2017	✓

No.	Topic Area/ Objective	Baseline Position as at 1 April 2017	Action Planned	Action Achieved/Outcome As at 31/03/2018	Target Date By whom	Status
2.	Maintain the IGSC sub committee structure to support the work of the IGSC	The number of sub-committees has been reduced to 4 (Off-site storage, Acute, Informatics & Data Quality). The other areas, namely Adults, Children's & Primary Care have assured committee that IG issues are raised via their Governance Committee This is a standing agenda item on the Committee's agenda	IG sub committee chairs to provide exception reports to the IGSC on a quarterly basis, as required. To receive the TOR and action plans from sub committees aligned to the IGSC on an annual basis To keep under review the work of the IG subcommittee structures with a view to streamlining provision of reports, TOR and action plans and in the light of the new Information Management Controls Assurance Standard	Updates provided to IGSC on 14/06/2017, 13/9/2017 & 13/12/2017 IGSC Sub-Committee Structure reviewed in accordance with revised Governance Structure	IGSC 31 March 2017	

No.	Topic Area/ Objective	Baseline Position as at 1 April 2017	Action Planned	Action Achieved/Outcome As at 31/03/2018	Target Date By whom	Status
3.	Controls Assurance	Baseline assessment of Information Management and ICT Controls Assurance Standards completed and submitted by 5 March 2018 both standards received the mandated compliance for 2016/2017	Submit updated controls assurance action plans for the Mid-Year Assurance Statement by September 2016, signed by relevant Director. Complete 1st baseline assessment for 2017/18 and submit to the Project Manager by agreed date (November 2017) – substantive compliance is required. Complete 2nd baseline assessment for 2017/18 and submit to Project Manager by agreed date (March 2018) – substantive compliance is required.	Substantive compliance achieved. Score awarded (self-assessment) 82% - 1% point improvement on 2016/2017	L McAree 31 December 2017 L McAree 31 Jan 2018	✓
/4.	Implementation of the General Data Protection Regulations	Regional GDPR Group established and developing action plan of associated works. Individual work items to be shared across the HSC. ICO also participates in this Group	Implementation of regional action plan Review of Guidance as it becomes available via the ICO website	Action plan agreed at IGSC on 14/06/2017. Standard IGSC agenda item moving forward. All actions on target	IGSC 31/3/18	✓

No.	Topic Area/ Objective	Baseline Position as at 1 April 2017	Action Planned	Action Achieved/Outcome As at 31/03/2018	Target Date By whom	Status
5.	Implementation of the Information Governance Strategy/Action Plan	Extant Information Governance Strategy & Action plan in operation. The action plan is incorporated into the Controls Assurance Plan and is reported upon via the IGSC.	Review of the Information Governance Strategy incorporating Framework in line with the DHSSPS Information Governance Framework and the Information Management Controls Assurance Standard	IG Strategy and IG policy currently being reviewed – minor adjustments required in light of new Data Protection legislation. 31/03/2018 – Due to conflicting work priorities this item will be carried forward to the 2018/2019 action plan	L McAree 31/12/2017	
6.	Internal Audit	Review recommendations of the ICT audit (Nov 2017) Review IM CAS (Feb 2016) and update action plan accordingly.	Update 2017/18 action plan in light of IA report. Discuss with IA feasibility of including a systems audit in the IA programme 2017/2018	In progress (see also (9) below) System audit issued by IG & CIT Governance 23/06/2017- audit closes 21/07/2017 System audit completed and report shared at IGSC on 13/9/17. Action plan is being progressed.	I Low L McAree S Stewart	 

No.	Topic Area/ Objective	Baseline Position as at 1 April 2017	Action Planned	Action Achieved/Outcome As at 31/03/2018	Target Date By whom	Status
7.	Publication Scheme	Trust's Publication Scheme in operation in line with ICO Model Publication Scheme.	Each IG Sub-Committee to take forward the publication of documentation on the Publication Scheme and this is reflected in their TOR.	31/03/2018 Completed and ongoing	IGSC Sub Committee Chairs 30/06/2017	
8.	DHSSPS Working Groups Information Governance Advisory Group SIRO Security Forum	Trust staff nominated to participate in the DHSSP Groups. SIRO and/or IG Manager actively participate at these meetings/fora. This is a standing agenda item on the committee's agenda	Report progress on work of each respective group and specific projects to the IGSC as a standard agenda item	Updates for each Group provided to IGSC on 14/06/2017, 13/9/2017, 13/12/2017 & 14/3/2018 Standard agenda item at IGSC	L McAree Quarterly	

