CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS

QUALITY REPORT 2016/17 – 6 MONTH MIDTERM REVIEW

MARCH 2017

1. INTRODUCTION

The Quality Report is one of the key ways that the Trust demonstrates to the public and its stakeholders that its services are safe, effective, caring and responsive.

The report gives the Trust the opportunity to provide an open and honest assessment of the quality of services that is delivered to our patients. It includes information on how we have performed against key quality priorities that were identified last year, in consultation with key stakeholders such as our Council of Governors.

This report provides a high-level update on progress with each of our priorities and seeks to answer the following questions:

- What is our current position,
- If relevant, what are the reasons for being 'off target', and
- What are the actions agreed to get back on target

The full year end positions will be reported in the Quality Report 2016/17 to be published in June 2017.

2. OVERVIEW OF CURRENT PERFORMANCE

The following areas highlight where we are on track to achieve the targets set out in our quality priorities:

- Improvements to the reporting and investigation of hospital associated thrombosis,
- Reducing the number of patients falls that result in serious injury,
- Reviewing patient deaths through the mechanism of the Mortality Review Panel,
- Reducing the number of avoidable cardiac arrests,
- Improving the in-hospital management of patients with dementia, and
- Increasing the number of staff participating in the Staff Friends & Family Test.

The following areas highlight where clinical teams have told us that targets are not currently being achieved and further action is now required:

- Reducing the number of hospital acquired pressure ulcers, and
- Improving the assessment and management of patients with sepsis.

For some other priorities performance will not be known until publication of national reports, i.e. national patient experience report 2016.

3. RECOMMENDATION

The Council of Governors is asked to:

- Note the position against each of the Trust quality priorities 2016/17,
- Comment on the actions that are being taken to correct and improve performance, where relevant.

Gary Schuster
Clinical Governance Manager

QUALITY REPORT 2016/17

6 MONTH MID-TERM REVIEW

INTRODUCTION

A Quality Report is a report about the quality of services provided by an NHS healthcare provider which is published annually and made available to the public. These formal documents help the pubic, patients and others to understand;

- what healthcare organisations are doing well,
- where improvements in clinical and service quality are required,
- an organisation's priorities for improvement for the coming year, and
- how an organisation has involved people who use their services, staff, and others in determining these priorities.

Each Quality Report includes details about quality priorities that the Trust has agreed to measure, monitor and report in the year. These align to the national dimensions of quality; patient safety, clinical effectiveness and patient experience.

This paper provides an update on progress with the Trust quality priorities for the first 6 months 2016/17 (April – September 2016).

RECOMMENDATION

Council of Governors is asked to note and accept the 6 month review of our quality priorities 2016/17.

Gary Schuster
Clinical Governance Manager

Clinical Quality Priorities 2016/17

	PATIENT SAFETY	Measured by	Monitored by	Reported to
1	Reduce the number of hospital acquired pressure ulcers (HAPU)	Open & Honest Report	Tissue Viability Group	CGSG
	Lead Contact(s): Debbie Cheetham – Lead Nurse Patient Safety			
	Target: Reduce avoidable category 2-4 HAPU by 25% in 2016/17 (and over the following 2 years)			

Progress

Current Position

- The Trust has agreed a Pressure Ulcer Improvement Plan (2016-1019) which outlines the strategies to reduce the incidence of hospital acquired pressure ulcers (HAPUs) over 2016-2019
- The improvement goal for CHS is a 25% reduction in avoidable category 2-4 HAPUs over the next 3 consecutive years (2016-2019). Using the metric of 'rate per 1,000 occupied bed days', this will amount to a gradual reduction from **2.33** (CHS 2015-2016 average) to **0.98**.
- The Trust's Open & Honest data is being utilised to map improvement, (although this will be triangulated with Safety Thermometer data and process measures, in the form of audit results).
- Performance over Q1 & Q2 2016-2017 is highlighted below. This shows that the Trust is **not** currently on track to achieve the improvement target for this year, i.e. a 25% reduction in cat 2-4 HAPUs.

	2015-16	April	May	June	July	Aug	Sept
CHS Actual	2.33	1.56	2.71	2.31	3.69	2.56	2.87
Target		2.28	2.23	2.18	2.13	2.08	2.04

The full Pressure Ulcer Improvement Plan Progress Report (October 2016) is attached below:

PU IMPROVEMENT PLAN - PROGRESS RE

Reason if off target (where applicable)

- Developments and new initiatives not fully embedded in practice yet which is compounded by busy working environments and competing demands

Actions to get back on target (where applicable)

- Introduction of Health Care Assistant Pressure Ulcer Champions – to help compliance with the "SSKIN Bundle"
- Establishment of a Pressure Ulcer Review Panel to provide the opportunity for a deep dive into the acre and management of patients who develop category 3-4 HAPUs
- The hosting of a Pressure Ulcer World Café to help generate a network of people to support improvement. Another World Café is being planned for Q3
- The planned introduction of monthly Matron audits of "SSKIN Bundle" to be rolled out across the Trust in Q3
- Introduction of Safety Cross / Calendar as a means to display pressure ulcer data in a visual format that is easily understood and interpreted by clinical staff. This currently being piloted in Care of the Elderly and will be rolled out in Q3

	PATIENT SAFETY	Measured by	Monitored by	Reported to
2	Improve the completion, documentation and visibility of Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) orders	Internal Reporting	Resuscitation Group	CGSG
	Lead Contact(s): Diane McDermott – Resuscitation Services Manager			
	Target: 10% improvement by Q4			

Progress

Current Position

Recent audits have been undertaken on the completion of documentation and visibility of DNACPR decisions in the Directorate of Rehabilitation and Elderly Medicine (January and October 2016).

A comparison of the results shows that out of 13 standards measured there was an improvement in compliance in 11 of those areas, i.e. correct filling of DNACPR notices in the notes, accurate completion of the DNACPR form including demographics, rationale for the decision and who it was communicated with, etc.

The two areas that have shown a decline are:

- All sections of the form are fully completed
- Decisions recorded in the nursing healthcare records

Reason if off target (where applicable)

- In 79% of cases, doctors are not completing the DNACPR form in its entirety.
- In 71% of cases nursing staff are not recording the decision in nursing healthcare records i.e. V6.

Actions to get back on target (where applicable)

- Resuscitation department to continue to deliver training to all new doctors during their induction
- Review trust policy once national guidance is published in 2017

	PATIENT SAFETY	Measured by	Monitored by	Reported to
3	Improve the reporting and investigation of hospital associated VTE events	Internal report	Venous Thromboembolism Group	CGSG
	Lead Contact(s): Chair VTE Group			
	Target: Improved identification of patients that require RCA investigations and to move to a medically led RCA investigation process			

Progress

Current Position

- The Trust VTE Group has agreed (October 2016) a revised process for investigating all cases of hospital acquired thrombosis which will be much more clinically led and involves oversight from the VTE Group.
- The process involves triaging a list of patients on a monthly basis who have had either a new episode of VTE during their hospitals stay or have been readmitted within 90 of discharge following an inpatient stay of at least 24 hours. This allows the identification of genuine cases for clinical review.
- The responsible consultant for each confirmed case of HAT will be asked to undertake a case review using the national proforma and a judgement will be made on whether the episode could have been prevented.
- The outcomes of all cases, and any lessons learnt for the Organisation, will be presented at the quarterly VTE Group before a composite report is shared with Commissioners.

Reason if off target (where applicable)

- There has been a delay in implementing the new arrangements as the key consultant involved in the initial triage of patients for clinical review has been on planned leave.

