South Eastern Health and Social Care Trust

Paper No. SET 35/17

Annual Report on Information Governance As At 31 March 2017

Policy Profile	
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Approval Profile	
Information Governance Steering Committee:	Via email Consultation Process,
Trust Board:	22 June 2017

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Annual Report on Information Governance as at 31 March 2017

1.0 Introduction

This is a report on the Trust's Information Governance arrangements from the 1 April 2016 to 31 March 2017. It is based on the criteria within the Information Management (IM) Controls Assurance Standard (CAS) issued by the Department of Health, Social Services & Public Safety (DHSSPS) in September 2013. The IM CAS was not subject to internal audit in 2016/2017.

The report also outlines the assurance process and criteria which must be assessed to achieve compliance with the IM CAS. The report underpins the Department of Health (DoH [formerly DHSSPS]) Information Management Framework, highlights progress to date in the implementation of the Framework and identifies the Trust's priorities for 2017/2018. Self-assessment confirmed an overall score of 81% in the IM CAS, 2016/2017. This score falls within the substantive compliance range set by the DoH.

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).

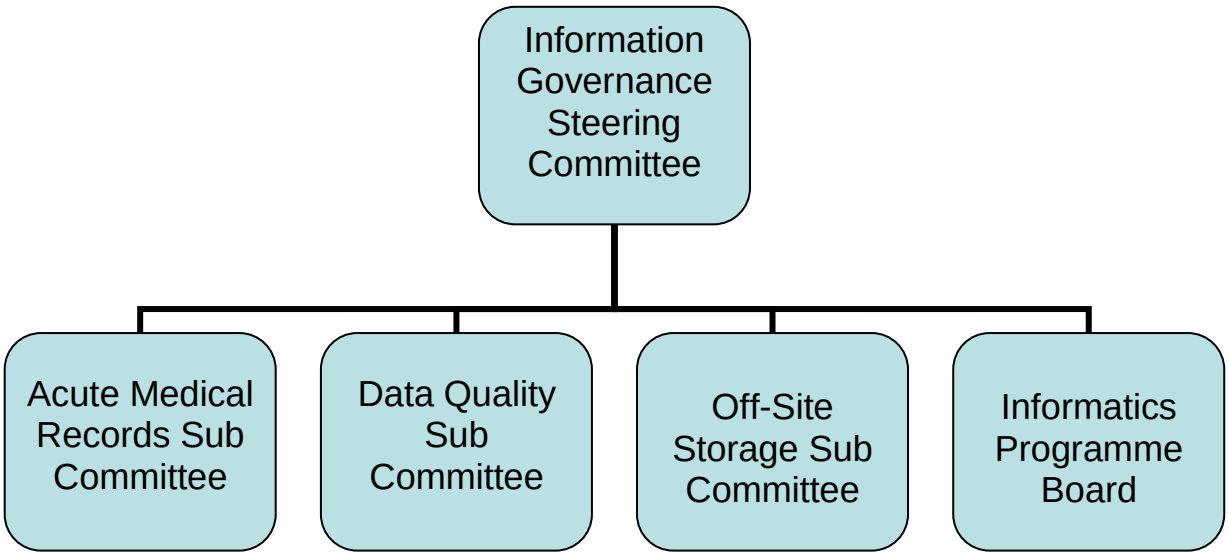
Information Governance (IG) should be recognised within an organisation as an integral part of good practice and embedded in the Trust's culture. It forms a vital part of the Trust's practices and business plans. It should not be viewed or practiced as a separate programme. As an integral corporate function, 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. The Information Governance Department has also participated in Information Governance Sub-Committees (IGSC) which are multidisciplinary groups set up by the Trust to progress and improve information governance practices across the Trust, in line with the priorities identified by the IGSC.

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

The IGSC is a sub-committee of the Corporate Control 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 2016/2017 (September, 2016) and has reduced these sub-committees to four namely Acute, Data Quality, Off-Site Storage and Informatics Programme Board. The Adult Services & Prison Healthcare, Primary Care & Older Peoples and Children's Services Sub-committees have been subsumed into their respective Directorate Governance Committees which include Information Governance as a standing agenda item. The IGSC includes a standard agenda item inviting Chairpersons of each Sub-Committee to report by exception in respect of IG issues.

The IGSC agenda format was also reviewed to ensure inclusion of presentations on Information Governance (IG) initiatives or projects that required IG input on a 6 monthly basis.

