INFORMATION
to share or
not to share

Annex to “The First Year”

Information: To share or not to share

The Independent Information Governance Oversight Panel's report to the Secretary of State for Health

Annex to The First Year Report

December 2014

Introduction

The three annexes presented here provide further detailed information related to the implementation of the Caldicott2 report and should be read in the context of "The First Year" — The Independent Information Governance Oversight Panel's report to the Secretary of State for Health, December 2014.

Annex 1 presents a summary of progress on implementing the recommendations of Caldicott2, according to the information available up to 30th September 2014.

Annex 2 presents a summary assessment of the relationship between the actions envisaged by the Government's Response to Caldicott2 and the actual recommendations in Caldicott2.

Annex 3 presents some data from the IG Toolkit comparing Version 10 (V10) performance with Version 11 (V11) with some explanatory notes.

The first two annexes present judgements by the Panel based on the evidence available. They are not intended as absolute measures of performance, but are intended to aid constructive debate on what needs to happen next.

Annex 1: Progress on recommendations, commitments & expectations

Introduction

This Annex sets out the recommendations of Caldicott2 with their associated "commitments and expectations" from the Government's response. It provides a summary of the reported position from the main organisations responsible for delivering the commitments for the position up to 30th September 2014. Additional information (where relevant) is also presented and the Panel's judgement on progress on each recommendation is presented.

Progress on Recommendation One

Recommendation One stated: ***"People must have the fullest possible access to all the electronic care records about them, across the whole health and social care system, without charge. An audit trail that details anyone and everyone who has accessed a patient's record social care records. The Department of Health (DH) and NHS Commissioning Board (NHS England) should drive a clear plan for implementation to ensure this happens as soon as possible."***

The Government's response and the reported "progress at 30 September 2014" are set out below:

The DH committed to: "Work with partner organisations to consider how electronic access might be extended to care records outside the NHS".	The reported progress: "*The Department will work with other members of the National Information Board on the NIB strategy that will include broadening access to records across health and care*".
The DH committed to: "*Commission an options analysis to determine whether audit trails are the best approach*".	The reported progress: "*The Department has agreed to sponsor a standard relating to this. In addition, the Department is considering how best to enable people to see how their data has been shared and is likely to start by seeking an independent view on this matter.*"
NHS England committed to: "Lead work on electronic access to health records."	The reported progress: "*Work on electronic access to health records is being led by the patient online programme (within the Patient & Information Directorate).*[1] *NHS England is supporting general practices in achieving their contractual obligations to offer the following by March 2015:* • Online booking of appointments; • Online ordering of repeat prescriptions; • Online access to summary information (as a minimum) held in patients' own records

[1] see http://www.england.nhs.uk/ourwork/pe/patient-online/ for a general overview.

	Online access to records within general practices contractual obligations for 2015/16 will cover all coded information held in patients' records."

Additional information from NHS England:

The Patient Online programme is supporting GPs in meeting their electronic access commitments under the GMS.

NHS England has developed guidance to support identify access management, and to deliver its obligation under the NHS Act 2006. GP Practices delivering online services must have regard to this guidance. The guidance is due to be published in December 2014.

Additionally, NHS England has collaborated with the Royal College of GPs in developing further guidance materials to support identity verification, proxy access, and issues relating to coercion.

All Spine enabled systems, whether nationally or locally procured, implement role based access control, and include functionality to support the role of the Privacy Officer regarding the alert and access monitoring. This requirement is specified in GP Systems of Choice, National Service Provider and Local Service Provider contract.

More than 80% of practices already offer online appointments and booking of prescriptions. However availability of online access to records remains low. This is because the right configuration of the software required has only just been made available by the two major suppliers. Practices are now enabling this service at a good pace and substantial progress in the last quarter's figures is expected.

Anticipated progress:

- *March 2015 — online services as described above*
- *March 2016 — expanded services as agreed in the GMS/PMS contracts for 2015/16.*

In addition to the committed actions NHS England has reported**:** "*NHS England produced a Fair Processing Strategy. Work is in hand on an implementation plan. The care.data programme is currently taking part in a listening exercise which includes a key element of understanding the expectations around patient communication.*" This contributes to the delivery of this recommendation.

Assessment:

IIGOP welcomes the current position as good progress in challenging circumstances. We note the work taking place on identity management and look forward to having the opportunity to review those materials**.**

Conclusion: **Good progress**

Progress on Recommendation Two

Recommendation Two stated: *"For the purposes of direct care, relevant personal confidential data should be shared among the registered and regulated health and social care professionals who have a legitimate relationship with the individual. Health and social care providers should audit their services against NICE Clinical Guideline 138, specifically against those quality statements concerned with sharing information for direct care."*

The Government's response and the reported "progress at 30 September 2014" are set out below:

The DH committed to:	The reported progress:
"Take the revised Caldicott principles into consideration when reviewing the Care Quality Commission regulations".	"Complete"
The DH committed to: *"Include the recommendation on the use of NICE Clinical Guideline 138 in the ongoing work with the bodies who provide guidance and best practice advice to local authorities and to care providers and regulators and professional bodies"*	The reported progress: *More work is required to fully understand the recommendation as early discussions with stakeholders have revealed that there is not a good understanding of the intended benefits of this action to all the bodies mentioned in the commitment"*
An expectation on all organisations: *"Expect that relevant personal confidential data is shared among the registered and regulated health and social care professionals who have a legitimate relationship with the individual."*	The reported progress: *There is evidence of good progress in local areas, but there are challenges across some organisational boundaries.*
An expectation on Local NHS Providers: *"Audit their information sharing practices in adult NHS services against NICE Clinical Guideline 138".*	The reported progress: See additional information below.

An expectation on Local Commissioners: *"Use the NICE Quality Standard 15 in commissioning and monitoring adult NHS services (in relation to information sharing)"*	The reported progress: See additional information below.
The NHS Employers Federation committed to: *"Work together with Trade Union Partners through the National and Regional Social Partnership Forums to identify areas of good practice which can inform future development work starting with a joint workshop with NHS England and Social Partnership Forum partners in September 2013."*	The reported progress: *NHS Employers have held the meeting and a follow up with RCN and NHS England to explore the role of nurses in adopting and spreading technology and data sharing. NHS England's National IT strategy was presented at the Embedding Partnership Working Group (EPWG). Over this year we will seek to use the regional Social Partnership Forum (SPF) work programmes to help local implementation.* *In order to seek best practice case studies the SPF have made links with relevant Chairs of Information Governance networks e.g. London Health and Social Care Information Governance Managers Forum which meets every 2 months and they address issues raised by Caldicott2 and the SIGNs group (Strategic Information Governance Network) is also part of the new Information Governance Alliance* See also additional information below.
CQC committed to "The evolving approach to information governance monitoring work will focus on how well information is used and shared to support delivery of good quality care and ensure that it can assess the effectiveness of information sharing in different settings and pathways of care."	CQC have reported progress on this (and Recommendation Four) as follows; "*The development of our monitoring function is focused on the role that information plays in supporting delivery and improvement of good quality care. Key areas of focus are: having good quality care records; ensuring information needed to plan and deliver care to individuals is available in a timely way; sharing appropriate information at discharge, referral, transfer and transition to support ongoing care; quality of data and information that is used to provide assurance and drive improvement in quality of care. (see also further information below)*

Additional Information:

CQC noted "The development of our health and social care regulatory model has placed emphasis on asking the right questions. In the context of information governance this means asking questions that enable us to effectively assess how well providers use information to support good care. We then take evidence gathered into account in our ratings. The key areas outlined above feature within our new assessment framework for all sectors which has been widely tested and consulted on. The approach was launched for the majority of services in October 2014, including NHS trusts, GP practices and adult social care services.

Further development work will continue, particularly to ensure that inspection teams are well-supported, we collect appropriate and sufficient evidence and we are able to use our findings to identify common trends concerns and examples of good practice.

Initial analysis work of some inspection reports from our first new approach pilot inspections has started to identify some common areas of concern including poor quality of care records, quality of data being used to monitor care and cumbersome or poorly coordinated IT and care records systems.

The role of information, specifically effective information sharing, has also been considered as part of our thematic work. We have asked relevant questions in a themed review on care for people with dementia to be published October 2014 and a review of services for people who experience a mental health crisis for publication early 2015. Relevant findings will form part of our evidence for our monitoring activity.

We intend to publish a report on our findings from the first few years of monitoring in 2015. We also aim to work more closely with partner organisations, including the ICO, HSCIC and NHS England to share relevant findings and better understand the picture of performance. "

NHS Employers also noted:

> *"There is another group, independent to the NHS and Local Authorities called London Connect and sponsored by the Mayor of London, they meet every 3 months, and have a number of product work streams, some of which were triggered by Caldicott2. These networks have been asked to share case studies with the EPWG group which next meets 7th December.*

Peter Knight, NHS England presented to the SPF Strategic Group on Informatics September 23rd and it was agreed that the SPF will engage with the publication being written October/November 2014, they will also be part of the task and finish group which will be established following this publication. A meeting on 24th November will identify how the regional SPFs can support this work."