No.	Topic Area/ Objective	Baseline Position as at 1 April 2017	Action Planned	Action Achieved/Outcome As at 31/03/2018	Target Date By whom	Status
9.	Implement internal information governance audits.	A number of audits are undertaken within Directorates which include information governance elements. These are not formally recorded by the IGSC however, in light of the Information Governance Controls Assurance Standard IG Audit activity is included as a standard agenda for each of the IG Sub-Committees	Audits Planned 2017/2018;- ICO Training audit (questionnaire across Trust [June] and visit 24/8/17) Audit of locum forms (post DPA undertaking) in conjunction with HR Medical Staffing	Systems audit has taken priority along with ICO training audit which is currently ongoing., Awaiting official report from ICO – verbal update positive Audit of Locum forms has been re-scheduled owing to other work priorities. 31/03/2018 - Due to conflicting work priorities the audit of locum forms will be carried forward to the 2018/2019 action plan	L McAree 31/03/2018	✓ ✓ ●
10.	Information Governance Policies, Procedures & Guidelines	All IG policies, procedures and guidelines are up to date and available on I-connect. Tracker Table maintained and monitored via the IGSC on a quarterly basis.	Continue to review extant policies in line with current review cycle and develop new policies, procedures and guidelines as required.	All policies published/reviewed in line with Trust policy.	L McAree 31/12/2017	✓

No.	Topic Area/ Objective	Baseline Position as at 1 April 2017	Action Planned	Action Achieved/Outcome As at 31/03/2018	Target Date By whom	Status
11.	Training Needs Analysis and Training Programmes for Information Governance	Extant TNA in operation. Training programme in place and operational for 2017/18 98% of Trust staff have completed DPA training as at 31/12/2016 post DPA Undertaking	Review and update TNA for IG Continue to roll out the training programme for IG for 2017/2018	Regional Training sub-group of IGAG reconvened (Chaired by SET) – the working of this Group will feed into the Trust TNA (as will the ICO report into DPA training [currently ongoing]) IGAG Training Sub Group has met on a 2 occasions – technical updates with Leadership Centre to prepare costings.	L McAree 31/12/17	
12.	Assurance Reports – Information Governance	2016/2017 SIC contained information on IG as required. SIRO Assurance Statement was prepared obo SET and submitted to the DHSSPS on	Prepare draft section for –Governance Statement on Information Risk for 2018/2019, when required (circa April/May) Prepare draft SIRO Assurance Statement for 2016/2017, when required (circa April/May)	Mid-year statement (2017/2018) completed	I Low L McAree	

No.	Topic Area/ Objective	Baseline Position as at 1 April 2017	Action Planned	Action Achieved/Outcome As at 31/03/2018	Target Date By whom	Status
13.	IG Risk Assessments	Assistant Directors are responsible for ensuring that any IG risks are documented in their DRR and the PID/PSD action plans as appropriate.	Follow up on the outcome of PID/PSD action plans with Assistant Directors (which include issues for IG risk assessment as part of the action plan). To undertake review of Directorates' Information Asset Registers	This is scheduled for Autumn 2017. SIRO requested IAOs to review and validate Information Asset Registers by 22/9/17 All registers returned and currently being reviewed by IG.	L McAree 30/09/2017	✓
14.	Privacy Advisory Committee	The Personal Data Guardians (Mr Martyn and Mr Whittle) attend meetings of the PAC on a regular basis. IG Leads also to be invited wef 2017/2018.	To update IGSC members on developments in respect of PAC work on a regular basis following attendance at PAC meetings.	IG leads invited to attend annual PAC meeting, September 2017.	Mr Martyn Mr Whittle 31/03/2018	✓
15.	Awareness Programme for Undertaking Privacy Impact Assessments	PIA guidance published by the Information Commissioner's Office (March 2014). This will be updated in light of GDPR	Raise awareness across Trust of the need to undertake PIA for existing procedures and new projects which involve the processing of personal/sensitive information Determine how to take this matter forward on a corporate basis	This will be taken forward in line with GDPR action plan Head of IG met with ITT and discussed need for PIA to be built into Project documentation. ITT has confirmed project documentation has been updated accordingly.	S Stewart L McAree	✓