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 has also been appointed.

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.

The Director of Human Resources & Corporate Affairs attended SIRO Training on 16 May 2016. In addition, a number of Assistant Directors/Senior Managers across the Human Resource & Corporate Affairs and Planning, Performance & Informatics Directorates attended SIRO/IAO training on 29 November 2016.

4.0 Information Governance Policy and Procedures – 2016/2017

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. 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 – 2016/2017

The programme of work for 2016/2017 was primarily focused on achieving substantive compliance in the IM CAS, viz:-

- Establishment of a Data Protection Task & Finish Group to oversee implementation of recommendations as set out in the ICO Undertaking;
- Achieve substantive compliance in the IM CAS and undertake programme of work to ensure continued embedding of the CAS throughout the Trust;
- Update and review of the Information Governance sub-committee structure;
- Participate in regional tender for off-site storage (award withheld due to increased cost, service continued under a single tender action (STA) for a 12 month period);
- Continued implementation of IG training and utilisation of e-learning platforms;
- Implementation of the SIRO Says Campaign, raising awareness amongst staff of service user confidentiality and measures to help minimise data breaches;
- Establishment and monitoring of Key Performance Indicators (KPIs);
- Provision of Freedom of Information (FOI) and Data Protection statistical data to Directorate Performance Reviews , mid and year-end Accountability Reviews;
- Implementation of a series of audits i.e. audit of FOI process across the Trust;
- Establishment of a National Audits Register recording all National Audits which the Trust participates and provides data;
- Provision of advisory role on all Information Governance issues (to include Records Management, Data Protection, Confidentiality and Freedom of Information);
- Participation in a number of regional co-production projects with local Councils and the Department of Infrastructure to ensure that appropriate governance arrangements are in place for the sharing of data for new initiatives;
- Assess and review need for Data Access Agreements with third parties;
- Review of IG Policy and Procedure in accordance with internal procedure;
- Development of FOI disclosure log;
- Promotion of work through publication of resources on the IG intranet site;
- Inclusion of information governance within the Lessons Learnt Committee forum and inclusion of IG summary within the quarterly Incident Report and,
- Continued participation in the DHSSP Information Governance Advisory Group.

A copy of the IGSC programme of work for 2016/17, including progress report as at 31 March 2017, is attached at Appendix 2, for information.

7.0 Baseline Assessment of the Information Management Controls Assurance Standard – 2012/2013

Results of 1st Baseline Assessment – 4 November 2016

The first baseline assessment was completed by 4 November 2016 and a score of 79% was achieved.

Results of 2nd Baseline Assessment – 2 March 2017

The second assessment was completed by self-assessment and a score of 81% was achieved.

The Trust's final score was 81% and this was submitted to the DoH in May 2017.

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

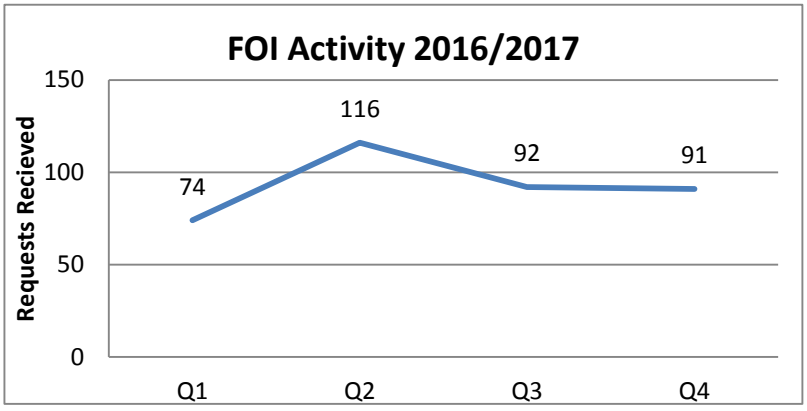
8.1 Freedom of Information Requests & Environmental Information Regulations

Freedom of Information (FOI) and Environmental Information (EIR) requests are co-ordinated and processed centrally via the IG team. During the period 01/04/16 - 31/03/17, 373 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 2016/2017