Actions to get back on target (where applicable)

- The new process will be communicated to all senior doctors and clinical teams across the Organisation.
- The local process will get back on track with the August cohort of patients.
- The local process will now be co-ordinated by the Clinical Governance Department

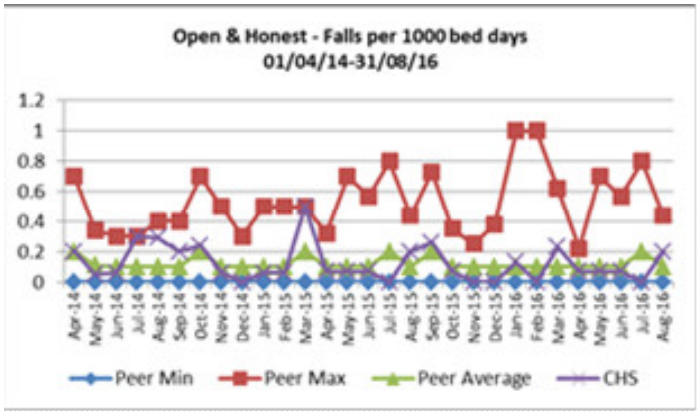
	PATIENT SAFETY	Measured by	Monitored by	Reported to
4	Reduce the number of patient falls that result in serious harm	Incident reporting system	Falls Group	CGSG
	Lead Contact(s): Debbie Cheetham – Lead Nurse Patient Safety			
	Target: To sustain our current position of being below the regional and national average for patients suffering harm from a fall in hospital.			

Progress

Current Position

Consistently better than the reported peer averages for patients suffering harm from a fall in hospital (with the exception of the Open & Honest data 2014-2015). This position is supported by the results of the most recent (2015) annual national audit of inpatient falls by the Royal College of Physicians, which indicates that CHS is the top performing trust in the region. The audit measures practice against NICE guidance on falls assessment and prevention (NICE CG 161.

	2015/16		2016/17	
	ST	O&H	ST	O&H
Total No. Hospital Falls	23 ↓	17 ↓	5 ↓	10 ↓
Average rate / 1,000 bed days	0.28 ↓	0.09 ↓	0.14 ↓	0.10 ↑
Total No. Low Harm	19 ↓		5 ↓	
Total No. Moderate Harm	3 ↓	16 ↓	0 ↓	8 ↓
Total No. Severe Harm	1 ↔	0 ↓	0 ↓	2 ↑
Total No. Death	0 ↔	1 ↔	0 ↔	0 ↓
Reported Peer Average	0.45	0.12	0.43	0.13



Reason if off target (where applicable)

Actions to get back on target (where applicable)

The Trust's Hospital Falls Reduction Group is leading on this quality priority. The purpose of the group is to oversee the implementation of guidelines for the prevention and management of in-patient falls within the Trust by:

- Providing professional expertise and ensuring that the Trust Prevention and Management of Hospital Based Falls policy and guidance is consistent with national clinical standards set out by the National Institute of Health & Social Care Excellence (NICE); the National Patient Safety Agency and Royal College of Physicians
- Providing leadership within the Trust for the prevention and reduction of hospital falls for in-patients,
- Acting as a point of contact for and updating the Clinical Governance Steering Group on all hospital based falls prevention and management of in-patients.
- Promoting best practice through the development of local protocols based on national best practice guidelines, such as NICE clinical guidance, National Patient Safety Agency and Royal College of Physicians

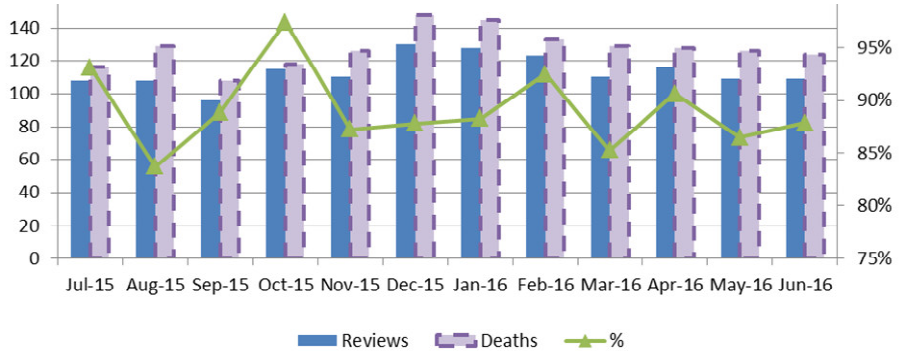
The group continue to monitor falls data and incidents and ultimately drive improvements in relation to falls risk assessment and management within CHS.

	CLINICAL EFFECTIVENESS	Measured by	Monitored by	Reported to
1	Review Trust mortality and minimise avoidable deaths	National mortality indicators Outcomes from the Mortality Review Panel	Mortality Review Group	CGSG
	Lead Contact(s): Ian Martin – Medical Director David Laws – Chair Mortality review Panel Gary Schuster – Clinical Governance Manager			
	Target (s): a) To review > = 80% of patient deaths using the MRP process b) Achieve > = 90% of responses from departmental reviews c) Full participation in the national mortality case record review programme			

Progress

Current Position

a) The Mortality Review Panel has reviewed 87.9% of deaths in Quarter 1 2016/17. CHSFT continues to have the highest review rate in the North East. Target has been achieved.



b) 10 reviews have prompted a departmental review in Quarter 1. All cases (100%) have received a local response with many indicating actions or improvements to be undertaken as a direct result of engagement in the mortality review process. Target has been achieved.

Reason if off target (where applicable)

c) There has been minimal progress in implementation of the national mortality case record review programme, beyond the appointment of a national programme provider. Any progress or impact for local Trusts will be highlighted, in the first instance, at the Regional Mortality Group for which City Hospitals plays a full and active part.

Actions to get back on target (where applicable)

- No specific actions but will expect details about the National Mortality Case Record Review Programme to be announced soon

	CLINICAL EFFECTIVENESS	Measured by	Monitored by	Reported to
2	Improve the process of fluid management and documentation	Local clinical audit	Nutrition Group	CGSG
	Lead Contact(s): Debbie Cheetham – Lead Nurse Patient Safety & Chair Nutrition Group			
	Target: Increase % for each element of the audit undertaken in January 2016			

Progress

Current Position

Improvement in some elements of the audit, but deterioration in others in most recent audit (Sept 2016). Work to date, in the form of staff engagement events, has focused on understanding operational challenges which will inform the improvement plan and associated action plan.

	May 2015	Jan 2016	Sept 2016
Any special instructions written?	N/R	15.5%	11.2% ↓
Chart completed fully over 24 hours?	49.5%	78.4% ↑	78.3% ↔
Drinking water available next to patient?	73.9%	80.4% ↑	79.0% ↔
IV infusions prescribed and given during time period?	18.0%	(no % given)	(no % given)
Were these IV infusions recorded on fluid balance chart?	12.6%	78.3% ↑	67.6% ↓
Does output appear to be accurately recorded?	18.0%	43.3% ↑	28.7% ↓
Number where output not accurately recorded:	82.0%	56.7% ↓	71.3% ↑
If output not accurately recorded, is frequency of passing urine recorded rather than the volume?	28.8%	59.7% ↑	89.2% ↑
Balance box completed?	10.8%	38.1% ↑	31.5% ↓
Fluid balance summary chart in place?	27.9%	34.0% ↑	44.1% ↑
Does fluid balance summary chart cross check with fluid balance chart?	20.7%	57.6% ↑	71.4% ↑

Reason if off target (where applicable)

Actions to get back on target (where applicable)

The Trust's Nutrition Steering Group is leading on this quality priority. The purpose of the group is to provide strategic leadership and co-ordination for all aspects of nutrition and hydration across the Trust to facilitate best practice and a positive patient, visitor and staff experience.

The group is currently devising a Nutrition & Hydration Improvement Plan which will be completed in Q4.