No.	Topic Area/ Objective	Baseline Position as at 1 April 2017	Action Planned	Action Achieved/Outcome As at 31/03/2018	Target Date By whom	Status
16.	Historical Inquiry Abuse Investigation	SET HIAI team established and links to Regional HIAI. IGSC representatives attending local meetings of the HIAI on a regular basis	To update members on developments in respect of the Inquiry and its impact on the Trust.	Decision regarding establishment of a Redress Board awaited. 31/03/2018 – there has been no further advice/guidance issued by the DoH therefore this will be carried forward to the 2018/2019 action plan	Mr Whittle 31/3/18	

Symbols used to indicate achievability status

 Achievable – on course to achieve target

 Doubtful – Effort required/behind schedule in achieving target

 Not Achievable – Target not achievable or serious concern/major effort required to achieve target

 Achieved – Target achieved

Information Management Controls Assurance Standard 2017 / 2018
Broken Down by Individual Criteria, Evidence Obtained & Score

Criterion	Description	Evidence Required	Evidence Obtained	Score	Achieved	Target Level
1	There is an Information Governance Management Framework supported by policies, strategies and improvement plans which sets out how the organisation manages Information Governance	Information Governance Management Framework has been signed off by the Board or equivalent senior management tier and the key governance bodies have been established and are active. The IG policies have been communicated to staff and there are strategies and/or improvement plans in place to deliver IG improvements	The Trust follows the DHSSPS Information Governance Framework and in addition has developed an Information Governance Management Framework document to support the Trust's Information Management Strategy and Policy	85%	Substantive	Substantive
2	An effectively supported Senior Information Risk Owner takes ownership of the organisations information risk policy and information risk management strategy	SIRO and supporting Information Risk Management leads (IAOs and supporting staff) are appropriately trained and conduct regular risk reviews for all keys assets. The arrangements for information risk management are regularly reviewed to ensure they remain current and effective. The SIRO successfully completes strategic information risk management training at least annually.	SIRO and IAO structure in place within Trust. Training provided to SIRO and Senior Management. IG risk is incorporated into the quarterly risk Directorate Risk Assessments. Information Asset registers also available for each IAO.	85%	Substantive	Substantive
3	Documented and implemented procedures are in place for the effective management of corporate records	Corporate Records Management procedures implemented. All staff members have access to and have been effectively informed of procedures.	The Trust follows the guidance provided in the DHSSPS document Good Management Good Records, DHSSP Code of Practice on Protecting the Confidentiality of Service User Information, Public Records Act (NI) 1923, Disposal of Document s (NI) Order 1925. Professional Codes of Practice for recordkeeping are also adhered by professional staff. Good Management Good Records – Section 1 – good practice document which outlines the roles and responsibilities of staff. GMGR covers all records in both electronic and paper format. Part 2 provides an HSC Disposal Schedule.	85%	Substantive	Substantive