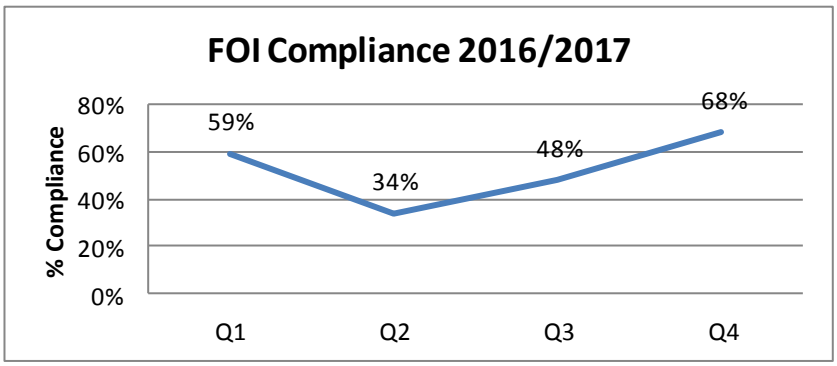
Graph 1A illustrates volume of FOI requests received per quarter.

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, 'whatdotheykow.com' and commercial organisations. This is consistent with previous years.

Compliance across each of the quarters fluctuated. There was a notable drop in compliance in Quarter 2 due to a high volume of requests received in relation to Care Homes. This coincided with annual planned holiday leave. Staff shortages and staff changeovers within IG also contributed to the rise in timeframe breaches.

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.

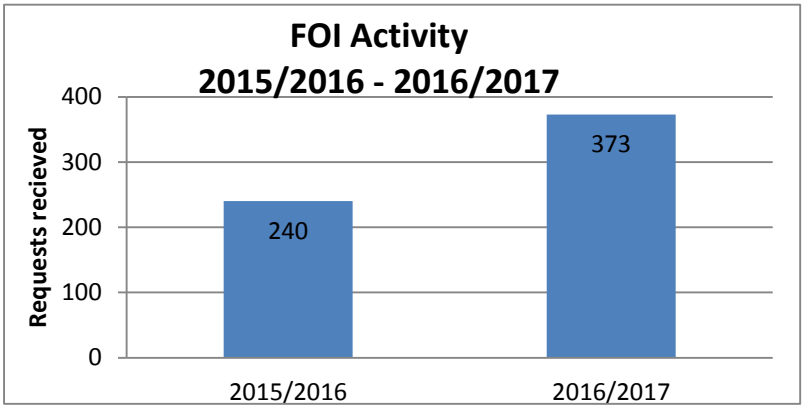
In comparison with 2015/2016 statistics this year has seen an increase (+133) of FOI requests. This represents a 55% increase in activity. Compliance rates in activity have remained static (2015/2016 = 52%, 2016/2017 = 51%).

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.

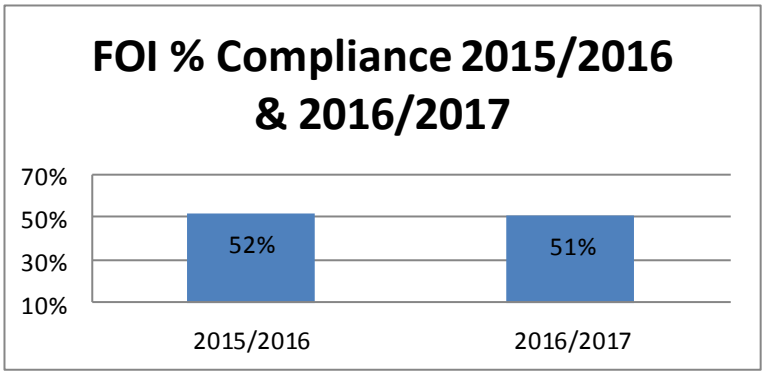
FOI Totals and % Compliance for 2015/2016 & 2016/2017

Graphs 2A & 2B illustrate comparison volume and % compliance data in respect of FOI requests received 2015/2016 & 2016/2017.

Graph 2A



Graph 2B



A total of 43 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 14 requests were re-opened. The volume of re-opened cases processed this year represents a 207% increase on the previous year.

An FOI Disclosure log has been developed and FOI responses are now published on to the Disclosure log by the IG Department. This is in line with guidance issued by the Information Commissioner's Office (ICO).