<table>
<tr><th></th><th>CLINICAL EFFECTIVENESS</th><th>Measured by</th><th>Monitored by</th><th>Reported to</th></tr>
<tr><td>3</td><td>Improve the assessment and management of patients with sepsis</td><td>CQUIN tracker and upload to national Unify system</td><td>Sepsis Group</td><td>CGSG</td></tr>
<tr><td></td><td colspan="4">Lead Contact(s): Aly Roy – Chair Sepsis Group, Tallulah Armit – Clinical Governance Facilitator, Gary Schuster – Clinical Governance Manager</td></tr>
<tr><td></td><td colspan="4">Target: Implementation of CQUIN targets for both ED, PED, Paediatric and adult in-patient areas (sepsis screening, administration of antibiotics and empiric review).
a) % of ED/ PED admissions who are screened according to local protocol – 90% each Quarter. Inpatients – Q1 – Action plan (25% payment), Q2 – Monitoring plan (25%), Q3 – Provide baseline in Q3 (25%) Agree targets for Q4, Q4 – Achieve targets set in Q3 (25%)
b) % of Acute Sepsis ED admissions with Empiric Review within 72 hours – 90% each Quarter. Inpatients - Q1 – Action plan (25% payment), Q2 – Monitoring plan (25%), Q3 – Provide baseline in Q3 (25%) Agree targets for Q4, Q4 – Achieve targets set in Q3 (25%)
c) % of Acute Sepsis Inpatient admissions with Empiric Review within 72 hours. Inpatients - Q1 – Action plan (25% payment), Q2 – Monitoring plan (25%), Q3 – Provide baseline in Q3 (25%) Agree targets for Q4, Q4 – Achieve targets set in Q3 (25%)</td></tr>
<tr><td>Progress</td><td colspan="2">Current Position

<u>Emergency Department (ED)</u>

<table><tr><td></td><td>Q1 2015/16</td><td>Q1 2016/17</td></tr><tr><td>ED Screening</td><td>65.33%</td><td>62.67%</td></tr><tr><td>ED antibiotics</td><td>40.85%</td><td>50.00%</td></tr><tr><td>ED Empiric Review</td><td>94.05%</td><td>98.25%</td></tr></table>Note – award of partial payment of 50% for performance 50%-89%

<u>Inpatients (IP)</u>

• Q1 – Development of Action plan (Target achieved and full CQUIN payment)
• Q2 – Monitoring Plan (Target achieved and full CQUIN payment)

Reason if off target (where applicable)

• Adoption of new (complex) processes in busy clinical environments with competing demands
• The challenge of the timescales associated with the CQUIN targets</td><td colspan="2">Actions to get back on target (where applicable)

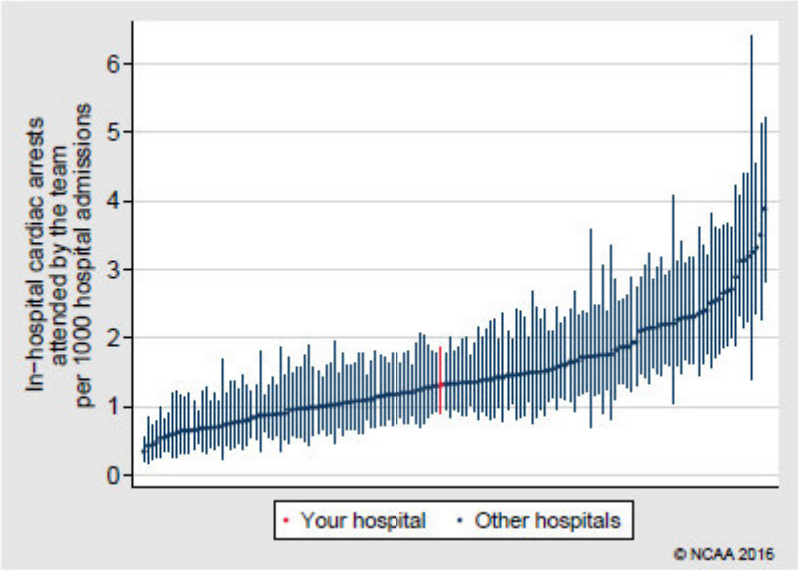
• Adoption of regional approach to sepsis assessment and management practices
• Performance monitoring overseen by the Trust Sepsis Group and escalation to CGSG if required
• Further changes to sepsis screening tool and grade of sepsis reporting
• Trust Sepsis Lead raising the profile and clarifying the Trust expectation on sepsis practices
• Development of targeted training and education with staff (using Critical Care Outreach Team) and the provision of generic sepsis awareness sessions
• Ward based monitoring reports (on level of sepsis screening) sent out fortnightly – to help staff engage in the process
• Regular visits to wards to resolve any staff queries and demonstrate functionality of the screening process</td></tr>
</table>

	CLINICAL EFFECTIVENESS	Measured by	Monitored by	Reported to
4	Reduction in the number of avoidable (predictable) cardiac arrests	Local action plan	Resuscitation Group	Clinical Governance Steering Group
	Lead Contact: Dianne McDermott – Resuscitation Services Manager			
	Target: Improvement of 5% for 2016 /17			

Progress

Current Position

The incidence of cardiac arrests attended by the Arrest Team per 1,000 hospital admissions for the year 2015/2016 was 1.45 (Source: National Cardiac Arrest Audit). The target is for a 5% reduction which equates to a rate of 1.37 per 1,000 admissions or better. In Quarter 1 2016/17 the Trust has achieved an above target rate of 1.35. The reason for this may that staff are beginning to appropriately recognise deterioration in patients, and thus preventing cardiac arrest, and this recognition is becoming embedded in training and clinical practice.



Reason if off target (where applicable)

On target.

Actions to get back on target (where applicable)

- Recognition of the critically ill patient resulting in earlier initiation of appropriate treatment and prevention of cardiac arrest with use of the NEWS system.

	PATIENT EXPERIENCE	Measured by	Monitored by	Reported to
1	Improve the in-hospital management of patients with dementia	Local action plan	Dementia Group	PCPEC
	Lead Contact: Julie McDonald – Deputy Director of Nursing & Quality (Corporate Lead) Dr Lesley Young – Consultant and Clinical Dementia Lead (Clinical Lead)			
	Target: Implement the priorities from the national audit of in-hospital management of patients with dementia			

Progress

Current Position

- Compliance with NICE guidelines 103 to screen all adult in-patients aged 65years +
- Ward compliance with completion cognitive screening of patients 65years+ displayed on ward dashboards data information Launchpad
- Development of environment standards is included in the Dementia action plan which is monitored by Patient, Carer, Public Experience Committee
- Mental Capacity Act training to be included in the safeguarding adults e-learning programme mandated for all clinical staff
- Embedding the core principles of the carers charter including carers passport, caring for carers algorithm

Reason if off target (where applicable)

On target

Actions to get back on target (where applicable)

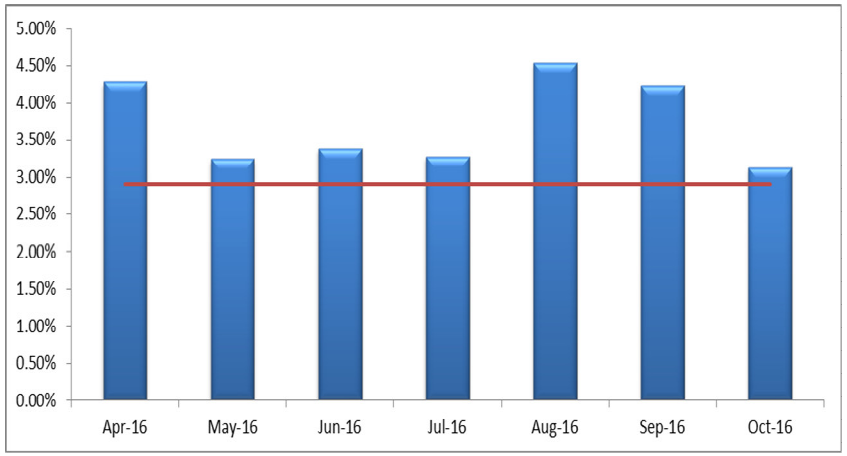
- Safeguarding Adults e-learning programme developed awaiting sign off from Human Resources Steering group (HRSG)
- Cognitive screening tool 4AT to include inpatients 65years+ now live
- Following a meeting with Director of Estates it was agreed that the Dementia Environment Standards should apply to any areas that require decoration or refurbishment and any new build. Draft standards developed, awaiting ratification.