4	Documented and publicly available procedures are in place to ensure compliance with the Freedom of Information (FOI) Act 2000 and Environmental Information Regulations 2004 (EIR)	Documented procedures in place. All staff aware of their responsibilities. Compliance regularly reviewed/checked.	Procedures in place and FOI is included in IG eLearning suite	85%	Substantive	Substantive
5	Staff are provided with clear guidance on keeping personal information secure and on respecting the confidentiality of service users	Documented procedures in place. All staff aware of their responsibilities. Compliance regularly reviewed/checked.	Procedures in place and DPA is included in IG eLearning suite	80%	Substantive	Substantive
6	Information Governance awareness and mandatory training procedures are in place and all staff are appropriately trained	All new staff members have completed IG training. Training needs are regularly reviewed and re-evaluated when necessary. Action is taken to test and follow up staff understanding of IG	Documented in IG training needs analysis and annual IG training programme. Training has been updated regionally to incorporate the requirements of GDPR	80%	Substantive	Substantive
7	The Information Governance agenda is supported by adequate confidentiality and data protection skills, knowledge and experience which meet the organisation's assessed needs	Role of Personal Data Guardian & Confidentiality and Data Protection work incorporated into the broader IG arrangements	Roles and responsibilities are detailed in a number of IG policy and procedures. Confidentiality and Data Protection are included within the Trust's IG Framework	85%	Substantive	Substantive
8	The Information Governance agenda is supported by adequate information quality and records management skills, knowledge and experience	Appropriate Information Quality and RM Framework in place with adequate skills, knowledge and experience to successfully co-ordinate and implement the information quality and records management agenda. Information quality and RM arrangements are co-ordinated by the led manager/officers but are incorporated within the broader IG arrangements	The Trust has a Records Management Policy and Procedures which are applicable to all records including health/care records. The ADs with responsibility for Health/Care records are members of the IGSC. IAOs are responsible for the quality and management of records within their Directorate	80%	Substantive	Substantive

9	Contractual arrangements that include compliance with information governance requirements are in place with all contractors, support organisations and individuals carrying out work on behalf of the organisation	Appropriate clauses on compliance with IG have been put into all contracts and/or agreements. The action has been implemented and all existing staff are aware of their obligations for IG. Appropriate checks are completed on all new staff, they are appropriately, trained and provided with guidelines to ensure they are aware of their obligations for IG before they start handling person identifiable information. Reviews and or audits are conducted to obtain assurance that all third parties that have access to the organisation's information assets are complying with contractual IG requirements. Staff awareness of their responsibilities and their compliance with IG requirements is checked and monitored	There are contractual records management and confidentiality clauses contained within the terms of the contract between the Trust and any 3rd parties. The contract used for independent providers are standard across all programmes of care and require providers to comply with all relevant legislation including data protection and confidentiality. Operational Managers supported by the Contracts Manager meet with the 3rd party providers on a regular basis to review the contract and performance at these meetings any issues in terms of IG requirements would be discussed. The Trust works with the providers to develop knowledge of data protection and confidentiality issues through training and awareness sessions. Letters issued to Suppliers re, GDPR requirements.	80%	Substantive	Moderate
10	As part of the information lifecycle management strategy, an audit of corporate records has been undertaken	An audit of corporate records has been undertaken in several (at least four) corporate areas of the organisation. An audit of all corporate records has been carried out providing a comprehensive understanding of all the corporate records held. A full report has been produced for senior management or Board to review and sign off and an improvement plan has been developed to tackle any identified problem areas that have not already been dealt with	An information asset register detailing all records held by the Directorate/Dpt is held by each IAO.	85%	Substantive	Substantive

11	There are appropriate procedures for recognising and responding to individuals requests for access to their personal data	Subject access requests are actioned by fully trained and resourced staff and all staff members are aware of the need to support subject access requests, and where in the organisation such requests should be directed. The procedure has been implemented effectively to meet the statutory deadlines. The SAR procedure is regularly reviewed, and where necessary, additional measures have been implemented to assess and improve performance in meeting the statutory timeframes (or any more restricted timeframes required by the subject access request procedure)	All staff complete mandatory DPA training which includes the subject access process. Subject access request form and procedure in place. Redaction policy available. The IG team provides an advisory role to all departments in respect of handling SARs. All community and primary care requests are centralised with the IG team. These tend to be the more complex requests and the team has experience and knowledge in dealing with these requests.	85%	Substantive	Substantive
12	In situations where the use of personal information does not directly contribute to the delivery of care services, such information must only be processed where there is a lawful basis to do so and objections to the disclosure of confidential personal information are appropriately respected	Guidelines are available to staff on when it is both lawful and appropriate to share confidential information and on respecting service users wishes. Approved Guidelines have been made available to at appropriate points in the organisation and all staff members have been effectively informed about the need to comply with them. Staff compliance with the guidelines is monitored to ensure, unless there is a legal reason not to, they respect the service user choices when disclosing confidential personal information	The Trust adheres to the DHSSPS Code of Practice on Protecting the Confidentiality of Service User Information and the DPA. Personal sensitive information for the purposes of secondary uses will be anonymised / pseudoannoymised	85%	Substantive	Substantive
13	Individuals are informed about the proposed uses of their personal information	Communication materials are supported by an active communications campaign to inform all individuals, including those with special/different needs, about how their personal information is used. Staff compliance with their responsibilities to ensure individuals have access to the communications material about the use of personal information is monitored and assured.	Contained within information leaflets and posters. Included in Hospital handbook . Adherence to Trust Equality Scheme	80%	Substantive	Substantive