In addition NHS England has reported: "*The Health and Social Care Act (2012) places a duty on NHS England to have regard to National Institute for Health and Care Excellence (NICE) Quality Standards. Commissioners should have regard to these standards in the planning of services they commission according to their population needs.*

Where providers have audited against NICE Clinical Guideline 138, Trusts may report on this although this will not be a mandated reporting requirement in the 2014/15 Quality Accounts. Organisations do have to report their overall Information Governance Assessment score from the Information Governance Toolkit in their Quality Account. This assessment reports on Information Quality and Management. Key areas that form part of the assessment relevant to this question include:

- Staff are provided with clear guidance on
  - keeping personal information secure;
  - respecting the confidentiality of service users, the duty to share information for care purposes

They also reported: "Further work on consent, dissent and objections recording is underway within the IG Programme and by the Strategic IG Team. NHS England programmes include consideration of this issue and how to ensure patient choice is recorded and respected"; and "Reference to the NHS Constitution was included in the NHS standard contract, NHS England has limited purview in relation to social care. It can be included in guidance to social care providers and other persons registered with the CQC and through joint commissioning" as contributing to the delivery of this recommendation.

Assessment:

IIGOP welcomes the progress made by CQC and the responses from NHS England and the NHS Employers Federation. Their evidence helps to confirm other sources that there is evidence of good regional and local collaboration (e.g. London Connect). The Health and Social Care (Safety and Quality) Bill presents a significant opportunity to embed the 'duty' to share which would be a significant step forward in supporting this recommendation.

Conclusion: **Good Progress**

Progress on Recommendation Three

Recommendation Three stated: *"The health and social care professional regulators must agree upon and publish the conditions under which regulated and registered professionals can rely on implied consent to share personal confidential data for direct care. Where appropriate, this should be done in consultation with the relevant Royal College. This process should be commissioned from the Professional Standards Authority."*

The Government's response and the reported "progress at 30 September 2014" are set out below:

The DH committed to:	The reported progress:
"*Commission the Professional Standards Authority to work with other organisations to ensure that all health and social care professional regulators publish consistent guidance that reflects the messages in the HSCIC's Confidentiality Code of Practice.*"	The DH initially reported that PSA had started to engage with stakeholders. PSA were commissioned to "*to work with the regulators to agree on publishing guidance describing when all registered health and care professionals can rely on implied consent to share personal confidential data for the direct care of patients and service users.*" Subsequently the work has stopped for a variety of reasons, including resource issues and the very different schedules by regulators to update their guidance.

Additional Information:

In addition NHS England reports: "*NHS England's support of the Stage 1 Accredited Safe Havens, enabled by approvals under regulations enabled by s. 251 of the NHS Act 2006, is supporting the development of operational knowledge about issues generated by this recommendation. Further work is being undertaken by the Data Services for Commissioners work stream within the IG Programme 2014-15 and NHS England's contribution to proposed Regulations about the issue. Whilst the HSCIC's Code of Practice does not specifically address the requirements for ASHs it does set out many of the requirements for the safe handling of confidential information.*" as contributing to the delivery of this recommendation.

Assessment:

IIGOP notes that this recommendation has not proceeded as envisaged. It may be more appropriate for the individual regulators to commit to delivering their components of the recommendation. In proceeding with this recommendation there is a need to recognise the challenge that regulators currently update their guidance at different frequencies and times.

The work reported by NHS England is noted.

It may be appropriate to revise the tasks and plan to deliver the revised tasks to achieve the desired outcome. This would benefit from an overarching framework of programme management.

Conclusion: **No evidence of consistent progress.**

Progress on Recommendation Four

Recommendation Four stated: *"Direct care is provided by health and social care staff working in multi-disciplinary 'care teams'. The Review recommends that registered and regulated social workers be considered a part of the care team. Relevant information should be shared with members of the care team, when they have a legitimate relationship with the patient or service user. Providers must ensure that sharing is effective and safe. Commissioners must assure themselves on providers' performance.*

Care teams may also contain staff that are not registered with a regulatory authority and yet undertake direct care. Health and social care provider organisations must ensure that robust combinations of safeguards are put in place for these staff with regard to the processing of personal confidential data."

The Government's response and the reported "progress at 30 September 2014" are set out below:

The ISCG (now the IG Forum) committed to: *"Consider how best to support the extension of the Information Governance Toolkit across local authorities".*	The reported progress: *We note that some limited changes were made to Version 12 of the toolkit and that there is a three year programme of fundamental review and change to reflect a wider range of issues.*
NHS England committed to: *"Give a clear steer to commissioners of care on the need to monitor provider information governance performance through using a variety of mechanisms, and to take account of the findings of inspection reports published by the CQC where poor information sharing practice has been identified".*	NHS England reported: *"Most Mental Health Trusts are 'partnership' trusts. They employ or second social workers as part of the multi-disciplinary team, and discharge social care responsibilities on behalf of local authorities. Where this is not in place, Trusts and Local Authorities have data-sharing agreements between them to ensure a robust exchange of data. Statutory providers undertake the Information Governance Toolkit as part of their IG arrangements, and this provides assurance to commissioners on data quality and arrangements to share information.* *Information governance arrangements are included in contractual arrangements with external contracts to ensure standards are maintained. (See also further information below.)*

NHS England committed to: "Include actions to take the Caldicott recommendations forward, for example in work on the CCG Assurance Framework and the Standard Contract."	See above
In response to this recommendation (and recommendation two) the CQC committed to: "*The evolving approach to information governance monitoring work will focus on how well information is used and shared to support delivery of good quality care and ensure that it can assess the effectiveness of information sharing in different settings and pathways of care*".	CQC response set out against recommendation two.
An expectation was that Leading national organisations would: *"Take action to establish the right conditions for improved sharing".*	In response NHS England committed to: *"Include actions to take the Caldicott recommendations forward, for example in work on the CCG Assurance Framework and the Standard Contract".* The NHS Development Trust Authority advised that: '(We have established) *Memoranda of Understanding and information sharing agreements with key partners together with staff training to heighten awareness.'* More recently the IGA has published the "five rules" document for consultation.[2]
Additional Information: *NHS England has highlighted that "Bristol Mental Health Services are currently provided by a consortium of statutory and voluntary sector providers. There is a universal data sharing agreement in place between all the agencies that meets data sharing requirements and allows care and treatment to be provided by several agencies across the city, according to the individual needs. The legal basis for sharing information is the data processing notice that each organisation registers with the ICO's office — this states what information is processed, for what purposes and with whom at a very high level."*	

[2] The leaflet is at: https://www.gov.uk/government/consultations/data-sharing-for-health-care-professionals-guidance-leaflet.

Assessment: IIGOP notes the progress reported and the recent publication of the consultation on the "five rules". However the challenge to multidisciplinary teams working across organisations remains. There is no evidence that the challenge of dealing with unregulated care staff is being progressed with clear guidance with some local organisations identifying this as a barrier to progress across organisations.
Conclusion: **Some progress has been made, but significant challenges remain.**

Progress on Recommendation Five

Recommendation Five stated: *"In cases when there is a breach of personal confidential data, the data controller, the individual or organisation legally responsible for the data, must give a full explanation of the cause of the breach with the remedial action being undertaken and an apology to the person whose confidentiality has been breached."*

The Government's response and the reported "progress at 30 September 2014" are set out below:

The DH committed to:	The reported progress:
"Work with the social care, public health and research sectors to support them in any specific local actions relating to reported data breaches".	*"The incident reporting aspects of the IG Toolkit have been extended to cover local authorities, public health and social care bodies although this is not mandatory for them. Researchers who gain permissions to access PCD under regulation 5 also have to complete the IG Toolkit which binds them to reporting data breaches using the incident reporting tool".*
All organisations were expected to *"Seek advice from the ICO and refer to the HSCIC's Confidentiality Code of Practice for further advice on managing and reporting data* breaches".	The reported progress: CQC reported *"Data breaches are handled in accordance with government guidelines and reported via the Information Governance Toolkit. Advice is sought from ICO and HSCIC as required."*
All organisations were expected to *"Explain and apologise for every personal data breach, with appropriate action agreed to prevent recurrence."*	The reported progress: The CQC reported: *"Contacting data subjects, explaining and apologising, and then learning from any data breaches are key considerations in our information security processes for handling data breaches."*

Additional Information:

NHS England has committed to: "*Include data breaches in scope for the duty of candour including in any monitoring and reporting*". It has also *reported: "The HSCIC reports quarterly on breaches. Investigations are ongoing to see if this report can better meet NHS England's needs. CSU breaches are reported to NHS England via a weekly breach report sent by the HSCIC external IG team. NHS England's Serious Incident Requiring Investigation tool captures and records all breaches and updates are provided to the National IG group via reports on a quarterly basis."*

The NHS Trust Development Authority reported: *"As a small organisation not dealing directly with patients, the NHS TDA has not experienced a data breach that required ICO reporting, therefore advice so far has been in policy development and practical arrangements." And w*ith regard to the commitment to explain and apologise for every personal data breach, with appropriate action agreed to prevent recurrence that "*This is incorporated into the NHS TDA's own complaints policy, FOI arrangements and correspondence function*".

Assessment:

IIGOP notes the responses, but also notes that the scale of changes in the IG Toolkit have been relatively modest, with the social care community not being part of its mandate. We also note that V12 of IG Toolkit has not been approved as an Information Standard. We are aware that a more formal review and improvement plan for the IG Toolkit has been developed. We look forward to the opportunity to review that programme of work.

Conclusion: **Some progress has been made, but further work is needed including scrutiny of updated versions of the IG Toolkit and analysis of the results over time.**

Progress on Recommendation Six

Recommendation Six stated: *"The processing of data without a legal basis, where one is required, must be reported to the board, or equivalent body of the health or social care organisation involved and dealt with as a data breach.*

There should be a standard severity scale for breaches agreed across the whole of the health and social care system. The board or equivalent body of each organisation in the health and social care system must publish all such data breaches. This should be in the quality report of NHS organisations, or as part of the annual report or performance report for non-NHS organisations."