	PATIENT EXPERIENCE	Measured by	Monitored by	Reported to
2	Reducing cancellations of outpatient consultations	Local performance data	Performance / Service Improvement	Operations Committee
	Lead Contact: Alison King – Acting Head of Performance & Improvement, Laura Bond – Service Improvement Manager			
	Target: Reduce the number of outpatient cancellations by 10% during 2016/17			

Progress

Current Position

Performance at Trust level from April to date is shown below. Increases in cancellations in April, August and September were due to sickness, annual leave, Doctor availability and capacity issues (i.e. unable to rebook cancellations).



Specialty level cancellations show that the top 5 specialties for the year to date are: Gastro, Anaesthetics, Gynaecology, Neurology and ENT.

Reason if off target (where applicable)

Cancellations under 6 week's accounts for the majority of cancellations (80%). This is due to sickness, booked outside of the e-referral system, reason not specified and no Dr available (registrar). Annual leave <6 weeks only accounts for 9% of all cancellations under 6 weeks.

Actions to get back on target (where applicable)

- Monthly analysis is provided to Divisional General Managers and Directorate Managers and feedback requested on actions to be taken
- The cancellation reason 'booked outside of the e-referral system' is not the primary reason for the cancellation. This is used whereby the cancelled appointment cannot be re-booked in the e-referral system due to capacity issues. Work is ongoing with outpatients so that the actual reason for the cancellation is recorded
- Demand and capacity models are in place for the majority of specialties which help Directorates and outpatients plan capacity to meet demand proactively. This should reduce the number of cancellations due to annual leave however the consultant contract only requires 6 weeks' notice to be given by consultants
- Looking at demand and capacity to see if any capacity can be 'protected' to reschedule cancelled patients i.e. ensure the capacity to re-book patients in within a reasonable timescale
- Ensure the is process followed re: Directorate Managers and Clinical Directors signing off annual leave requests and cancelling clinics

	PATIENT EXPERIENCE	Measured by	Monitored by	Reported to
3	Improve the timeliness of response to patient complaints	Local performance data	Directorates / Help & Advice Service	PCPEC
	Lead Contact: Julie McDonald – Deputy Director of Nursing & Quality			
	Target: Reduce backlog of complaints to <20%			

Progress

Current Position

At the end of Q2, 52 of 106 complaints awaiting a first response are out of agreed timescales (49%). There is no backlog in the Help and Advice Service (HAAS).

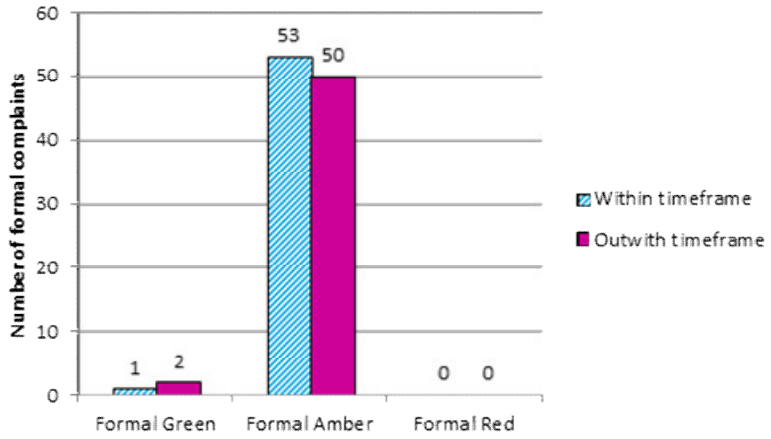


Fig 1: All ongoing complaints within and out with timeframes in accordance with policy – position at the end of Sept 2016

Reason if off target (where applicable)

On target

Actions to get back on target (where applicable)

- Increase in HAAS staffing and review of roles and responsibilities.
- All Quality Risk Facilitators are now in post.
- Report developed to provide transparency of outstanding complaints, and enable performance monitoring and KPI.
- Complaints Process Review workshop planned for Q3.
- Monitoring by PCPEC.

	PATIENT EXPERIENCE	Measured by	Monitored by	Reported to
4	Increase the % of patients who reported they had a positive experience (Q72 - Overall…….)	National In-patient Survey	Patient Experience / Clinical Governance	PCPEC
	Lead Contact: Julie McDonald – Deputy Director of Nursing & Quality			
	Target: Improve score against 2015 performance (2015 = 8.1/10)			
Progress	**Current Position** The Trust is currently carrying out the fieldwork for the 2016 National Inpatient Survey with the results expected to be published in Autumn 2017. The exact date will be made know soon. Therefore the score for this particular question is unknown. In terms of sharing the results from the 2015 Inpatients Survey, the following have been carried out: • Communication plan developed and action planning session with key staff undertaken • Results shared at OMG and with Matrons and Ward Managers • Staff engagement event held in September 2016 (World café), with pledges made by individual wards and departments • Trust wide good practice sharing event on NHS Charge Day October 2016 **Reason if off target (where applicable)** Not applicable	**Actions to get back on target (where applicable)** Not applicable until publication of national data expected in Spring 2017.		

<table>
<tr><th></th><th>STAFF EXPERIENCE</th><th>Measured by</th><th>Monitored by</th><th>Reported to</th></tr>
<tr><td>1</td><td>Increase the number of staff participating in the staff FFT</td><td>National FFT data</td><td>Nursing & Quality</td><td>PCPEC</td></tr>
<tr><td></td><td colspan="4">Lead Contact: Julie McDonald – Deputy Director of Nursing & Quality</td></tr>
<tr><td></td><td colspan="4">Target: Increase the number of staff participating in staff FFT – 20% improvement on 2015/16 total responses, i.e. 1857 to 2228</td></tr>
<tr><td>Progress</td><td colspan="2">Current Position

<table>
<tr><th></th><th colspan="2">Total</th><th colspan="2">Recommended</th></tr>
<tr><td>How likely are you to recommend this organisation to friends and family if they needed care or treatment</td><td>Q1
864</td><td>Q2
976</td><td>Q1
83%</td><td>Q2
82%</td></tr>
<tr><td>How likely are you to recommend this organisation to friends and family as a place to work</td><td>Q1
864</td><td>Q2
976</td><td>Q1
73%</td><td>Q2
69%</td></tr>
<tr><td>Total to date</td><td colspan="2">1850</td><td colspan="2"></td></tr>
</table>
To achieve 2228 (20% increase), requires 378 responses in Q4 (no survey in Q3 due to the National Staff Survey).

Q1 results shared with directorates, Trust wide ‘You Said/We Did’ communications delivered.

Reason if off target

On target

Actions to get back on target (where applicable)

Not applicable</td><td colspan="2"></td></tr>
</table>

CONCLUSION

The introduction of the Quality Report demonstrates that providers are committed to improving quality from the Board to the front line. They help develop corporate ownership of the quality agenda and give Boards a greater ability to drive improvements. They also give Trusts' an opportunity to describe their performance and identify where they feel progress is needed.

This paper provides a 6 month update against each of the quality priorities to be formally reported within the Quality Report 2016/17. The Trust is on target to achieve the majority of priorities using the information available at the time of writing. In some other areas, the outcomes from action plans will be know towards the end of the reporting period.

The final Quality Report will be completed in May 2017.

Gary Schuster
Clinical Governance Manager

CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS

SELECTION OF GOVERNOR INDICATOR FOR EXTERNAL ASSURANCE (TRUST QUALITY REPORT 2016/17)

MARCH 2017

1. INTRODUCTION

All NHS Trusts are required to produce statements about the the quality of care they provide to their communities as part of their annual reports. For Foundation Trusts, this is known as a Quality Report which incorporates the requirements of the national Quality Accounts Regulations as well as NHS Improvement's additional reporting requirements.

There is also an obligation for Trusts to acquire external assurance on their Quality Reports which includes substantive testing on two mandatory indicators and one local indicator, the latter to be selected by the Council of Governors. The assurance exercise is undertaken by externally appointed accredited auditors. Subjecting these indicators to independent scrutiny improves the quality and integrity of data on which Trust performance reporting and monitoring depends. Details about the external assurance process have recently been published by NHS Improvement: https://improvement.nhs.uk/uploads/documents/Detailed_req_for_assurancefor__qual_repts_16-17_.pdf

2. OVERVIEW OF TESTING PROCESS FOR THE LOCAL INDICATOR

NHS Foundation Trusts are required to get assurance through substantive sample testing over one local indicator, as selected by the Governors of the Trust.