14	Where required, protocols governing the routine sharing of personal information have been agreed with other organisations	Data Access Agreements are up to date and data destruction notifications which form part of the agreement have been received and are up to date. The PDGF is taking responsibility for actively reviewing the Protocol and DAAs	PDG oversees the implementation of the protocol within the Trust and is responsible for signing off Trust's DAAs	85%	Substantive	Substantive
15	All person identifiable data processed outside of the UK complies with the Data Protection Act 1998 and Department of Health Social Services and Public Safety guidelines	All transfers of personal data to countries outside of the UK fully comply with DPA. Where the review of overseas transfers reveals that appropriate contracts are not already in place for existing transfers, the organisation ensures that new contractual arrangements are signed. Transfers of personal data to non-UK countries are regularly reviewed to ensure they continue to fully comply with the DPA	Information leaflets and patient consent to holding personal sensitive data outside UK/EEA i.e. emerging technologies to assist in patient care i.e. diabetes. If data is transferred to USA the Trust will require sight of Safe Harbour Agreement Notification with ICO, if relevant Advisory role via the PDG and Information Manager Trust can avail of advice and guidance from the legal Directorate Completion of Data Access Agreements Information leaflets and patient consent to holding personal sensitive data outside UK/EEA i.e. emerging technologies to assist in patient care i.e. diabetes If data is transferred to USA the Trust will require sight of Safe Harbour Agreement Notification with ICO, if relevant Advisory role via the PDG and Information Manager Trust can avail of advice and guidance from the legal Directorate Completion of Data Access Agreements Information leaflets and patient consent to holding personal sensitive data outside UK/EEA i.e. emerging technologies to assist in patient care i.e. diabetes	80%	Substantive	Substantive

			If data is transferred to USA the Trust will require sight of Safe Harbour Agreement Notification with ICO, if relevant Advisory role via the PDG and Information Manager Trust can avail of advice and guidance from the legal Directorate Completion of Data Access Agreements Information leaflets and patient consent to holding personal sensitive data outside UK/EEA i.e. emerging technologies to assist in patient care i.e. diabetes If data is transferred to USA the Trust will require sight of Safe Harbour Agreement Notification with ICO, if relevant Advisory role via the PDG and Information Manager Trust can avail of advice and guidance from the legal Directorate Completion of Data Access Agreements DAA updated to reflect needs of the GDPR			

16	The processes for all transfers of hardcopy and digital person identifiable and sensitive information have been identified, mapped and risk assessed; technical and organisational measures adequately secure these transfers	Appropriate Information Quality and Records management framework in place and adequate skills, knowledge and experience to successfully co-ordinate and implement the information quality and records management agenda. Information quality and Records Management arrangements are co-ordinated by the lead manager/officers but are incorporated within the broader IG arrangements	Each Directorate holds an information asset register which identifies all personal/personal/ sensitive information processed to include storage, means of transfer, risk assessment and retention/disposal of their information. On receipt of the audit report recommendations, an Action Plan is drawn up and tabled at the Trust Clinical coding Forum. The updated Action Plan is shared with PMSID following each Coding Forum meeting.	75%	Substantive	Moderate
17	The confidentiality of service user information is protected through use of pseudonymisation and anonymisation techniques where appropriate	Robust IG processes have been established to support the implementation of the pseudonymisation/anonymisation plan. Business processes are reviewed to ensure that the organisation remains compliant with the requirements to protect the confidentiality of service user information	Staff adhere to Professional codes of conduct i.e. GMC and Social Work and H R contracts of employment Information Systems and Coding Teams adhere to respective standards and anoymisation techniques HSC Honest Broker Service in place which Trusts have signed up to. (see 17.3) Information which is made available to the public via the publication of official statistics is aggregated to ensure anonymisation. Where patient level datasets are required to be provided other techniques such as banding, data masking etc. are employed when possible.	85%	Substantive	Substantive