The Government's response and the reported "progress at 30 September 2014" are set out below:	
DH committed to: *"Ask CIPFA and SOLACE to include a reference to publishing data breaches when next updating their guidance Annual Governance Statements".*	The reported progress: "Not yet begun".
The DH committed to: *"Work with local authorities to encourage them to publish details of incidents".*	The reported progress: *"The Department worked with the local authority CIO council to create a new requirement which has been implemented into latest local authority version of the IG Toolkit. It is not mandatory this year".*
DH also committed to: *"Ask the Leeds project to include incident reporting in its work".*	The reported progress: "The Department worked with the local authority CIO council to create a new requirement which has been implemented into latest local authority version of the IG Toolkit. It is not mandatory this year".
Monitor are committed to: *"When they next update their requirements for foundation trusts' annual reports, consider including a requirement to publish all data breaches".*	
NHS England are committed to: *"When they next update their requirements for Quality Accounts, consider including a requirement to publish all data breaches".*	NHS England reported: *"NHS England has both national, regional, area team and hosted body Caldicott guardians and national, regional and hosted body SIROs. The National Caldicott Guardian and SIRO are Executive Directors and sit on NHS England's Board. Annual report to be published imminently addresses Corporate IG responsibilities. The IGT was completed and reported to senior management along with details of SIRIs. IGTs were completed for National and Regional Offices. Caldicott Guardian and SIRO is in post nationally, with Regional Officers supporting. One Area Team did not meet level 2 in the toolkit but this has been remedied since."*

The NHS Trust Development Authority are committed to: *"When they next update their requirements for trusts' annual reports, consider including a requirement to publish all data breaches".*	The NHS Development Trust Authority advised that: 'They are ensuring that p*olicies on reporting and managing incidents are in place and reported to the Executive Team.'*
Local commissioners are expected to: *"Investigate, manage, report and publish personal data breaches and ensure that commissioned bodies are investigated, managed, reported and published appropriately*".	This should be evidenced in the reports from IG Toolkit breaches reporting tool.
Additional Information: *NHS England further reports: "Dependent on DH, ongoing discussions in relation to Public Health. NHS England has delegated responsibility for delivering many screening services."* The CQC committed to: *"Clarifying that CQC's uses of information and sharing with partners are explained in their Code of Practice on Confidential Personal Information. They advised they do not provide healthcare services, therefore are not a primary collector of patient information."* Monitor advised that: *"They are going to report when they next review the Regulatory Accounting Framework."* Assessment: IIGOP notes the continuing support for the commitments and that NHS England has confirmed that its annual reporting does include the required information. The evidence of compliance will only become clear in late May or June 2015 when more annual reports are likely to be available. IIGOP would also welcome opportunity to review the "standard severity scale".	
Conclusion: **Some progress is evidenced.**	

Progress on Recommendation Seven

<table>
<tr><td colspan="2">Recommendation Seven stated: "All organisations in the health and social care system should clearly explain to patients and the public how the personal information they collect could be used in de-identified form for research, audit, public health and other purposes. All organisations must also make clear what rights the individual has open to them, including any ability to actively dissent (i.e. withhold their consent)."

The Government's response and the reported "progress at 30 September 2014" are set out below:</td></tr>
<tr><td>The ICO committed to: "Support ongoing work by others to ensure that a clear and easily understandable message on how their information is used is delivered to patients, people who use care and support and the wider public".</td><td>The ICO reported that:

'Their commitment was to support work on these recommendations. As work does not appear to have commenced they are unable to provide support.'</td></tr>
<tr><td>All organisations expected to: "Clearly explain to patients and the public how the personal information they collect could be used in de-identified form for research, audit, public health and other purposes".</td><td>The reported progress:

See additional information below.</td></tr>
<tr><td>And, all organisations expected to: "Make clear what rights the individual has open to them, including any ability to actively dissent".</td><td>The reported progress:

See additional information below.</td></tr>
<tr><td colspan="2">Additional Information:

The CQC committed to: "Patients' information rights being explained to them on their website."

The NHS Trust Development Authority advised with regard to the commitment to explain and apologise for every personal data breach, with appropriate action agreed to prevent recurrence that as in Recommendation 2&5: 'This is incorporated into the NHS TDA's own complaints policy, FOI arrangements and correspondence function'.

The NHS Trust Development Authority advised: 'As a small organisation not dealing directly with patients, the NHS TDA has not experienced a data breach that required ICO reporting, therefore advice so far has been in policy development and practical arrangements.'</td></tr>
</table>

NHS England reported: *"NHS England's Fair Processing Strategy is available on NHS England website and was published in March 2014. A Fair Processing implementation plan is in development to inform the proposed strategy. Stakeholders were consulted throughout the creation of this strategy to inform both the strategy and implementation."*

Assessment:

IIGOP notes the responses and is pleased with the practice reported by national organisations. We are aware that the *care.data* programme has had to respond to this challenge and we are aware of the work in progress. See the section of the report on *care.data* for further commentary.

Conclusion: **Some progress, but much more required.**

Progress on Recommendation Eight

Recommendation Eight stated: *"Consent is one way in which personal confidential data can be legally shared. In such situations people are entitled to have their consent decisions reliably recorded and available to be shared whenever appropriate, so their wishes can be respected. In this context, the Informatics Services Commissioning Group must develop or commission guidance for the reliable recording in the care record of any consent decision an individual makes in relation to sharing their personal confidential data; and a strategy to ensure these consent decisions can be shared and provide assurance that the individual's wishes are respected."*

The Government's response and the reported "progress at 30 September 2014" are set out below:

The DH committed to:	The reported progress:
"Work with NHS England to develop a consent management standard, consider how best to enable implementation of mechanisms for sharing the decisions of individuals between different systems and recommend to the ISCG that these standards are considered a priority".	*DH reported: "A proposal for a consent management standard has been accepted in principle — we are now looking for funding to take forward its development (probably through the IG Alliance)".* NHS England initially reported: "*NHS England is currently exploring opportunities to contribute to this recommendation.*" And more recently: "*NHS England is contributing to this work stream with … the Caldicott Guardian for the HSCIC".*

NHS England committed to: Include the proposed new standard on consent management within the Technology Strategy, due to be published in December 2013.	
Additional Information: *IIGOP is aware that the HSCIC are taking the lead in this area of work.*	
Assessment: IIGOP notes the reallocation of the leadership of this recommendation to HSCIC, which is essential to underpin the use of electronic records to appropriately share information. We look forward to the opportunity to review the outcomes of this work.	
Conclusion: **Progress has been limited, but recent developments are promising.**	

Progress on Recommendation Nine

Recommendation Nine stated: *"The rights, pledges and duties relating to patient information set out in the NHS Constitution should be extended to cover the whole health and social care system."* The Government's response and the reported "progress at 30 September 2014" are set out below:	
DH committed to: *"Work with the adult social care sector to consider how, where they do not already exist, the rights, pledges and duties of the NHS Constitution might be extended to the adult social care system".*	The reported progress: *"The rights have been included in the local authority toolkit requirements. More work is required on the duties and pledges".*
The ICO committed to: *"Support work to increase awareness among patients and the public about the existence of the NHS Constitution and what it contains".*	The ICO advised that: '*Their commitment was to support work on these recommendations. As work does not appear to have commenced they are unable to provide support.*'

Additional Information: NHS England reported: "*The 2014/15 Standard Contract includes a range of new and revised requirements relating to implementation of recommendations in the Francis report, including more explicit wording on the requirement for all parties, including any sub-contractors, to abide by the NHS Constitution (SC1 Compliance with the Law and the NHS Constitution)*"
Assessment: IIGOP notes the reported progress. We look forward to seeing the outcomes of the considerations of the duties and pledges in relation to social care.
Conclusion: **Some progress made, more required.**

Progress on Recommendation Ten

Recommendation Ten stated: *"The linkage of personal confidential data, which requires a legal basis, or data that has been de-identified, but still carries a high risk that it could be re-identified with reasonable effort, from more than one organisation for any purpose other than direct care should only be done in specialist, well-governed, independently scrutinised and accredited environments called 'accredited safe havens'. The Health and Social Care Information Centre must detail the attributes of an accredited safe haven in their code for processing confidential information, to which all public bodies must have regard.*
The Informatics Services Commissioning Group should advise the Secretary of State on granting accredited status, based on the data stewardship requirements in the Information Centre code, and subject to the publication of an independent external audit."

The Government's response and the reported "progress at 30 September 2014" are set out below:

DH committed to: *"Lead work to confirm the challenges to be overcome and the options for consideration in relation to commissioners' access to personal confidential data — across the NHS, public health and research".*	The reported progress: *"Through the data sharing executive oversight group, the Department is leading work on this - for the longer term, medium term and short term solutions".*
CAG-HRA committed to: *"Provide additional guidance on the website to applicants who are intending to seek approval under Section 251 to use personal confidential data".*	

ISCG committed to: "Consider the establishment of accredited safe havens".	"*HSCIC and NHS England have set out the requirements for a Stage 1 ASH as part of an application under Regulations enabled by Section 251. This application (CAG 2-03(a)/2013) allows for a data set which includes only one strong identifier. This application supports the ongoing commissioning services and has explored issues about the need for Accredited Safe Havens and what they can provide. Feedback and learning from the work of the Accredited Safe Havens, the Controlled Environments for Finance and their work with the HSCIC's Data Services for Commissioners Regional Offices is shared through regular meetings of the CSU IG Leads and the DSCRO Leads. NHS England has contributed to the proposed Regulations for Protecting Health and Care Information, providing a response to the consultation and to the ongoing process led by the Department of Health.*"
NHS England committed to: "*Review the intelligence requirements for NHS commissioners' access to personal confidential data, identify options to meet these data needs and, where alternatives to using personal confidential data cannot be found, work with the Department to identify options that could satisfy these requirements*".	See additional information below.
Additional Information: *IIGOP is aware of the work that has progressed in relation to Commissioners access to information and appropriate regulations or approvals. We also note that interim cover for some commissioning functions ended on 31st March 2015.*	
Assessment: IIGOP notes the work that has been undertaken securing interim legal basis for access to person identifiable for some commissioning functions. We also note the public consultation on longer term regulations including those related to ASHs and await the publication of the results. We also note that interim cover for some commissioning functions ends on 31st March 2015.	
Conclusion: **Some progress has been made, but more work required.**	

Progress on Recommendation Eleven

<table>
<tr><td colspan="2">Recommendation Eleven stated: "The Information Centre's code of practice should establish that an individual's existing right to object to their personal confidential data being shared, and to have that objection considered, applies to both current and future disclosures irrespective of whether they are mandated or permitted by statute. Both the criteria use to assess reasonable objections and the consistent application of those criteria should be reviewed on an ongoing basis."