The testing strategy for the indicator is not defined by NHS Improvement; it is for the auditors to determine as it is, in part, determined by the specific processes and controls in place at the Trust. However, auditors will need to document the systems used to produce the specified indicator, perform a 'walkthrough' of the system to get an understanding of the data collection process, and then test the indicator against supporting documentation to get assurance on the following dimensions of data quality, namely;

- Accuracy - is the data recorded correctly and is it in line with the methodology for calculation,
- Validity - has the data been produced in compliance with relevant requirements,
- Reliability - has the data been collected using a stable process in a consistent manner over a period of time,
- Timeliness - is the data captured as close to the associated event as possible and available for use in a reasonable time period,
- Relevance - does all the data used to generate the indicator meet eligibility requirements as defined by guidance, and

- Completeness - is all relevant information, as specified in the methodology, included in the calculation.

The auditor will provide a report on the findings and make any necessary recommendations for improvements on the local indicator, this is known as 'The Governors' Report'.

3. SELECTION OF THE LOCAL INDICATOR

Governors have the freedom to select an indicator of their choice. However the Trust has previously provided a short list of potential indicators that are auditable and where measurement and reporting systems exist (see list below). This has generally helped Governors in their decision-making. To reiterate, there is a no obligation for Governors to select any indicators from the following list but they do provide possible examples:

- Patient safety incidents resulting in severe harm or death (previously used in 2013/14),
- Hospital acquired pressure ulcers categorised as grade 3/4,
- Adult inpatients who have had a VTE (venous thrombo embolism) risk assessment on admission to hospital using the clinical criteria of the national tool,
- Achieve 95% overall harm free care for all elements of the NHS Safety Thermometer (used in 2015/16),
- Reducing cancellations of outpatient appointments,
- Timeliness of response to patients complaints, and
- Percentage of electronic clinical communications that were sent to GPs within 24 hours following an A&E attendance, excluding those patients who are admitted as a result of their attendance.

Once a local indicator is selected this will be communicated to external auditors and they will then begin to plan their assurance work which is expected to be completed by May 2017.

4. RECOMMENDATION

The Council of Governors is asked to:

- Note the requirements for external assurance testing,
- Select one local indicator for external testing that will be included in the Quality Report 2016/17.

Bob Brown
Director of Quality & Transformation

Gary Schuster
Clinical Governance Manager

CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

DEPARTMENT OF INFORMATION MANAGEMENT AND TECHNOLOGY

INFORMATION GOVERNANCE TOOLKIT – CHS AND CHURCH VIEW

COUNCIL OF GOVERNORS

MARCH 2017

1. INTRODUCTION AND BACKGROUND

The Information Governance Toolkit is now in its fourteenth year, and has evolved to the point where it is being used by over 25,000 organisations.

The purpose of this paper is to provide an overview of Information Governance (IG) and the IG Toolkit. The paper will then highlight the process City Hospitals Sunderland NHs Foundation Trust (CHS) has followed in completing the IG Toolkit, and will summarise the scores for the end of March 2017. Subject to approval, the final submission is to be made on 31st March 2017.

2. WHAT IS INFORMATION GOVERNANCE?

Information Governance is to do with the way organisations process or handle information. It covers the holding, obtaining, recording, use and sharing of that information. It specifically addresses how the organisation meets its legal obligations and how it secures the information it holds.

Information Governance applies to all information held by the organisation but is also specifically concerned with personal information (ie that relating to patients/service users and employees), and corporate information (eg financial and accounting records).

Information Governance provides a way for employees to deal consistently with the many different rules about how information is handled, including those set out in:

- The Data Protection Act 1998;
- The Common Law Duty of Confidentiality;
- The Confidentiality NHS Code of Practice;
- The NHS Care Records Guarantee for England;
- The Social Care Records Guarantee for England;
- The international information security standard: ISO/IEC 27002: 2013 and ISO/IEC 27001:2013;
- The Information Security NHS Code of Practice;
- The Records Management NHS Code of Practice;
- The Freedom of Information Act 2000;
- The Human Rights Act article 8;
- The '*Report on the Review of Patient Identifiable Information (The Caldicott Report*)' and the '*Information: To share or not to share? The Information Governance Review (Caldicott 2 Review)*';

- Information: To share or not to share - Government Response to the Caldicott 2 Review.

Whilst a key focus of Information Governance is the use of information about service users, it applies to information and information processing in its broadest sense, and underpins both clinical and corporate governance. Accordingly it should be afforded appropriate priority.

The four fundamental aims of Information Governance are:

- To support the provision of high quality care by promoting the effective and appropriate use of information;
- To encourage responsible staff to work closely together, preventing duplication of effort and enabling more efficient use of resources;
- To develop support arrangements and provide staff with appropriate tools and support to enable them to discharge their responsibilities to consistently high standards;
- To enable organisations to understand their own performance and manage improvement in a systematic and effective way.

3. WHAT IS THE INFORMATION GOVERNANCE TOOLKIT?

The Information Governance Toolkit is a Department of Health (DH) Policy delivery vehicle that NHS Digital (formerly the Health and Social Care Information Centre (HSCIC)) is commissioned to develop and maintain. It draws together the legal rules and central guidance set out by DH policy and presents them in in a single standard as a set of information governance requirements. The organisations in scope of this are required to carry out self-assessments of their compliance against the IG requirements on 3 occasions during the year – Baseline in July, performance update in October and a final submission at the end of March.

4. WHAT ARE THE IG TOOLKIT REQUIREMENTS?

City Hospitals Sunderland NHS Foundation Trust

For Acute Trusts (including FTs), the IG Toolkit consists of 45 requirements divided across 6 initiatives:

- Information Governance Management;
- Confidentiality and Data Protection Assurance;
- Information Security Assurance;
- Clinical Information Assurance;
- Secondary Uses Assurance;
- Corporate Information Assurance.

Church View Medical Practice

For GP Practices, the IG Toolkit consists of 13 requirements divided across 3 initiatives:

- Information Governance Management;
- Confidentiality and Data Protection Assurance;
- Information Security Assurance.

5. WHAT IS THE PURPOSE OF THE IG ASSESSMENT?

The purpose of the assessment is to enable organisations to measure their compliance against the law, information security standards and central guidance, and to see whether information is handled correctly and protected from unauthorised access, loss, damage and destruction.

Where partial or non-compliance is revealed, organisations must take appropriate measures (eg assign responsibility, or put in place policies, procedures, processes & guidance for staff), with the aim of making cultural changes and raising Information Governance standards through year-on-year improvements.

The ultimate aim is to demonstrate that the organisation can be trusted to maintain the confidentiality and security of personal information. This in turn increases public confidence that the NHS and its partners can be trusted with personal data.

6. WHO HAS TO CARRY OUT THE IG ASSESSMENT?

All health and social care service providers, commissioners and suppliers must have regard to the Information Governance Toolkit Standard approved by the Standardisation Committee for Care Information (SCCI), which replaces the Information Standards Board (ISB) for Health and Social Care (ISB), and is a sub-group of the National Information Board (NIB).

All organisations that have access to NHS patient data must provide assurances that they are practising good information governance and use the IG Toolkit to evidence this. Where services are commissioned for NHS patients, the commissioner is required to obtain this assurance from the provider organisation and this requirement should be set out in the commissioner-provider contract.

With changes planned to commissioning structures and with increasingly diverse care providers, Sir David Nicholson, and Christopher Graham, Information Commissioner published a joint letter to ensure that everyone continues to give Information Governance the priority and attention it needs. The letter signalled the intention of the NHS and the Information Commissioner's Office to work together in supporting the NHS to deliver good Information Governance. The letter was distributed to all Chief Executives of NHS Trusts and the relevant commissioners or performance regulators at the time (5th September 2011).