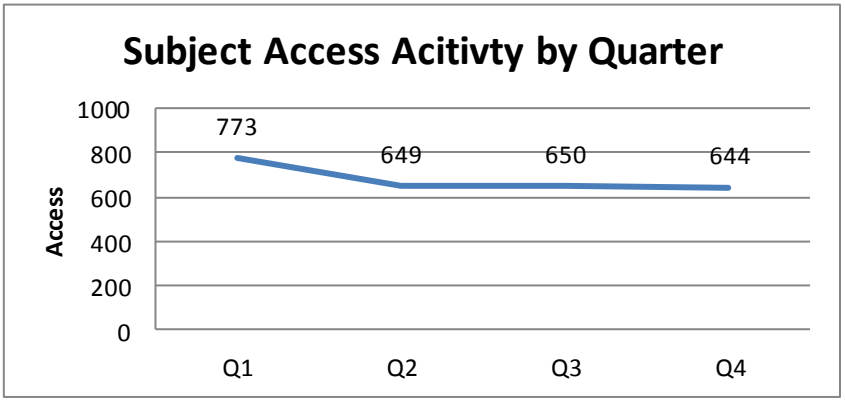
8.2 Subject Access

Subject access requests (SARs) are input by the IG, Mental Health, Prison Healthcare & the Medical Records Departments. A total of 2,716 requests were received. SAR volumes per quarter and compliance per quarter are illustrated in Graphs 3A & 3B below.

DPA Activity & Compliance by Quarters 2016/2017

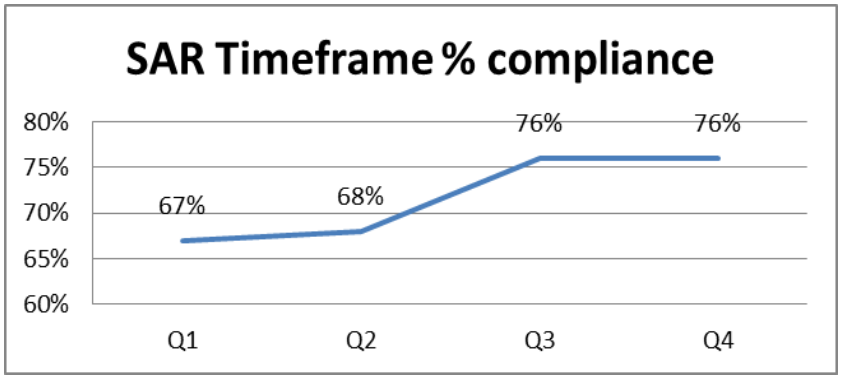
Graph 3A illustrates volume of SARs received per quarter.

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).

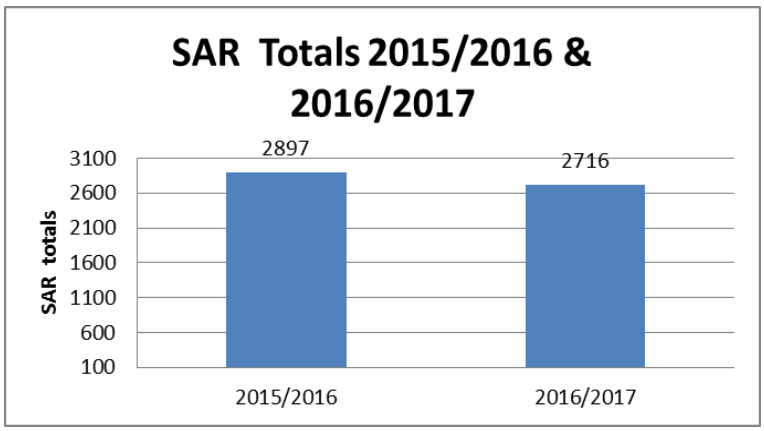
Requests processed by the Information Governance team are complex, particularly with regard to requests relating to family and child care. Due to the enormity of the recorded information contained in Social care files, and the need for a Social Work Practitioner to review the file prior to release, delays have incurred. In the case of complex requests, the Social Work Practitioner will maintain contact with the requestor and the IG team will keep the applicant informed of progress. During 2016/2017 there has been an increase in the number of requests for historical social work records.

In comparison with 2015/2016 statistics this year has seen a recorded decrease of 6.2% in the number of SAR requests processed.