The Government's response and the reported "progress at 30 September 2014" are set out below:</td></tr>
<tr><td>The BMA committed to: "With NHS England, explore reasons for abnormal number of objections to sharing of information with care.data."</td><td>Cannot yet progress until care.data objections are monitored.</td></tr>
<tr><td>HSCIC committed to:

"Monitor the rate of objections to the sharing of information with the new care.data service".</td><td>The reported progress:

HSCIC have advised that: "They have discussed their commitment with care.data and the programme has confirmed that the objections are for the live care.data service. Care.data is not live and so to date there are no objections. The need for monitoring the rate of objections in the live service is recognised."</td></tr>
<tr><td>NHS England committed to:
"With BMA, explore reasons for abnormal number of objections to sharing of information with care.data".</td><td>The reported progress:

Cannot yet progress until care.data objections are monitored.</td></tr>
<tr><td>Leading national organisations are expected to:

"Have regard to the HSCIC's Confidentiality Code of Practice and promote the Code of Practice and the objection details to employers and organisations".</td><td>The NHS Development Trust Authority advised that:

'The HSCIC's Confidentiality Code of Practice has informed the review of information governance policies and communication on information sharing, including in guidance to the NHS Trust sector.'</td></tr>
<tr><td colspan="2">Additional Information:

The progress of the care.data programme is covered in the main report.</td></tr>
<tr><td colspan="2">Assessment:

IIGOP notes the continued commitments in relation to care.data and the guidance produced by HSCIC.</td></tr>
<tr><td colspan="2">Conclusion: Some progress, further work required.</td></tr>
</table>

Progress on Recommendation Twelve

Recommendation Twelve stated: *"The boards or equivalent bodies in the NHS Commissioning Board, clinical commissioning groups, Public Health England and local authorities must ensure that their organisation has due regard for information governance and adherence to its legal and statutory framework. An executive director at board level should be formally responsible for the organisation's standards of practice in information governance, and its performance should be described in the annual report or equivalent document. Boards should ensure that the organisation is competent in information governance practice, and assured of that through its risk management. This mirrors the arrangements required of provider trusts for some years."*

The Government's response and the reported "progress at 30 September 2014" are set out below:

DH committed to:	The reported progress:
"Ask delivery partners such as Skills for Care and the National Skills Academy to ensure that their products support the appropriate application of information governance".	"Not yet begun."
CQC committed to: *"Use the HSCIC's Confidentiality Code of Practice to inform its monitoring plans for information governance".*	CQC reported: *"Continue with their work on CQC's Code of Practice on Confidential Personal Information which is under review. The HSCIC Code is being used in this review, and they will consult with HSCIC on our draft Code."*
The HSCIC committed to: *"Build new requirements into the next release of the toolkit to cover the relevant aspects of the issues in recommendation 12".*	
NHS England committed to: *"Include actions to take the Caldicott recommendations forward, for example in work on the CCG Assurance Framework and the Standard Contract".*	See progress against recommendation four.
NHS England committed to: *"Require NHS commissioning organisations to provide reassurance on recommendation 12 and to publish findings".*	

NHS Leadership Academy committed to: "*Include the new duty to share in guidance for NHS boards and Top Leaders Programme*".	
All organisations are expected to: *"Use the best practice contained in the HSCIC's Confidentiality Code of Practice when reviewing their information governance practices to ensure that they adhere to the required standards*".	*CQC reported:* *"Ensure that CQC uses and submits the IG Toolkit and that their annual returns are reviewed by their Information Governance Group and approved by their SIRO."* *As part of their ongoing commitment CQC advised: Re: Use of HSCIC Confidentiality code of practice: The Code of practice is referenced in the current guidance for providers about how to meet quality and safety regulations as a document which they should take into account. This will also be the case for equivalent guidance which will be published when new regulations come into force in April 2015. The latest version of the Code will be referenced; they will work with the HSCIC to ensure they reflect key issues within the new Code once it is published.*
All organisations expected: "*That social care providers use the Information Governance Toolkit*".	
Local commissioners are expected to: *"Implement appropriate arrangements in relation to information governance including the demonstration of strong leadership on information governance and adopt information governance procedures that are equivalent to those already established by healthcare providers*".	

Additional Information:

The NHS Development Trust Authority advised that: *'The HSCIC's Confidentiality Code of Practice has informed the review of information governance policies and communication on information sharing, including in guidance to the NHS Trust sector.' And* that: *'The Information project Board consists of four board directors - Medical, Finance, Strategy and Communications along with the Director of Information & Analysis. Policies and procedures are informed by best practice and guidance from the ICO and HSCIC.'*

Assessment:

IIGOP notes the responses. It is not clear what action is being taken to ensure that social care providers are informed of what is expected of them, nor clarity on the way small and medium enterprises might be supported particularly in the social care space.

Conclusion: **Some progress, but more work required.**

Progress on Recommendation Thirteen

Recommendation Thirteen stated: *"The Secretary of State for Health should commission a task and finish group including but not limited to the Department of Health, Public Health England, Healthwatch England, providers and the Information Centre to determine whether the information governance issues in registries and public health functions outside health protection and cancer should be covered by specific health service regulations."*

The Government's response and the reported "progress at 30 September 2014" are set out below:

The DH committed to:	The reported progress:
"*Lead a review into whether public health activity should have further statutory support to process confidential personal information where alternative arrangements are insufficient*".	"*PHE are considering this in parallel with the consultation on data sharing regulations during June and July 2014*"

Additional Information:

Assessment:

IIGOP notes the response and looks forward to the opportunity to consider the outcomes of the PHE review. However, the commitment does not fully address the recommendation.

Conclusion: **Some progress, more work required.**

Progress on Recommendation Fourteen

Recommendation Fourteen stated: *"Regulatory, professional and educational bodies should ensure that information governance, and especially best practice on appropriate sharing, is a core competency of undergraduate training; and information governance, appropriate sharing, sound record keeping and the importance of data quality are part of continuous professional development and are assessed as part of any professional revalidation process."*

The Government's response and the reported "progress at 30 September 2014" are set out below:

DH committed to:	The reported progress:
"*Work with The College of Social Work and Higher Education Institutes to ensure that social work qualifying courses contain the most up-to-date legal requirements and best practice*".	"*Not yet begun*".
The DH committed to: "*Work with Skills for Care to ensure that appropriate training is available for social care workers*".	The reported progress: "*The requirement for annual training has been included in the social care IG Toolkit. The Department has not yet engaged with Skills for Care*".
The Academy of Medical Royal Colleges committed to: "*Include information governance in reviews of curricula for postgraduate training*".	
Health Education England committed to "Work with professional regulators and education institutions to incorporate the revised Caldicott principles, a single set of terms and definitions and good practice into curricula and work relating to bands 1–4 and other staff,"	Health Education England advised that: "*IG work is at an early stage and that they fully support the idea of a single set of Terms and Conditions for all curricula.*"

Additional Information:

As part of their commitment and in line with Recommendation 14 (and 2): NHS Employers have advised that: *NHS Employers have held the meeting and a follow up with RCN and NHSE to explore the role of nurses in adopting and spreading technology and data sharing. NHS England's National IT strategy was presented at the EPWG. Seeking permission to share case studies of good practice. Over this year we will seek to use the regional SPF work programmes to help local implementation.*

The Social Partnership Forum Embedding Partnership Subgroup met on 31st March and agreed that identification of a good case study which has good practices in information governance and good systems in place will be used to produce advice for staff messages. Also to identify best mechanism for sharing good practice in information governance. Consideration of having a Caldicott update at the wider SPF meeting in October 14.

In order to seek best practice case studies the SPF have made links with relevant Chairs of IG networks e.g. London Health and Social Care Information Governance Managers Forum which meets every 2 months and they address issues raised by Caldicott 2 and the SIGNs group (Strategic Information Governance Network) is also part of the new Information Governance Alliance

There is another group, independent to the NHS and Local Authorities called London Connect and sponsored by the Mayor of London, they meet every 3 months, and have a number of product work streams, some of which were triggered by Caldicott 2. These networks have been asked to share case studies with the EPWG group which next meets 7th December.

Peter Knight, NHS England presented to the SPF Strategic Group on Informatics September 23rd and it was agreed that the SPF will engage with the publication being written October/November 2014, they will also be part of the tasks and finish's group which will be established following this publication. A meeting on 24th November will identify how the regional SPFs can support this work."