It remains Department of Health policy that all bodies that process NHS patient information, for whatever purpose, should provide assurance via the IG Toolkit.

'Personalised Health and Care 2020: a framework for action' published by the National Information Board reinforces the need to build and sustain the trust and confidence of the public in the collection, storage and use of their sensitive personal data. The framework requires that the IG Toolkit is further developed to reflect enhanced Information Governance and data security requirements.

IG Toolkit assessments must be completed and published by all bodies that process the personal confidential data of citizens who access health and adult social care services. These include, but are not limited to:

- NHS organisations (Acute Trusts, Ambulance Trusts, Mental Health Trusts, Clinical Commissioning Groups) including Foundation Trusts and NHS Community Health Providers;
- NHS England;
- NHS Digital;
- Local Authority Adult Social Care;
- Local Authority Public Health;
- Primary Care providers (Community Pharmacies/Dispensing Appliance Contractors, Dental Practices, Eye Care Services, General Practices);
- DH arms' length bodies that closely support care services (ie executive agencies such as the Medicines and Healthcare Products Regulatory Agency; special health authorities such as the NHS Business Services Authority);
- Bodies commissioned or otherwise contracted to provide services by any of the above;
- Public Health England.

In addition to the NHS mandate above, other organisations are required to provide IG assurances via the IG Toolkit as part of business/service support processes or contractual terms. That is, for these organisations annual IG Toolkit assessments are required for either or both of two purposes:

- To provide IG assurances to the Department of Health or to NHS commissioners of services;
- To provide IG assurances to NHS Digital as part of the terms and conditions of using national systems and services including N3, Choose and Book etc.

7. WHO WILL ACCESS THE IG TOOLKIT SUBMISSION?

One of the primary aims of the IG Toolkit process is to force a change in the culture of NHS organisations. In order to do so, the results of the IG Toolkit will be made widely available. Likely scenarios are summarised below:

- The Public: Results and scores for all NHS organisations are now available via the internet for the public, media and other organisations to view;
- The Information Commissioner (ICO): The ICO may choose to access this information to judge IG maturity as part of their investigation into any issue, complaint or incident;
- Care Quality Commission (CQC): The CQC now use the IG Toolkit to assess outcomes in their wider assessments;
- Internal Audit: Accessed as part of assurance on IG and information security programmes;
- External Audit: It is possible that the IG Toolkit submission could be audited externally;
- Commissioners: It is expected that increasingly commissioning bodies will pay further attention to an organisation's IG status as they assess the quality of an organisation and its processes.

8. INFORMATION GOVERNANCE TOOLKIT VERSION 14

Submission Deadlines

Interim submissions have been made, as required, by the following deadlines:

- Baseline assessment by 31 July 2016;
- Performance update by 31 October 2016.

The submission deadline for the final Version 14 assessment for all organisations is:

- Final submission by 31 March 2017.

Evidence Upload

The system allows you to specify evidence to support your assessment (eg a policy or procedure document). You can either upload evidence files directly to the IG Toolkit or reference an internet/intranet address or other location. The system tells you what evidence is expected for each requirement but there is inbuilt flexibility so you can also specify your own additional evidence.

Assessment Scoring

An organisation can see its current (and target) percentage score on the Assessment Summary page. The grading scheme is as follows:

- **Satisfactory** (coloured green): level 2 or level 3 achieved on all requirements.
- **Not Satisfactory** (coloured red): level 2 or level 3 not achieved on all requirements.

The main purpose of the IG Toolkit is to drive improvement, and a 'Not Satisfactory' (red) status is an effective way to get IG high up on the corporate agenda.

9. INFORMATION GOVERNANCE TOOLKIT – 2016/17 ACTIVITIES

CHS has again undertaken a full review of performance against the Information Governance Toolkit ready for the year-end submission to NHS Digital for the end of March 2017 (To be approved by Executive Committee, Council of Governors and Board of Directors). This has been reviewed and approved by CHS Information Governance Group (IGG) on 7th March 2017.

During 2016/17, there has been a continued focus on:

- CHSFT – Reviewing and refreshing/updating all evidence to sustain at least level 2 performance against all requirements;
- Church View – Reviewing and refreshing/updating all evidence to sustain at least level 2 performance against all requirements.
- CHSFT and Church View – Focusing on requirement 112 which pertains to ensuring that 95% of all staff have received Information Governance training during the year.

As usual, the process has been independently reviewed by Audit**one** who have been engaged in the process and are in the final stages of auditing the recommended toolkit submissions for both CHSFT and Church View. Audit**one** are assessing that:

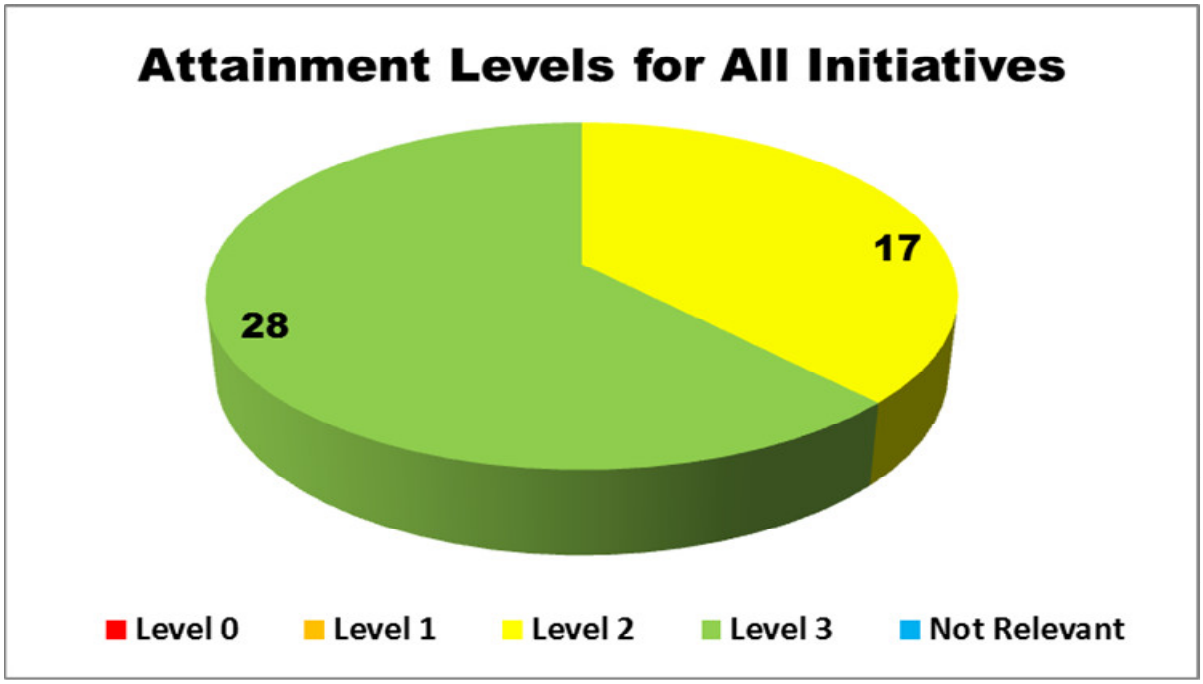
- Appropriate governance arrangements are in place;
- From the evidence, that the submitted IG Toolkit scores are a reasonable assessment of current performance.

Approval is to also be acquired from Executive Committee, Council of Governors and Board of Directors prior to making the final submission.

10. INFORMATION GOVERNANCE TOOLKIT – END MARCH 2017 STATUS

10.1 CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

The following represents the performance level evidenced for CHSFT for the March 2017 submission:



The table shows that of the 45 requirements, all 45 are assessed as being at Level 2 or Level 3. In detail:

- 17 show evidence that complete to Level 2;
- 28 show evidence to Level 3.