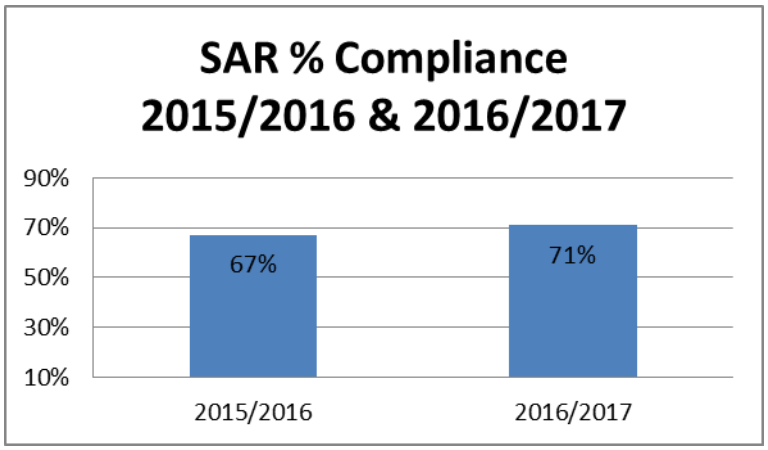
Quarterly compliance reports are provided to the IGSC and are also included in the Trust's reporting cycle through Directorate Performance Reviews, Mid-Year Reviews and the Balanced Scored Card.

SAR comparison data for 2014/2015 & 2015/2016 are represented in graphs 4A & 4B below.

Graph 4A



Graph 4B



A total of 16 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 2016/2017 (3089) saw a decrease of 1.5% activity compared with 2014/2015 (3137).

At the time of reporting, Prison Healthcare has not recorded all subject access requests on to the reporting system.

8.3 Internal Reviews & Complaints to the Information Commissioner

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

Four requesters sought internal review following receipt of the initial Trust response. All initial decisions were upheld.

There were no 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 523 IG incidents (IR1) were reported during 2016/2017. 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 2016/2017 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 did not report any incidents to the ICO during 2016/2017. The Trust is working with the Public Health Agency (PHA) in respect of a single email incident that occurred in the PHA (15/11/2016) involving a number of patient laboratory results, 44 of which related to this Trust. The incident was contained, and the recipient of the email has confirmed that the email was not opened and was destroyed immediately. The matter was referred to the ICO by the PHA. The outcome of the PHA & ICO investigation is awaited.

In October 2016, the ICO completed a follow-up assessment of the actions taken by the Trust which consisted of a desk based review of documentary evidence supplied by the Trust. The ICO concluded that the Trust had taken the appropriate steps and put plans in place to address the requirements of the undertaking and to mitigate the risks highlighted in the undertaking. A statement to that effect is published on the ICO website.

Any issues specifically identified by the IGSC are managed via the Risk Management & Governance Risk Register or are escalated to the Corporate Risk Register. The ICO undertaking was added to the Risk Management & Governance Risk Register as a Trust-wide risk in June 2016. Following the receipt of the ICO follow up decision, this item was subsequently removed (December 2016) from the aforementioned Risk Register.

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 – 2017/2018

A Controls Assurance Standard Action Plan has been prepared 2017/2018 to progress the recommendations arising from the Trust's audits (2016/2017) and the DoH Information Governance Framework. Priority actions for this period will include:-

- Ensure recommendations of the Internal Audit on Information Management are progressed and reported to the IGSC;
- Participate in the Information Commissioner's Training Audit (June 2017);
- Continued participation on regional fora to progress actions required for implementation of the General Data Protection Regulations (GDPR) in May 2018;
- Establish Trust Task & Finish Group in respect of GDPR implementation if required;
- Preparation and issue of monitoring reports to senior managers in respect of compliance with both Subject Access requests and FOIs;
- Continued implementation of a programme for review of information governance risk assessments and Directorate Information Asset register ;
- Re-audit FOI process to ensure that it is sufficiently streamlined to promote compliance with legislative timeframes;
- In conjunction with ICT colleagues undertake a Systems Audit;
- Achieve substantive assurance in the Information Management Controls Assurance Standard;
- Award of Regional Off-Site storage contract;
- Continued roll-out and monitoring of Training & Awareness;
- Roll-out of Datix to Medical Records, Downe Hospital and,
- Continued promotion of the Data Quality Agenda

10.0 Summary and conclusion

This report provides an overview of the developments within Information Governance during 2016-2017 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 81% substantive compliance (75-100%) with the standard.

The IGSC endorsed the content of this report via email communication during June 2017 for submission to the Trust Board at their next meeting on June 2016.