18	There is consistent and comprehensive use of the Health+Care Number (HCN) in line with the Department's best practice guidance	All retrospective and future HSC Demographic Improvement Group feedback reports are addressed. Progress/highlight reports, in line with local government arrangements are reported to the Trust Board	The HCN is used as the regional patient/client identifier on all information systems. Where feasible, a HCN interface is integrated to the system to maximise its use in both acute and community systems. The Trust has included the HCN on all correspondence and notes. At present there is no standardisation of the wristbands however the proposed new wristband contains the HCN and also barcodes which will be used in future along with scanners to identity the patient more securely. The wristband is currently being piloted in a number of areas throughout the Trust i.e. in the Downe and Lagan Valley. The HCN and use of same is being lead regionally. All staff are informed about the HCN as part of system training. In addition when errors are found in the data held by the Health+Care Index, Trust staff are encouraged to report the errors to the Data Quality Team for resolution with the Regional Demographics Service	85%	Substantive	Substantive
19	Procedures are in place to ensure the accuracy of service user information on all systems and/or records that support the provision of care	Data collection and validation activities are regularly monitored. All staff collecting and recording data are effectively trained to do so and dedicated staff take appropriate action where errors and omissions are identified. Regular audits and reviews are carried out to monitor the effectiveness of data collection and validation activities	Reference is included in Trust correspondence to patients to check their demographic details and contact the Trust should there be any inaccuracies. Yes, the Trust utilises regional guidance where available in respect of the collection and recording of information and in addition where required local guidance is also developed and provided to users Data cleansing mechanism in place in respect of the HCN. SET validity rate for HCN is highest in NI.	75%	Substantive	Moderate

20	A multi-professional audit of clinical records across all specialties has been undertaken	The approach to auditing clinical and social care records has been implemented and all staff are informed of their responsibilities with regards to clinical recording keeping. An audit of clinical and social care records has been completed for professional groups across all specialties with audit results being fed back to health and social care professionals and actions taken to improve/maintain performance.	The Trust has a programme of audit across all specialities. Each Directorate's audit meeting is held on a monthly basis. The audits agreed at Directorate level are registered with the Safe & Effective Care Department for audit assistance and shared learning of outcomes. The Multi-professional Audit Steering Committee and Convenors Group meet 3 times per year. The Committee reviews outcomes of audits and results and strategic audit direction for the Trust is discussed. An Audit Conference is held annually – this is another opportunity for Trust-wide shared learning. The Safety, Quality & Experience Journal is published quarterly and in addition, a monthly newssheet is also issued, Both these publications reference significant patient safety and audit initiatives	80%	Moderate	Moderate
21	Procedures are in place for monitoring the availability of paper health/care records and tracing missing records	The procedures for the monitoring and availability of paper health/care records have been implemented and action taken where availability of records is considered poor. Staff compliance checks are routinely undertaken to ensure staff are following the record tracking process and appropriately reporting unavailable or missing records	There is a Missing Records Procedure Records Management Procedure & Policy Contingency arrangements via availability of electronic records when physical file is not available If chart not available the practitioner can access information on the patient via the Electronic Care Records, Patient Centre	80%	Substantive	Substantive