To achieve this performance, since the March 2016 submission, the Trust has reviewed and refreshed data against all requirements. Scores have been maintained against all requirements, with the exception of:

- **302 – Security Incident/Event Reporting** – Level 2 to a Level 3 - This was identified for improvement in the annual benchmarking exercise. It was further enhanced with assurances within RRG and QRA reports to the Executive Committee.
- **303 – Registration Authority Obligations** – Level 2 to a Level 3 – This was due to the implementation of the RA Policy and procedures, review of access control positions and monitoring of smartcards.

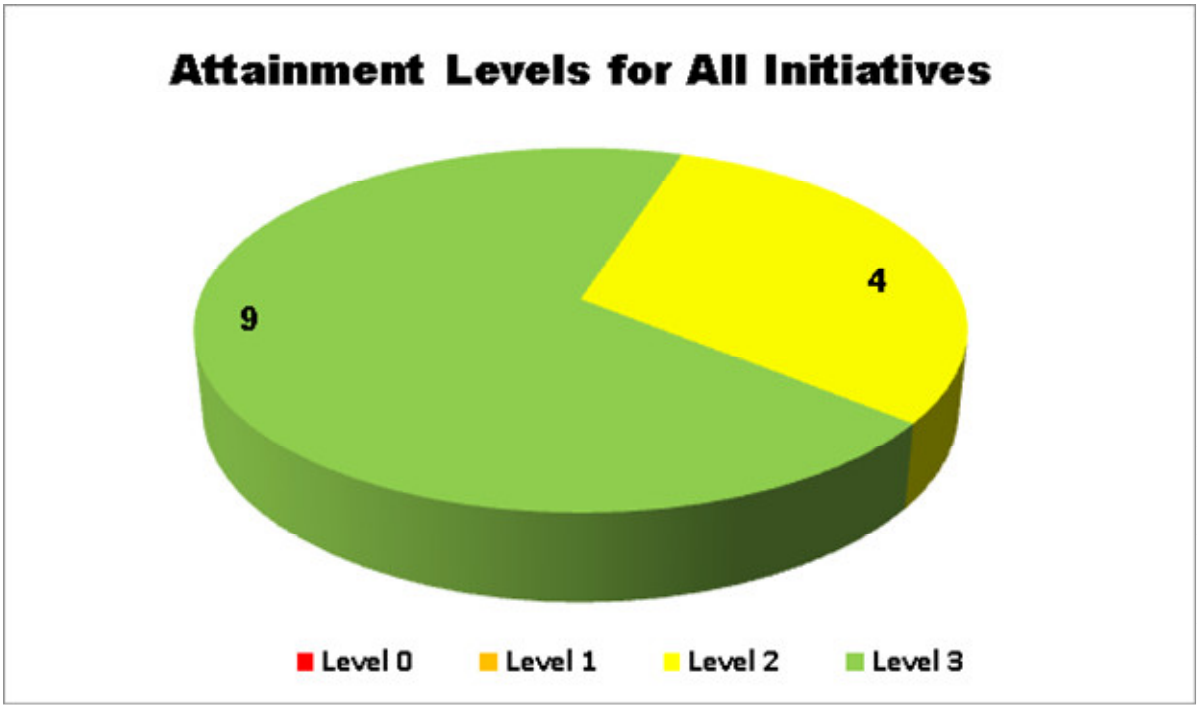
- **505 – Clinical Coding Audit** – Level 3 to a Level 2 (projected) – Final outcome is awaited from a separate clinical coding audit – This is due to an anticipated deterioration of the quality of clinical coding.

The total percentage compliance for all initiatives is **87% = Satisfactory** (coloured **green**).

Details against all 45 requirements are included in **Appendix A**.

10.2 CHURCH VIEW MEDICAL CENTRE

The following represents the performance level evidenced for Church View for the March 2017 submission:



This showed that of the 13 requirements, 13 were assessed as being in at Level 2 or Level 3. In detail:

- 4 show evidence that complete to Level 2;
- 9 show evidence to Level 3.

To achieve this performance, since the March 2016 submission the Trust has reviewed and refreshed evidence against all requirements to maintain these scores. Scores have been maintained against all requirements, with the exception of:

- **116 – Contracts** – Level 2 to 3 – This was due to the contracts for Church View staff being pulled in line with existing CHS contract arrangements and processes. These ensure Information Governance clauses are clearly and appropriately written into contracts.
- **212 – Consent** – Level 3 to 2 – This was due to the changes in the IG Toolkit requirement and expectations of the service pertaining to routine audits/monitoring and satisfaction surveys ensuring service users understand their consent choices.

The total percentage compliance for all initiatives is **89%** = **Satisfactory** (coloured **green**).

Details against all 13 requirements are included in **Appendix B**.

11. CONCLUSIONS & RECOMMENDATIONS

Governors are asked to note the contents of this report and comment accordingly.

Subject to assurance being provided by Audit**one**, confirmation of the outcome of the separate clinical coding audit against requirement 505 (for CHS), and approval from Executive Committee, Council of Governors and Board of Directors, the scores to be submitted as part of the March 2017 submission are as follows:

11.1 City Hospitals Sunderland NHS Foundation Trust

This showed that of the 45 requirements, 45 were assessed as being in at Level 2 or Level 3. In detail:

- 17 show evidence that complete to Level 2;
- 28 show evidence to Level 3.

The total percentage compliance for all initiatives is **87%** = **Satisfactory** (coloured **green**).

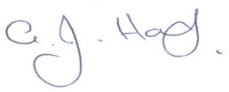
11.2 Church View Medical Centre

This showed that of the 13 requirements, 13 were assessed as being at Level 2 or Level 3. In detail:

- 4 show evidence that complete to Level 2;
- 9 show evidence to Level 3.

The total percentage compliance for all initiatives is **89%** = **Satisfactory** (coloured **green**).

Governors are asked to approve the submission of the Information Governance Toolkit on 31st March 2017 on this basis.



Andrew Hart
Director of Information Management and Technology
March 2017

Appendix A – City Hospitals Sunderland's Requirements/Scores

Information Governance Management						
Req No	**Key Req**	**Description**	**IGT v13 March 16**	**IGT v14 March 17**	**Sponsor**	**Lead**
12-101	**Y**	There is an adequate Information Governance Management Framework to support the current and evolving Information Governance agenda	**3**	**3**	**J Pattison**	**A J Hart**
12-105		There are approved and comprehensive Information Governance Policies with associated strategies and/or improvement plans	**3**	**3**	**J Pattison**	**A J Hart**
12-110	**Y**	Formal contractual arrangements that include compliance with information governance requirements, are in place with all contractors and support organisations	**3**	**3**	**J Pattison**	**P Robinson**
12-111	**Y**	Employment contracts which include compliance with information governance standards are in place for all individuals carrying out work on behalf of the organisation	**3**	**3**	**K Griffin**	**D Little**
12-112	**Y**	Information Governance awareness and mandatory training procedures are in place and all staff are appropriately trained	**3**	**3**	**K Griffin**	**D Little**

Confidentiality and Data Protection Assurance						
Req No	**Key Req**	**Description**	**IGT v13 March 16**	**IGT v14 March 17**	**Sponsor**	**Lead**
12-200	**Y**	The Information Governance agenda is supported by adequate confidentiality and data protection skills, knowledge and experience which meet the organisation's assessed needs	**3**	**3**	**I Martin**	**A J Hart**
12-201	**Y**	Staff are provided with clear guidance on keeping personal information secure, on respecting the confidentiality of service users, and on the duty to share information for care purposes	**2**	**2**	**I Martin**	**A J Hart**
12-202	**Y**	Personal information is shared for care but is only used in ways that do not directly contribute to the delivery of care services where there is a lawful basis to do so and objections to the disclosure of confidential personal information are appropriately respected	**2**	**2**	**I Martin**	**A J Hart**
12-203	**Y**	Individuals are informed about the proposed uses of their personal information	**2**	**2**	**L Stores**	**A Anderson**
12-205		There are appropriate procedures for recognising and responding to individuals' requests for access to their personal data	**3**	**2**	**L Stores**	**A Anderson**
12-206		There are appropriate confidentiality audit procedures to monitor access to confidential personal information	**2**	**3**	**L Stores**	**A Anderson**
12-207		Where required, protocols governing the routine sharing of personal information have been agreed with other organisations	**2**	**2**	**I Martin**	**A J Hart**
12-209	**Y**	All person identifiable data processed outside of the UK complies with the Data Protection Act 1998 and Department of Health guidelines	**NR**	**2**	**I Martin**	**A J Hart**
12-210	**Y**	All new processes, services, information systems, and other relevant information assets are developed and implemented in a secure and structured manner, and comply with IG security accreditation, information quality and confidentiality and data protection requirements	**2**	**2**	**A J Hart**	**S Joyce**