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
Records Management Policy Statement	SET/Gen (108) 2014	July 2015	December 2017
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
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
Retention & Disposal Schedule (Good Management, Good Records DHSSPSNI)	NA	November 2011	Currently under review by DoH
Policy on the Use of the Internet	SET/Gen/ (94) 2014 SET/GEN (142)	April 2014 April 2016	April 2016 November 2021
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 Framework incorporating Strategy	SET/Gen(109) 2015	December 2014	January 2017
Information Governance Policy	SET/Gen (123) 2015	September 2015	September 2018
FOI Policy	SET/Gen (122) 2015	June 2015	July 2018
Policy Code of Practice on Protecting Confidentiality of Service User Information	ST/Gen (145) 2016	May 2016	November 2019
Data Protection Policy Statement	SET/Gen/Mge (60) 2012 SET/GEN(146) 2016	April 2012 Sept 2015	August 2018

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
Data Access Agreement	Application form issued by the DoH NI	June 2012	December 2012
Release of Records Authorisation Form		December 2015	January 2018

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	Guidelines issued by the Information Governance Department	January 2017	January 2020

ITEMS CURRENTLY UNDER REVIEW & TO BE CONSIDERED IN LINE WITH NEW INFORMATION MANAGEMENT CONTROLS ASSURANCE

Policy to support Protocol for Sharing Service User Information for Secondary Uses (DHSSPS Guidance)	Develop Policy to support DHSSPS Protocol once ratified for circulation by DHSSPS	25 April 2012- advice provided to all Assistant Directors	DHSSPSNI currently consulting on the introduction of Secondary Purposes Legislation (September 2014)
Social Media Policy	In development via the Communications team	May 2017	
Policy for Processing Freedom of Information (FOI) Requests	SET/Gen (61) 2012	April 2012	September 2015 At consultation -03/11/2016 Feedback received – comments re numbering accepted Return to SEC for Scrutiny (15/3/17) Endorsed by Author 8/5/17
Policy and Procedure for Redaction of Patient/Client/Service User Records	SET/Gen (79) 2013	September 2013	September 2015 At consultation -03/11/2016 No comments received With SEC for Scrutiny 15/3/17
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.
Staff Guidance for Handling Vexatious & Repeated Requests under the Freedom of Information Act 2000 and the Data Protection Act 1998	NEW – Response to comments from Consultation currently being prepared by Information Governance Department Scrutiny completed – with Director for sign off (9/5/17)

South Eastern Health & Social Care Trust

Information Governance Steering Committee
Action Plan 01/04/2016
Updated 31/05/2016
Updated 30/06/2016
Update 30/09/2016
Update 09/12/2016
Updated 22/02/2017
Updated 31/03/2017

ACTION PLAN FOR THE INFORMATION GOVERANCE STEERING COMMITTEE 2016/2017

No.	Topic Area/ Objective	Baseline Position as at 1 April 2016	Action Planned	Action Achieved/Outcome As at 30/09/2016	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	31/5/2016 - ToR and action plan endorsed at IGSC meeting on 25/4/2016	IGSC 30 June 2016	✓
2.	Appointment of Senior Information Risk Owner	Director of Human Resources & Corporate Affairs retired on 25/2/2106. Deputy SIRO in place.	Appointment of Director of Human Resources & Corporate Affairs 2016/2017. SIRO role is included in the Job Description	31/5/2016 - SIRO training undertaken 16/5/2016	IGSC 30/4/16	✓

No.	Topic Area/ Objective	Baseline Position as at 1 April 2016	Action Planned	Action Achieved/Outcome As at 30/09/2016	Target Date By whom	Status
3.	Maintain the IGSC sub committee structure to support the work of the IGSC	Seven IG sub committees have been agreed and are operational 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 sub committee 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	31/5/2016 - Sub-Committee Chairs asked to submit action plans as at 31/3/2016 and submit action plans and ToR 2016/2017 30/09/2016- Reminder for action plans issued August, 2016. Discussed at IGSC 14/9/2016 and agreed that IG could be included in Governance meetings for all Operational areas (Adult to be confirmed) The Directorate's Governance meeting TOR would need to record inclusion of IG issues. 14/09/2016 – IGSC agreed changes to the IGSC sub-committee structure. Action plans required for Off-site storage, Informatics Programme Board, Acute Services & Data Quality by 31/3/17 9/12/2016 – update provided and recorded in IGSC minute	IGSC 31 March 2017	✓