Assessment:

IIGOP notes the position, however, as education and training appropriate to function is critical to delivery of the changes in culture required to underpin the recommendations of Caldicott 2, IIGOP strongly urges DH to ensure that this recommendation is pursued with vigour in the coming months.

Conclusion: **Progress slow and needs to be invigorated.**

Progress on Recommendation Fifteen

Recommendation Fifteen stated: *"The Department of Health should recommend that all organisations within the health and social care system which process personal confidential data, including but not limited to local authorities and social care providers as well as telephony and other virtual service providers, appoint a Caldicott Guardian and any information governance leaders required, and assure themselves of their continuous professional development."*

The Government's response and the reported "progress at 30 September 2014" are set out below:

The DH committed to: *"Undertake further work to support the appointment, training and development of Caldicott Guardians in social care and local government and research".*	The reported progress: "*Not yet begun*".
NHS England committed to: "Include actions to take the Caldicott recommendations forward, for example in work on the CCG Assurance Framework and the Standard Contract."	See progress on recommendation four above. .
All organisations are expected to: "*Appoint a Caldicott Guardian or Caldicott lead with access to appropriate training and support*".	
All organisations are expected to: "*Local authorities consider extending Caldicott Guardian arrangements to children's services*".	
All organisations are expected to: "*Strengthen their leadership on information governance*".	

Additional Information:

The CQC advised as part of their commitment that:

> *"The Chief Inspector of Hospitals is CQC's Caldicott Guardian who receives support from the Information Rights Manager and Information Security Manager and has received training." And that: "CQC's SIRO is their Executive Director of Strategy & Intelligence. Their IG leadership and structure will be reviewed as part of their Information Governance Strategy."*

The NHS Development Trust Authority advised that:

"Dr Kathy McLean, Medical Director, is their Caldicott Guardian."

The NHS Development Trust Authority advised that:

"The Information project Board consists of four board directors - Medical, Finance, Strategy and Communications along with the Director of Information & Analysis."

Assessment:

IGOP has noted the responses, however it is not clear what actions have been taken to ensure that small health and care enterprises have been encouraged to appoint Caldicott leads. We are also aware that many Local Authorities have a Caldicott Guardian for the authority, including Children's Services and Public Health.

Conclusion: **Progress appears limited, more effort required.**

Progress on Recommendation Sixteen

Recommendation Sixteen stated: *"Given the number of social welfare initiatives involving the creation or use of family records, the Review Panel recommends that such initiatives should be examined in detail from the perspective of Article 8 of the Human Rights Act. The Law Commission should consider including this in its forthcoming review of the data sharing between public bodies."*

The Government's response and the reported "progress at 30 September 2014" are set out below:

The DH committed to:	The reported progress:
"*Work with the Department for Education and others to see whether there is a need to develop an approach to identifying and tackling bad practice*".	"*Work is progressing, albeit slowly*".
NHS England committed to: "*Contribute to this via participation in the IGA, the CQC's NIGC, and the IG Forum.*"	

Additional Information:

Assessment: IIGOP notes the limited progress and notes that the use of family records remains an area where there is lack of clarity about the legal gateways involved in their creation and use.
Conclusion: **Progress is very slow.**

Progress on Recommendation Seventeen

Recommendation Seventeen stated: *"The NHS Commissioning Board, clinical commissioning groups and local authorities must ensure that health and social care services that offer virtual consultations and/or are dependent on medical devices for biometric monitoring are conforming to best practice with regard to information governance and will do so in the future."*

The Government's response and the reported "progress at 30 September 2014" are set out below:

DH committed to:	The reported progress:
"*Explore what might be offered to support commissioners of social care for those offering virtual consultations and for medical devices used for biometric monitoring*".	"Not yet begun".
NHS England committed to: "*Develop guidance for those offering virtual consultations and utilising devices and holding personal confidential data, for example for remote telemonitoring on health matters*".	*"Technology Enabled Care Services (TECS) focuses on the use of the latest technology, in particular mobile technology, in the context of care pathways to improve outcomes. NHS England's TECS programme is developing a Commissioning Toolkit. The purpose of this is to provide guidance and supporting materials to commissioners of TECS services ……*
Additional Information: *The GPSoC framework currently includes asynchronous communications between practice and patient (not really e-consultation) and will include telehealth — including telemonitoring - at some future point.* *The GPSoC framework has further provision which may meet some of the required functionality in the future ……*	

Assessment: IIGOP notes the progress by NHS England in this challenging area, and looks forward to the opportunity to review the outcomes in due course. We note the lack of progress for support to social care, recognising the impact of resource constraints.
Conclusion: **Some good progress, but support for social care needs to be established.**

Progress on Recommendation Eighteen

Recommendation Eighteen stated: *"The Department of Health and the Department for Education should jointly commission a task and finish group to develop and implement a single approach to recording information about 'the unborn' to enable integrated, safe and effective care through the optimum appropriate data sharing between health and social care professionals"* The Government's response and the reported "progress at 30 September 2014" are set out below:	
DH committed to: "*Develop and implement an agreed approach to recording information about the unborn*".	The reported progress: "*Work is progressing, albeit slowly.*"
Additional Information: IIGOP is aware of the pragmatic approach that has been adopted for the Child Protection Information System using the mother's NHS number as a common identifier. Though not ideal, this approach does assist with information sharing in this important area until the broader, sustainable solutions are identified.	
Assessment: Progress on a long term solution is slow, but the pragmatism in CPIS programme welcomed.	
Conclusion: **Little progress on long term solution.**	

Progress on Recommendation Nineteen

Recommendation Nineteen stated: *"All health and social care organisations must publish in a prominent and accessible form: a description of the personal confidential data they disclose; a description of the de-identified data they disclose on a limited basis; who the disclosure is to; and the purpose of the disclosure."*

The Government's response and the reported "progress at 30 September 2014" are set out below:

All organisations are expected to: *"Ensure that the information provided to inform citizens about how their information is used does not exclude disadvantaged groups".*	The CQC advised as part of their commitment that: *"The information that CQC uses to inform people of how their information is used will be reviewed under their Information Governance Strategy."* The NHS Development Trust Authority advised that: *'The NHS TDA does not deliver direct patient services and uses data sets from the HSCIC.'* NHS England reported: *"NHS England has a Fair Processing Policy in place which covers some of the requirements stated. Work to expand this policy to include all required information will start in 2015 with a view to be completed in June 2015."*

Additional Information:

The work of HSCIC, including the "Partridge Report" contribute to progress in this area.

Assessment:

IIGOP notes the responses and is aware that many local organisations have addressed this recommendation to some extent. But it is unclear if local organisations are working to common/appropriate standards.

Conclusion: **Some progress evidenced, future monitoring will enable a more robust assessment.**

Progress on Recommendation Twenty

<table>
<tr><td colspan="2">Recommendation Twenty stated: “The Department of Health should lead the development and implementation of a standard template that all health and social care organisations can use when creating data controller to data controller data sharing agreements. The template should ensure that agreements meet legal requirements and require minimum resources to implement.”

The Government’s response and the reported “progress at 30 September 2014” are set out below:</td></tr>
<tr><td>ISCG committed to: “Commission work to produce a data sharing agreement template”.</td><td>NHS England reported: “We have developed a draft template Data Controller Agreement for Joint Data Controllers that is currently being tested with the HSCIC in relation to care.data. Once that Agreement is in place it will assist in setting the standard for a national template. This is currently with the HSCIC awaiting feedback. A Data Sharing Agreement template has also been created.

Patient Information Advisory group guidance is currently in development. This guidance will be tailored to the health and social care environment

Challenges include a lack of clarity around Joint Data Controllers and Data Controllers in Common. This could be explained as part of health and social care focused guidance. However, we would benefit by knowing that local agreements cover all the required aspects.

Positive stories include organisations working well together to ensure agreements are in place.”</td></tr>
<tr><td colspan="2">Additional Information:</td></tr>
<tr><td colspan="2">Assessment:

IIGOP notes the progress made by NHS England, which may, or may not, address whole system challenges</td></tr>
<tr><td colspan="2">Conclusion: Positive progress made, but need to ensure fit for purpose including social care.</td></tr>
</table>

Progress on Recommendation Twenty One

Recommendation Twenty One stated: *"The Health and Social Care Information Centre's Code of Practice for processing personal confidential data should adopt the standards and good practice guidance contained within this report."* The Government's response had no commitments or expectations associated with his recommendation.	
No commitments or expectations agreed.	
Additional Information: *IIGOP is aware of the work undertaken by HSCIC in this area.*	
Assessment: IIGOP welcomes the work done within HSCIC in relation to this recommendation.	
Conclusion: **Good Progress**	

Progress on Recommendation Twenty Two

Recommendation Twenty Two stated: *"The information governance advisory board to the Informatics Services Commissioning Group should ensure that the health and social care system adopts a single set of terms and definitions relating to information governance that both staff and the public can understand. These terms and definitions should begin with those set out in this document. All education, guidance and documents should use this terminology."* The Government's response and the reported "progress at 30 September 2014" are set out below:	
DH committed to: "*Ask leading organisations to extend the use of the glossary (once agreed) across the health and care system*".	The reported progress: "*Waiting for the glossary to be agreed.* "
ISCG committed to: "*Agree a single set of terms for information governance and consider whether it should be adopted as a standard*".	The reported progress: After delays, work is now underway through the IG Forum

Health Education England committed to: "Work with professional regulators and education institutions to incorporate the revised Caldicott2 principles, a single set of terms and definitions and good practice into curricula and work relating to bands 1–4 and other staff	Health Education England reported: *"They will ensure that all terminology is in accordance with a single set of terms and definitions and be easily readable."*
Additional Information:	
Assessment: IIGOP notes the delay with this work progressing, but welcomes recent evidence of progress. We further note that terminology is a key building block for many other recommendations.	
Conclusion: **After initial delay, work now progressing.**	

Progress on Recommendation Twenty Three

Recommendation Twenty Three stated: *"The health and social care system requires effective regulation to ensure the safe, effective, appropriate and legal sharing of personal confidential data. This process should be balanced and proportionate and utilise the existing and proposed duties within the health and social care system in England. The three minimum components of such a system would include a Memorandum of Understanding between the CQC and the ICO; an annual data sharing report by the CQC and the ICO; and an action plan agreed through the Informatics Services Commissioning Group on any remedial actions necessary to improve the situation shown to be deteriorating in the CQC-led annual 'data sharing' report."*

The Government's response and the reported "progress at 30 September 2014" are set out below:

The DH committed to: "*Work with the professional regulators and defence unions to promote the standards and good practice contained in the review*".	The reported progress: "*Not yet begun*".