Information Security Assurance						
Req No	**Key Req**	**Description**	**IGT v13 March 16**	**IGT v14 March 17**	**Sponsor**	**Lead**
12-300	**Y**	The Information Governance agenda is supported by adequate information security skills, knowledge and experience which meet the organisation's assessed needs	**3**	**3**	**A J Hart**	**S Joyce**
12-301	**Y**	A formal information security risk assessment and management programme for key Information Assets has been documented, implemented and reviewed	**2**	**2**	**J Pattison**	**A J Hart**
12-302	**Y**	There are documented information security incident / event reporting and management procedures that are accessible to all staff	**2**	**3**	**M Johnson**	**F Kay**
12-303	**Y**	There are established business processes and procedures that satisfy the organisation's obligations as a Registration Authority	**2**	**3**	**K Griffin**	**J Armstrong**
12-304	**Y**	Monitoring and enforcement processes are in place to ensure NHS national application Smartcard users comply with the terms and conditions of use	**2**	**2**	**K Griffin**	**J Armstrong**
12-305	**Y**	Operating and application information systems (under the organisation's control) support appropriate access control functionality and documented and managed access rights are in place for all users of these systems	**3**	**3**	**A J Hart**	**S Joyce**
12-307	**Y**	An effectively supported Senior Information Risk Owner takes ownership of the organisation's information risk policy and information risk management strategy	**3**	**3**	**J Pattison**	**A J Hart**
12-308	**Y**	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	**2**	**2**	**J Pattison**	**A J Hart**

12-309		Business continuity plans are up to date and tested for all critical information assets (data processing facilities, communications services and data) and service - specific measures are in place	**3**	**3**	**J Pattison**	**A J Hart**
12-310		Procedures are in place to prevent information processing being interrupted or disrupted through equipment failure, environmental hazard or human error	**3**	**3**	**A J Hart**	**S Joyce**
12-311		Information Assets with computer components are capable of the rapid detection, isolation and removal of malicious code and unauthorised mobile code	**3**	**3**	**A J Hart**	**S Joyce**
12-313	**Y**	Policy and procedures are in place to ensure that Information Communication Technology (ICT) networks operate securely	**3**	**3**	**A J Hart**	**S Joyce**
12-314	**Y**	Policy and procedures ensure that mobile computing and teleworking are secure	**2**	**2**	**A J Hart**	**S Joyce**
12-323	**Y**	All information assets that hold, or are, personal data are protected by appropriate organisational and technical measures	**2**	**2**	**J Pattison**	**A J Hart**
12-324		The confidentiality of service user information is protected through use of pseudonymisation and anonymisation techniques where appropriate	**2**	**2**	**J Pattison**	**L Mason**

Clinical Information Assurance						
Req No	**Key Req**	**Description**	**IGT v13 March 16**	**IGT v14 March 17**	**Sponsor**	**Lead**
12-400		The Information Governance agenda is supported by adequate information quality and records management skills, knowledge and experience	**3**	**3**	**C Harries**	**L Stores**
12-401	**Y**	There is consistent and comprehensive use of the NHS Number in line with National Patient Safety Agency requirements	**2**	**3**	**J Pattison**	**M Walls**
12-402		Procedures are in place to ensure the accuracy of service user information on all systems and /or records that support the provision of care	**3**	**3**	**J Pattison**	**M Walls**
12-404		A multi-professional audit of clinical records across all specialties has been undertaken	**3**	**3**	**I Martin**	**G Schuster**
12-406		Procedures are in place for monitoring the availability of paper health/care records and tracing missing records	**3**	**3**	**C Harries**	**L Stores**

Secondary Use Assurance						
Req No	**Key Req**	**Description**	**IGT v13 March 16**	**IGT v14 March 17**	**Sponsor**	**Lead**
12-501		National data definitions, standards, values and validation programmes are incorporated within key systems and local documentation is updated as standards develop	**3**	**3**	**J Pattison**	**M Walls**
12-502		External data quality reports are used for monitoring and improving data quality	**3**	**3**	**J Pattison**	**M Walls**
12-504		Documented procedures are in place for using both local and national benchmarking to identify data quality issues and analyse trends in information over time, ensuring that large changes are investigated and explained	**3**	**3**	**J Pattison**	**M Walls**
12-505		An audit of clinical coding, based on national standards, has been undertaken by a Clinical Classifications Service (CCS) approved clinical coding auditor within the last 12 months	**3**	**2**	**J Pattison**	**M Walls**
12-506		A documented procedure and a regular audit cycle for accuracy checks on service user data is in place	**3**	**3**	**J Pattison**	**M Walls**
12-507		The Completeness and Validity check for data has been completed and passed	**3**	**3**	**J Pattison**	**M Walls**
12-508		Clinical/care staff are involved in validating information derived from the recording of clinical/care activity	**2**	**2**	**J Pattison**	**M Walls**
12-510		Training programmes for clinical coding staff entering coded clinical data are comprehensive and conform to national clinical coding standards	**3**	**3**	**J Pattison**	**M Walls**

Corporate Information Assurance						
Req No	**Key Req**	**Description**	**IGT v13 March 16**	**IGT v14 March 17**	**Sponsor**	**Lead**
12-601		Documented and implemented procedures are in place for the effective management of corporate records	**2**	**2**	**C Harries**	**A Hetherington**
12-603		Documented and publicly available procedures are in place to ensure compliance with the Freedom of Information Act 2000	**3**	**3**	**C Harries**	**A Hetherington**
12-604		As part of the information lifecycle management strategy, an audit of corporate records has been undertaken	**2**	**2**	**C Harries**	**A Hetherington**

Appendix B – Church View's Requirements/Scores

Information Governance Management			
Req No	**Description**	**IGT v13 March 16**	**IGT v14 March 17**
12-114	Responsibility for Information Governance has been assigned to an appropriate member, or members, of staff.	**3**	**3**
12-115	There is an information governance policy that addresses the overall requirements of information governance	**3**	**3**
12-116	All contracts (staff, contractor and third party) contain clauses that clearly identify information governance responsibilities.	**2**	**3**
12-117	All staff members are provided with appropriate training on information governance requirements.	**3**	**3**

Confidentiality and Data Protection Assurance			
Req No	**Description**	**IGT v13 March 16**	**IGT v14 March 17**
12-211	All transfers of personal and sensitive information are conducted in a secure and confidential manner	**2**	**2**
12-212	Consent is appropriately sought before personal information is used in ways that do not directly contribute to the delivery of care services and objections to the disclosure of confidential personal information are appropriately respected.	**3**	**2**
12-213	There is a publicly available and easy to understand information leaflet that informs patients/service users how their information is used, who may have access to that information, and their own rights to see and obtain copies of their records.	**3**	**3**

Information Security Assurance			
Req No	**Description**	**IGT v13 March 16**	**IGT v14 March 17**
12-304	Monitoring and enforcement processes are in place to ensure NHS national application Smartcard users comply with the terms and conditions of use	**2**	**2**
12-316	There is an information asset register that includes all key information, software, hardware and services	**3**	**3**
12-317	Unauthorised access to the premises, equipment, records and other assets is prevented	**3**	**3**
12-318	The use of mobile computing systems is controlled, monitored and audited to ensure their correct operation and to prevent unauthorised access.	**2**	**2**
12-319	There are documented plans and procedures to support business continuity in the event of power failures, system failures, natural disasters and other disruptions.	**3**	**3**
12-320	There are documented incident management and reporting procedures.	**3**	**3**