No.	Topic Area/ Objective	Baseline Position as at 1 April 2016	Action Planned	Action Achieved/Outcome As at 30/09/2016	Target Date By whom	Status
4.	Controls Assurance	Baseline assessment of Information Management and ICT Controls Assurance Standards completed and submitted by 5 March 2016 both standards received the mandated compliance for 2015/2016	Submit updated controls assurance action plans for the Mid-Year Assurance Statement by September 2016, signed by relevant Director. Complete 1st baseline assessment for 2016/17 and submit to the Project Manager by agreed date (November 2016) – substantive compliance is required. Complete 2nd baseline assessment for 2016/17 and submit to Project Manager by agreed date (March 2017) – substantive compliance is required.	30/09/2016 – mid-year update submitted to Project lead 16/9/16 22/02/2017 – work ongoing to ensure 2nd baseline assessment submitted by 01/03/2017	L McAree 31 December 2016 L McAree 31 Jan 2017	✓ ✓
5.	Implementation of the Information Governance Strategy/Action Plan	Extant Records Management Strategy/Action plan in operation. The action plan is incorporated into the Controls Assurance Plan and is reported upon via the IGSC	Continued roll out of Information Governance Strategy incorporating Framework in line with the DHSSPS Information Governance Framework and the Information Management Controls Assurance Standard This item is linked to item 3 above. The Records Management Policy and Strategy feed into an overarching Information Governance Strategy which is a resource requirement for the new Information Management Controls Assurance Standard.	31/5/2016 - Head of Information Governance continues to participate in regional IG forums and DoH IGAG Ongoing 30/06/2016 – IGAG 16/6/16 no significant issues 09/12/2016 – IGAG meetings held 29/09/2016 & 24/11/16. Sub committee established to take forward EU GDPR (Nov 16) 22/02/2017 above groups continue to meet – in addition also participating in further regional work – Email retention and Integrated Passenger Network	L McAree 30/06/2016	✓

No.	Topic Area/ Objective	Baseline Position as at 1 April 2016	Action Planned	Action Achieved/Outcome As at 30/09/2016	Target Date By whom	Status
6.	Internal Audit	Review recommendations of the IG audit for IM CAS (Feb 2016) and update action plan accordingly.	Update 2016/17 action plan in light of IA report. Undertake audit of current access to various systems	30/06/2016 - IM CAS action plan is being progressed. Systems audit available in draft – Head of IG to discuss with Safe & Effective Care Directorate In progress 30/09/2016 – discussion ongoing with IA 09/12/2016 - Nov 16 – IA ICT audit completed and IG to discuss additional systems audit (Jan-March 2017)	L McAree 30/4/16 31/12/16	✓
8.	ICO Undertaking	Undertaking signed by Trust and Deputy Information Commissioner (date)	Develop and implement robust action plan in accordance with ICO Undertaking issued in respect to two data incidents – RFI reference COM0588800 (AE) & COM0563892 (FCC)	30/06/2016 – Task & Finish Group Chaired by the PDGs set up and meets on monthly basis. Preparation to instruct staff regarding training and monitoring training uptake in progress (deadline 5/8/16). Regular updates provided to EMT. In progress 30/09/2016 – Task & Finish Group meets monthly. Reports continue to be issued to EMT weekly. Response to Undertaking presented to EMT for approval on 20/9/2016. 09/12/2016 – ICO confirmed no further action required (24/10/16). Task & Finish Group stood down /12/2016	L McAree 30/9/16	✓ ✓ ✓

No.	Topic Area/ Objective	Baseline Position as at 1 April 2016	Action Planned	Action Achieved/Outcome As at 30/09/2016	Target Date By whom	Status
9.	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.	30/06/2016 - As well as Publication Scheme, Directorates in conjunction with the Communications Dpt are using Facebook to advertise and promote their services. 30/09/2016 – Regional Review of HSC internet sites/providers. 09/12/2016 – update requested from Communications 5/12/2016 awaited 22/02/2017 – Communications confirmed Northern Trust currently transferring information to new website c/f 2017/2018	IGSC Sub Committee Chairs 31/03/2017	✓
10.	DHSSPS Working Groups Information Governance Advisory Group	Trust staff nominated to participate in the DHSSP Groups. IG Manager actively participates 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	30/06/2016 – standing item on IGSC agenda. In progress 09/12/2016 – in progress 22/02/2017 – in progress	L McAree 31/03/2017	✓
11.	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 2016/2017;- Re-audit of FOI process Re-audit Redaction Policy	30/06/2016 – Redaction policy currently under review and will be subject to consultation in line with Trust consultation process Re-audit of FOI process scheduled for Q4. 09/12/2016 – in progress 22/02/2017 – stats being finalised for FOI audit (Dec 17) – report to be written	L McAree 31/03/2017	✓