CQC committed to:	The reported progress:
"*Agree a Memorandum of Understanding and produce an annual data sharing report with the ICO*".	Achieved
ICO committed to:	The reported progress:
"*Agree a Memorandum of Understanding and produce an annual data sharing report with the CQC*".	'*Achieved. Discussions have begun about the annual data sharing report.*'
Additional Information:	
Assessment: IIGOP welcomes the progress made by CQC and ICO, but is concerned by the lack of wider progress being evidenced.	
Conclusion: **Some progress, but more work required.**	

Progress on Recommendation Twenty Four

Recommendation Twenty Four stated: *"The Review Panel recommends that the Secretary of State publicly supports the redress activities proposed by this review and promulgates actions to ensure that they are delivered."* The Government's response and the reported "progress at 30 September 2014" are set out below:	
ISCG committed to:	The reported progress:
"*Drive implementation activity and monitor progress on all of the actions described in this response*".	HSCIC has established a Caldicott Implementation Monitoring Group, but there have been significant delays in appointing staff. The service has provided limited monitoring support until all resources in place.
Additional Information:	
Assessment: IIGOP notes the progress establishing CIMG and notes that it has not yet had opportunity "to drive implementation".	
Conclusion: **Work in progress.**	

Progress on Recommendation Twenty Five

Recommendation Twenty Five stated: *"The Review Panel recommends that the revised Caldicott principles should be adopted and promulgated throughout the health and social care system."*

The Government's response and the reported "progress at 30 September 2014" are set out below:

DH committed to:	The reported progress:
"*Promote the revised Caldicott principles*	"*The revised Caldicott principles have been promoted through publication of the Government response and the other actions described here*".
All organisations expected to: "*Use the revised Caldicott principles in all relevant information governance material and communications*".	The reported progress: The NHS Development Trust Authority advised that: '*The revised Caldicott principles have informed the review of information governance policies and communication on information sharing, including in guidance to the NHS Trust sector.*'
Leading organisations expected to: "*Welcome the revised Caldicott principles and work the principles into their guidance, training and other work programmes*".	The reported progress: As part of their ongoing commitment the CQC advised that: Re: MOU with ICO: CQC and the ICO have signed an MOU which sets out how they work together and share relevant information about services which both organisations regulate. They will continue to work together to strengthen and review this relationship. The NHS Development Trust Authority advised that: *'They welcomed the revised principles and have worked them into the guidance issued to the NHS Trust sector.'*
ISCG committed to: "Drive implementation activity and monitor progress on all of the actions described in this response."	HSCIC established CIMG.

Additional Information:

NHS England reported: "*Within NHS England's Standard Contract the revised Caldicott principles have been referenced and updated in provisions GC21 and SC23, which have drawn attention to aspects that would benefit from strengthening in order to address the requirements of the Caldicott Review. Specifically, these include:*

- proactive fair processing;
- consent for the use of data where applicable;
- anticipating data management requirements for contract termination;
- Assurance through information governance audit."

Assessment:

IIGOP welcomes the progress made. Efforts need to be maintained.

Conclusion: **Progress has been made, but effort needs to be maintained**.

Progress on Recommendation Twenty Six

Recommendation Twenty Six stated: *"The Secretary of State for Health should maintain oversight of the recommendations from the Information Governance Review and should publish an assessment of the implementation of those recommendations within 12 months of the publication of the review's final report."*

The Government's response and the reported "progress at 30 September 2014" are set out below:

IIGOP committed to:	The reported progress:
"*Report to the Secretary of State on progress annually, with the first report to be one year after publication of this government response*".	IIGOP established and produced this report.
ISCG committed to "Drive implementation activity and monitor progress on all of the actions described in this response."	The reported progress: HSCIC established CIMG
HSCIC committed to: "*Provide a team to support and co-ordinate the implementation of many of the actions in this response*".	The reported progress: HSCIC did establish the arrangements to deliver CIMG, but implementation was significantly delayed.

Additional Information:
Assessment: Despite delays in staffing CIMG, this report has been produced and other issues and concerns addressed by IIGOP.
Conclusion: **After a slow start, good progress has been achieved.**

Progress on Other Commitments & Expectations

Other Commitments & Expectations stated: The Government's response included four commitments and three expectations that are not explicitly linked to specific recommendations in Caldicott 2, but relate to the "Introduction" in that report.

The reported "progress at 30 September 2014" are set out below:

DH committed to *"Set the strategic vision and direction and act as steward of the system to deliver the review's recommendations".*	Reported Progress: *"Following the IG Accountability Review which resulted in the formation of the National Information Board, the governance arrangements for IG are still to be confirmed. It is expected that the strategic direction will be set by the Data Sharing Oversight Group chaired by Will Cavendish (DH) and the stewardship role for its delivery will be taken by the IG Forum (new name for ISCG IG sub-group)".*
DH committed to *"Work with national partners to set the framework for delivery through local organisations".*	The reported progress: *"The framework for delivery is the IG Toolkit. The latest edition of the IG Toolkit (v12) includes the revised Caldicott principles as requirements. In addition, the Department has set up the IG Alliance, in partnership with NHS England and HSCIC to provide a single source of truth for information governance. The Department is also supporting a Private Members Bill that proposes a new duty to share".* NHS England further reported: "*Requirement for guidance and agreement with stakeholders being developed. NHS England is contributing to the IG Alliance which will support this work. Have been working closely with DH in relation to the 5 rules guide for frontline staff.*"

DH committed to *"Routinely include information sharing and information Governance in all its work to improve care".*	Reported progress: *"Information Governance is high on the agenda for many policy teams and programme across the Department including the Integration and Pioneer teams and the BCF team. The IG policy team is working on new guidance (in collaboration with the IG Alliance). The DH internal policies have been updated and reflect the revised Caldicott principles".*
DH committed to: *"Consider what standards and guidance are needed to help people who are organising their own care".*	Reported progress: "Work on this has not yet begun although the Department has sponsored a new information standard for access to record".
DH committed to: *"Work with ADASS and the LGA to ensure that local authority commissioners of adult social care are supported and encouraged to lead the local action required".*	Reported progress: *"While not yet working on a plan of action with LGA and ADASS, the Department is working with Leeds and the local authority CIO council to demonstrate good practice on information governance issues in local government including the adoption of a local government version of the IG toolkit".*
All staff expected to: *"Look at information governance best practice and how it affects their work."*	
All organisations expected to: "Examine their existing arrangements, and lead by example with their local partners to make it easier to share information".	
Additional Information: As part of their commitment HSCIC advised: "*Their staff expected to: "Be aware that the duty to safeguard children or vulnerable adults may mean that information should be shared, if it is in the public interest to do so, even without consent".* *CIMG report:* *CIMG is in direct contact with over 50 national and local health and social care organisations that are reporting their implementation of C2 on a regular basis. The reporting is also subject to external independent assurance and verification. Over the coming 3 months, the CIMG will be extending its role in social care, attending local and national IG leads meetings and working with colleagues in the HSCIC to develop a web based collection tool. CIMG has submitted regular reports to IIGOP and has submitted its first report to form the basis of the first annual report from IIGOP to the Secretary of State (Health).*	

In addition, the HSCIC is hosting the newly launched Information Governance alliance (the IGA) that was set up in July 2014 in response to a request from the Independent Information Governance Oversight Panel (IIGOP) and its Chair, Dame Fiona Caldicott, that there should be a single authoritative source of information and guidance for the health and care sector. The primary aim is to help 'improve the quality of health and care services including people's experience of the services received' by enabling appropriate information sharing'. The IGA is a collaboration between the HSCIC, the Department of Health, NHS England and Public Health England (defined as the core members with responsibility for providing a resource). It is anticipated that other (non-core) members will join the IG Alliance over time and contribute resource, knowledge and expertise. The IGA is considering introducing a form of kite-marking on products, developing a library of resources as well as an assurance and co-ordinating the development of related products.

The IGA secondary aims are to improve information governance in health and social care by:

- *Providing a single authoritative source of information and guidance*
- *Providing support to front line staff, managers and their organisations to help them handle personal information confidently and in the best interests of people who use their services*
- *Developing the capacity and capability of the information governance profession by providing expert advice and a knowledge sharing network."*

NOTE: CIMG has gathered evidence from a significant number of health trusts and some local authorities which tends to confirm that committed organisations are making progress locally with delivering on expectations on the local health and care community, but have been challenged by the slow delivery of some key "building blocks" including terminology, advice on direct care and models of consent and objections.

Assessment:

Overall the health and social care system has made progress on delivering on the recommendations and conclusions of Caldicott2.