22	National data definitions, standards and validation programmes are incorporated within key systems and local documentation is updated as standards develop	service user information systems have validated programmes built in that are kept up-to-date and cannot be switched off or overridden by operational staff. All documentation for local systems is regularly reviewed and updated appropriately as standards develop. Validation programmes are regularly tested to ensure that errors are identified and acted upon. The effectiveness of the arrangements for updating local documentation is regularly reviewed in conjunction with appropriate stakeholders	The Trust records according to definitions and standards issued by the DOH and the HSC Board. If a query arises Information staff contact the Data Definitions Service at the HSC Board to seek clarification. The Information Department issues new guidance as procedures are changed. System Managers ensure system fields are updated accordingly to support recording. e.g. Regional guidance on recording Independent Sector data. Changes to Clinical Coding Standards are regularly received from the NHS Classification Service. These are approved and adapted for Northern Ireland by the Regional Clinical Coding Team, PMSID and all coding manuals are updated accordingly by Trust clinical coders. Queries from the Coding Team are submitted to the Regional Clinical Coding Department, which provides resolutions to each individual query. On receipt of coding query resolutions, all copies of clinical coding manuals are up-dated. SET use Patient Administration System (PAS) to record clinical coded data. Following conversion to updated versions of ICD10 and OPCS the PAS is updated by the Trust's ICT Department in conjunction with the Clinical Coding Manager to ensure validation.	85%	Substantive	Substantive

23	External data quality reports are used for monitoring and improving data quality	Data quality reports from external sources are followed up and appropriate corrections made. Report on data quality are shared with the Board/Senior management team or delegated sub-committee/group. Improvement plans have been developed for improving data quality and signed off by the information manager/senior management team or delegated sub-committee/group and appropriate resources have been allocated for improvements tot be made.	The Information/Data Quality teams currently use a series of daily/weekly/monthly DQ monitoring reports to assess and follow up on DQ errors. PAS data quality monitoring reports have been specifically developed and set up via BOXi and/or other system specific reporting tools. In addition the Performance and Information team investigates and actions any external data quality reports received from BSO.	85%	Substantive	Substantive
24	Audits of clinical coding, based on national standards, have been undertaken by a NHS Classifications Service approved clinical coding auditor within the last 12 months	clinical coding audit programme plan detailing annual audit programme is in place. Audit programme considers the clinical coding standards. Clinical coding auditor who has adhered to the Clinical Coding Auditor Code of Conduct within the last 12 months. Audit recommendations noted and actioned	Clinical Coding Audits were carried out in the South Eastern HSC Trust by the Regional Clinical Coding Team in 2014 and are due in 2017. This will be lead by PMSID Regional Clinical Coding Co-ordinator, who is an approved NHS Classifications Service clinical coding auditor. .	85%	Substantive	Substantive
25	A documented procedure and a regular audit cycle for accuracy checks on service user data is in place	the accuracy of service user data audits cover all key data items (or a locally agreed subset). The results are reported to the Board/senior management, or delegated sub-committee as part of ongoing data quality reviews. The data quality policy forms parts of the broader IG Policy. Actions are taken to address areas of persistently poor data quality	While the Trust does not have a documented procedure and regular audit cycle on care data there is regular monitoring in place for key datasets and complete adhoc audit checks on Data Quality errors in daily workload. This process is supported by completion of checklists. Performance and Information Department explored the feasibility of developing an annual audit programme with advice taken from the Trust Audit Department regarding assistance/registering of audits and outcomes.	70%	Moderate	Moderate

26	Clinical /care staff are involved in validating information derived from the recording of clinical/care activity	the strategy has been implemented, and clinical/care staff members are involved in validating the data they produce. The effectiveness of clinical/care staff validating information derived from the recording of clinical/care activity is monitored and any necessary improvements made	The organisation ensures that clinicians and care professionals are fully committed to improving the quality of information by identifying clinical champions, service leads in new implementation of information systems. Sub-Committees of the Information Governance Steering Committee will include this within respective programmes of work.	85%	Substantive	Substantive
27	Training programmes for clinical coding staff entering coded clinical data are comprehensive and conform to national standards	a programme of clinical coding refresher course training every 3 years for all clinical coding staff entering coded clinical information is in place that conforms to national standards. All clinical coders are supported in gaining Accredited Clinical Coder status by passing the National Clinical Coding Qualification (UK). Clinical Coders have attended clinical coding speciality and update training workshops when classification revisions require	All clinical coders employed in the South Eastern HSC Trust undertake the NHS Classification Service approved Clinical Coding Foundation Course. They continue their training on-the-job, working with experienced coders, who provide mentorship.	90%	Substantive	Substantive