No.	Topic Area/ Objective	Baseline Position as at 1 April 2016	Action Planned	Action Achieved/Outcome As at 30/09/2016	Target Date By whom	Status
12.	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. Draft IG Policy currently being being consulted upon internally	Continue to review extant policies in line with current review cycle and develop new policies, procedures and guidelines as required. Finalise SET IG Policy Re- launch of revised Good Management Good Records (estimated publication Sept 2016)	30/06/2016 – IG policy at final sign off stage. DPA and Code of Practice on Protecting Confidentiality are being forwarded to Scrutiny Panel. Vexatious Guidance (New Guidance) has been issued to Safe & Effective Care for consultation. 09/12/2016 – Redaction policy, Procedure for dealing with FOI, FOI internal review policy (new) and Vexatious Guidance all issued to S&EC for consultation. 22/02/2017 – Vexatious Guidance – queries raised by authorisation panel – currently working through FOI Internal Review and Vexatious – ICO happy to review comment	L McAree 31/12/2016	
13.	Training Needs Analysis and Training Programmes for Information Governance	Extant TNA in operation. Training programme in place and operational for 2016/17	Review and update TNA for IG Continue to roll out the training programme for IG for 2016/2017	30/6/2016 – TNA has been updated as part of the DPA Undertaking exercise 09/12/2016 as above.	L McAree 31/12/16 31/3/17	

No.	Topic Area/ Objective	Baseline Position as at 1 April 2016	Action Planned	Action Achieved/Outcome As at 30/09/2016	Target Date By whom	Status
14.	Assurance Reports – Information Governance	2015/2016 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 2015/2016, when required (circa April/May) Prepare draft SIRO Assurance Statement for 2015/2016, when required (circa April/May)	30/06/2016 – 2015/2016 Governance statement completed and submitted 22/02/2017 SIRO Assurance statement template awaited from DoH	I Low L McAree 30/04/2016	
15.	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	30/06/2016 – Information Asset Registers 2015/2016 completed 30/09/2016 - Annual review to commence Oct 2016 09/12/2016 due to work commitments associated with ICO Undertaking this work has been posted until Jan 17 22/02/2017 due to work competing work pressures review has not commenced – c/f 2017/2018	L McAree 30/06/2016	c/f 2017/2018 
16.	Privacy Advisory Committee	The Personal Data Guardians (Mr Martyn and Mr Whittle) attend meetings of the PAC on a regular basis.	To update IGSC members on developments in respect of PAC work on a regular basis following attendance at PAC meetings.	09/12/2016 – This is a standing item on IGSC agenda. 22/02/2017 – IG leads to be invited to annual PAC meeting	Mr Martyn Mr Whittle 31/03/2017	

No.	Topic Area/ Objective	Baseline Position as at 1 April 2016	Action Planned	Action Achieved/Outcome As at 30/09/2016	Target Date By whom	Status
17.	Awareness Programme for Undertaking Privacy Impact Assessments	New PIA guidance published by the Information Commissioner's Office (March 2014).	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	30/06/2016 – PIA completed in respect of SPACEBOX initiative in the Cared for Children sector – this initiative was presented to the IGSC on 15/06/2016 09/12/2016 above PIA currently being tested as part of the pilot project	L McAree 31/12/2016	✓
18.	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.	30/06/2016 – HIA has heard evidence in respect of facilities within the SET catchment. Await report (Feb 2017). 30/09/2016 IG lead and Senior Social Worker currently reviewing lessons learnt from the HIAI.	Mr Whittle 31/3/17	✓

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 2016 / 2017
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	80%	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 (16/05/16 & 9/11/16). IG risk is incorporated into the quarterly risk Directorate Risk Assessments. Information Asset registers also available for each IAO.	80%	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	80%	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. .	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	75%	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.	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.	80%	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 annoymised / 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			

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.	65%	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