The system has had to face significant challenges which have limited progress in many recommendations to date, but there are some promising signs that make us hopeful of greater success in the coming year.

Conclusion: **The overall conclusion is that the system should have done better**.

Annex 2: Summary gap analysis — Caldicott2 Recommendations and the Government Response

Purpose

This annex sets out a Gap Analysis of the difference between the Caldicott2 Recommendations and the Government's response (Commitments and Expectations). It was undertaken to inform discussions on conclusions and recommendations for the IIGOP report, "The First Year."

It should be noted that this exercise required a subjective judgement, intended to assist discussion rather than provide definitive assessments.

Table A: Summary of findings

The proposed commitments are not sufficient meet the recommendation	The proposed commitments will assist in delivering the recommendation but are not sufficient to deliver the recommendations without additional action(s).	The proposed commitments are capable of delivering the spirit of the recommendation, or deliver the recommendation in full.
Audit trail (1)	Relying on implied consent (3)	Board level responsibility (12)
NICE Guideline 138 (2)	Explanation and apologies for breaches (5)	Health service regulations extended (13)
Sharing within the multi-disciplinary care team (4)	Data breaches – standard severity scale (6)	Data controller to data controller template (20)
Organisations explaining use of data for indirect care (7)	Consent decisions reliably recorded (8)	Single set of terms and definitions (22)
Accredited Safe Havens (ASH) (10)	Constitution extended to cover social care (9)	3 components of effective regulation(23)
Publishing fair processing information (19)	Code of Practice(CoP) right to object (11)	SoS public support for redress activities (24)
	Training and professional development (14)	Caldicott Principles promulgated (25)
	Caldicott Guardians for all (15)	
	Art 8 and family records (16)	

	Virtual consultations/ medical devices - best practice (17)	
	Single approach to recording information about the unborn (18)	
	CoP adopting good practice and standards (21)	
	SoS maintain oversight of implementation of recommendations and (26)	

Table B: Mapping between C2 recommendations and Government Response

C2 Recommendation	Addressed by Gov. response	Lead Organisation	Comments/ Assessment
Introduction	1 Set the strategic vision and direction and act as steward of the system to deliver the review's recommendations.	DH	The commitments presented here underpin the ability of the system to deliver on the recommendations.
Introduction	2 Work with national partners to set the framework for delivery through local organisations.	DH	
Introduction	3 Routinely include information sharing and information governance in all its work to improve care.	DH	
Introduction	4 Consider what standards and guidance are needed to help people who are organising their own care.	DH	

44

Introduction	5 Work with ADASS and the LGA to ensure that local authority commissioners of adult social care are supported and encouraged to lead the local action required.	DH	
Introduction	31 Be aware that the duty to safeguard children or vulnerable adults may mean that information should be shared, if it is in the public interest to do so, even without consent.	All Staff	
Introduction	32 Look at information governance best practice and how it affects their work.	All Staff	
Introduction	33 Examine their existing arrangements, and lead by example with their local partners to make it easier to share information.	All Organisations	
1	6 Work with partner organisations to consider how electronic access might be extended to care records outside the NHS.	DH	These commitments do not directly address the recommendation and are not sufficient to deliver the recommendation.
1	7 Commission an options analysis to determine whether audit trails are the best approach.	DH	
1	73 Lead work on electronic access to health records.	NHS England	

2	8 Take the revised Caldicott principles into consideration when reviewing the CQC regulations.	DH	It’s not clear what the outputs are or how these commitments will address this recommendation. This could be amber if the relevance of alternatives is evidenced.
2	9 Include the recommendation on the use of NICE Clinical Guideline 138 in the ongoing work with the bodies who provide guidance and best practice advice to local authorities and to care providers and regulators and professional bodies.	DH	
2	34 Expect that relevant personal confidential data is shared among the registered and regulated health and social care professionals who have a legitimate relationship with the individual.	All Organisations	
2	46 Audit their information sharing practices in adult NHS services against NICE Clinical Guideline 138.	Local NHS Providers	
2	47 Use the NICE Quality Standard 15 in commissioning and monitoring adult NHS services (in relation to information sharing).	Local Commissioners	
2	72 Work together with Trade Union Partners through the National and Regional Social Partnership Forums to identify areas of good practice which can inform future development work starting with a joint workshop with NHS England and Social Partnership Forum partners in September 2013.	NHS Employers	

3	10 Commission the Professional Standards Authority to work with other organisations to ensure that all health and social care professional regulators publish consistent guidance that reflects the messages in the HSCIC's Confidentiality Code of Practice.	DH	The "agree" element is missing and outcomes not clear but should contribute to achieving the recommendation.
4	50 Take action to establish the right conditions for improved sharing.	Leading National Organisations	Care Team not defined. The IGTK actions not sufficient to engage wider social care. Actions by NHS E open to wide interpretation. Overall expectations too vague to ensure delivery of recommendation.
4	66 Consider how best to support the extension of the Information Governance Toolkit across local authorities.	ISCG	
4	74 Give a clear steer to commissioners of care on the need to monitor provider information governance performance through using a variety of mechanisms, and to take account of the findings of inspection reports published by the CQC where poor information sharing practice has been identified.	NHS England	

2, 4	56 The evolving approach to information governance monitoring work will focus on how well information is used and shared to support delivery of good quality care and ensure that it can assess the effectiveness of information sharing in different settings and pathways of care.	CQC	Should contribute to achieving recommendations.
5	11 Work with the social care, public health and research sectors to support them in any specific local actions relating to reported data breaches.	DH	Duty of candour meets the spirit. Other expectations and commitments are not underpinned by any new guidance. “failure to share” as a breach is not explicit.
5	35 Seek advice from the ICO and refer to the HSCIC’s Confidentiality Code of Practice for further advice on managing and reporting data breaches.	All Organisations	
5	36 Explain and apologise for every personal data breach, with appropriate action agreed to prevent recurrence.	All Organisations	
5	76 Include data breaches in scope for the duty of candour including in any monitoring and reporting.	NHS England	

6	12 Ask CIPFA and SOLACE to include a reference to publishing data breaches when next updating their guidance Annual Governance Statements.	DH	The incident reporting mechanism meets DPA reporting requirements, but does not fully reflect C2. Asking various organisations to "consider this recommendation when next updating their guidance" is not strong enough. It lacks appropriate definition of a data breach).
6	13 Work with local authorities to encourage them to publish details of incidents.	DH	
6	14 Ask the Leeds project to include incident reporting in its work.		
6	48 Investigate, manage, report and publish personal data breaches and ensure that commissioned bodies are investigated, managed, reported and published appropriately.	Local Commissioners	
6	71 When they next update their requirements for foundation trusts' annual reports, consider including a requirement to publish all data breaches.	Monitor	
6	77 When they next update their requirements for Quality Accounts, consider including a requirement to publish all data breaches.	NHS England	

6	84 When they next update their requirements for trusts’ annual reports, consider including a requirement to publish all data breaches.	NHS Trust Development Authority	
7	37 Clearly explain to patients and the public how the personal information they collect could be used in de-identified form for research, audit, public health and other purposes.	All Organisations	Although the onus is on all organisations, it needs to be underpinned by common language and understanding relating to consent management, and rights to object under non consent based legal gateways. These expectations will not, of themselves, deliver the recommendation.
7	38 Make clear what rights the individual has open to them, including any ability to actively dissent.	All Organisations	
7	63 Support ongoing work by others to ensure that a clear and easily understandable message on how their information is used is delivered to patients, people who use care and support and the wider public.	ICO	
8	15 Work with NHS England to develop a consent management standard, consider how best to enable implementation of mechanisms for sharing the decisions of individuals between different systems and recommend to the ISCG that these standards are considered a priority.	DH	It is not clear that such a standard would include the necessary guidance envisaged in the recommendation.
8	78 Include the proposed new standard on consent management within the Technology Strategy, due to be published in December 2013.	NHS England	

9	16 Work with the adult social care sector to consider how, where they do not already exist, the rights, pledges and duties of the NHS Constitution might be extended to the adult social care system.	DH	Although these commitments are welcomed, they do not directly address the extension to the "whole system". The challenge is one of leadership to the system.
9	64 Support work to increase awareness among patients and the public about the existence of the NHS Constitution and what it contains.	ICO	
10	17 Lead work to confirm the challenges to be overcome and the options for consideration in relation to commissioners' access to personal confidential data – across the NHS, public health and research.	DH	The commitments are positive contributions towards achieving the recommendations.
10	55 Provide additional guidance on the website to applicants who are intending to seek approval under Section 251 to use personal confidential data.	CAG-HRA	
10	67 Consider the establishment of accredited safe havens.	ISCG	
10	79 Review the intelligence requirements for NHS commissioners' access to personal confidential data, identify options to meet these data needs and, where alternatives to using personal confidential data cannot be found, work with the Department to identify options that could satisfy these requirements.	NHS England	

11	51 Have regard to the HSCIC's Confidentiality Code of Practice and promote the Code of Practice and the objection details to employers and organisations.	Leading National Organisations	Although care.data provides a positive focus for work related to this recommendation, it is essential that a whole system outcome is sought. This is not clear from the commitments.
11	54 With NHS England, explore reasons for abnormal number of objections to sharing of information with *care.data*.	BMA	
11	60 Monitor the rate of objections to the sharing of information with the new *care.data* service.	HSCIC	
11	80 With BMA, explore reasons for abnormal number of objections to sharing of information with care.data.	NHS England	
12	18 Ask delivery partners such as Skills for Care and the National Skills Academy to ensure that their products support the appropriate application of information governance.	DH	The range of commitments and expectations addresses the spirit of the recommendation. However, it is far from clear that the current version of the IG Toolkit is fully conformant with C2, and has appropriate version(s) for all social care providers.
12	39 Use the best practice contained in the HSCIC's Confidentiality Code of Practice when reviewing their information governance practices to ensure that they adhere to the required standards.	All Organisations	
12	40 That social care providers use the Information Governance Toolkit.	All Organisations	

12	49 Implement appropriate arrangements in relation to information governance including the demonstration of strong leadership on information governance and adopt information governance procedures that are equivalent to those already established by healthcare providers.	Local Commissioners	
12	57 Use the HSCIC's Confidentiality Code of Practice to inform its monitoring plans for information governance.	CQC	
12	61 Build new requirements into the next release of the toolkit to cover the relevant aspects of the issues in recommendation 12.	HSCIC	
12	81 Require NHS commissioning organisations to provide reassurance on recommendation 12 and to publish findings.	NHS England	
12	83 Include the new duty to share in guidance for NHS boards and Top Leaders Programme.	NHS Leadership Academy	
13	19 Lead a review into whether public health activity should have further statutory support to process confidential personal information where alternative arrangements are insufficient.	DH	Relates to the spirit of the recommendation.

14	20 Work with The College of Social Work and Higher Education Institutes to ensure that social work qualifying courses contain the most up-to-date legal requirements and best practice.	DH	The commitments are important, but not sufficient to deliver the recommendation. We recognise that the culture shift will take time, but this needs concerted leadership to ensure a firm basis for the future.
14	21 Work with Skills for Care to ensure that appropriate training is available for social care workers.	DH	
14	53 Include information governance in reviews of curricula for postgraduate training.	AMRC	
15	22 Undertake further work to support the appointment, training and development of Caldicott Guardians in social care and local government and research.	DH	The "all organisations" envisaged in the recommendation is wider than traditional views of the system.
15	41 Appoint a Caldicott Guardian or Caldicott lead with access to appropriate training and support.	All Organisations	Not clear how DH intend to deliver their "recommendation" other than through the Government Response.
15	42 Local authorities consider extending Caldicott Guardian arrangements to children's services.	All Organisations	
15	43 Strengthen their leadership on information governance.	All Organisations	
16	23 Work with the Department for Education and others to see whether there is a need to develop an approach to identifying and tackling bad practice.	DH	The focus of the recommendation was not "bad practice", nor exclusively focussed on the child, but rather, the different legal basis, and hence guidance, for family records.

16	24 Work with the Department for Education and others to ensure that appropriate arrangements for assessing the risk to a child are established.	DH	
17	26 Explore what might be offered to support commissioners of social care for those offering virtual consultations and for medical devices used for biometric monitoring.	DH	Basis for commissioners of social care be offering virtual consultations unclear. NHS commitment will contribute to meeting this recommendation, but does not of itself ensure that recommendation is delivered.
17	82 Develop guidance for those offering virtual consultations and utilising devices and holding personal confidential data, for example for remote telemonitoring on health matters.	NHS England	
18	25 Develop and implement an agreed approach to recording information about the unborn.	DH	It is not clear how this approach is to be developed, or the issues to be addressed. It is worth noting that since C2, when issue arose from different social care and health care practices, the health research community has indicated that not being able to identify foetus is impairing research e.g. monitoring drug regimens during pregnancy.

19	44 Ensure that the information provided to inform citizens about how their information is used does not exclude disadvantaged groups.	All Organisations	This does not address the specific recommendation to publish: • a description of the personal confidential data they disclose; • a description of the de-identified data they disclose on a limited basis; • who the disclosure is to; and • the purpose of the disclosure.
20	68 Commission work to produce a data sharing agreement template.	ISCG	The commitment, if delivered, will meet the recommendation.
21	No commitments		It is in the Confidentiality Guide
22	27 Ask leading organisations to extend the use of the glossary (once agreed) across the health and care system.	DH	When the commitments are realised, the recommendation will be met.
22	69 Agree a single set of terms for information governance and consider whether it should be adopted as a standard.	ISCG	
23	28 Work with the professional regulators and defence unions to promote the standards and good practice contained in the review.	DH	The commitments should deliver at least the spirit of the recommendation.
23	58 Agree a Memorandum of Understanding and produce an annual data sharing report with the ICO.	CQC	

23	65 Agree a Memorandum of Understanding and produce an annual data sharing report with the CQC.	ICO	
24, 26	70 Drive implementation activity and monitor progress on all of the actions described in this response.	ISCG	Although the commitment is expressed in vague terms, the actual actions to date have been positive.
25	29 Promote the revised Caldicott principles.	DH	The commitments are appropriate to deliver the recommendations.
25	45 Use the revised Caldicott principles in all relevant information governance material and communications.	All Organisations	
25	52 Welcome the revised Caldicott principles and work the principles into their guidance, training and other work programmes.	Leading National Organisations	
26	30 Report to the Secretary of State on progress annually, with the first report to be one year after publication of this government response.	IIGOP	The gaps identified in this exercise mean that the initial basis for the recommendation cannot be fully met. However, subsequent actions have been positive in terms of Secretary of State engagement and commitment.
26	62 Provide a team to support and co-ordinate the implementation of many of the actions in this response.	HSCIC	
4, 12, 15	75 Include actions to take the Caldicott recommendations forward, for example in work on the CCG Assurance Framework and the Standard Contract.	NHS England	See 4, 12 & 15 above

14, 22	59 Work with professional regulators and education institutions to incorporate the revised Caldicott principles, a single set of terms and definitions and good practice into curricula and work relating to bands 1–4 and other staff.	HEE	See 14 and 22 above.
24, 26	70 Drive implementation activity and monitor progress on all of the actions described in this response.	ISCG	See 24, 26 above

Annex 3: Information Governance Toolkit — Comparison of V10 data with V11 data for a sample of sectors

The analysis has focussed on the six groups of requirements in the IGTK for the following organisation type views: (of the 25 current and 4 archived views)

- General Practices
- Care Commissioning Groups & Contract Support Units
- Commercial Third Parties
- Community Health Providers
- Acute Trusts

The groups of requirements are:

- Information Governance Management
- Confidentiality and Data Protection Assurance
- Information Security Assurance
- Clinical Information Assurance
- Secondary Use Assurance
- Corporate Information Assurance

The initial analysis is presented in below. Care needs to be taken in interpreting the results for several reasons including:

- Minor changes to the toolkit itself.
- The toolkit is a self-assessment tool, not an independent audit.
- The numbers of organisations completing the toolkit (for example 8507 GP practices made returns for V10, whilst only 5894 made returns for V11).
- The number of requirements for which the returns were blank are, in some circumstances, significant (for example for GPs V10, there were an average of 2691 blanks for Information Governance Management requirements. However the V11 report has no blanks).
- Different settings do not have requirements for all six groups of requirements (for example GPs only report on 13 requirements covering only three of the groups, whereas CHPs have 39 requirements covering all six groups).

In theory, the different number of requirements and groups of requirements is intended to reflect the functions of the different settings. However it is not clear why GPs do not have any requirements relating to Clinical Information Assurance or secondary Use Assurance. It is more understandable that, at least for small GP practices, the Corporate Information Assurance is not a feature.

NOTE: For the tables that follow the reference numbers of the form 10-114, 10-115 etc. re references to specific ‘requirements’ in the IGTK. Column headings L0, L1, L2, L3 relate to the level of “achievement” against the requirements.[1]

[1] Further information at https://www.igt.hscic.gov.uk/

General Practice Information

IGTK V10 — Self Assessment Scores — GPs															
		8507 organisations													
		L0	%	L1	%	L2	%	L3	%	Blanks	%	NRs	%	EX	%
Information Governance Management	10-114	15.0	0.2	37.0	0.4	3288.0	38.7	2484.0	29.2	2683.0	31.5	0.0	0.0	0.0	0.0
	10-115	16.0	0.2	9.0	0.1	2945.0	34.6	2850.0	33.5	2687.0	31.6	0.0	0.0	0.0	0.0
	10-116	15.0	0.2	16.0	0.2	2888.0	33.9	2891.0	34.0	2697.0	31.7	0.0	0.0	0.0	0.0
	10-117	10.0	0.1	36.0	0.4	3392.0	39.9	2372.0	27.9	2697.0	31.7	0.0	0.0	0.0	0.0
Average		14.0	0.2	24.5	0.3	3128.3	36.8	2649.3	31.1	2691.0	31.6	0.0	0.0	0.0	0.0
Confidentiality and Data Protection Assurance	10-211	9.0	0.1	17.0	0.2	3233.0	38.0	2553.0	30.0	2695.0	31.7	0.0	0.0	0.0	0.0
	10-212	7.0	0.1	9.0	0.1	3909.0	46.0	1878.0	22.1	2704.0	31.8	0.0	0.0	0.0	0.0
	10-213	10.0	0.1	55.0	0.6	4023.0	47.3	1718.0	20.2	2701.0	31.8	0.0	0.0	0.0	0.0
Average		8.7	0.1	27.0	0.3	3721.7	43.7	2049.7	24.1	2700.0	31.7	0.0	0.0	0.0	0.0
Information Security Assurance	10-304	15.0	0.2	30.0	0.4	3171.0	37.3	2502.0	29.4	2712.0	31.9	77.0	0.9	0.0	0.0
	10-316	12.0	0.1	46.0	0.5	2460.0	28.9	3283.0	38.6	2706.0	31.8	0.0	0.0	0.0	0.0
	10-317	18.0	0.2	29.0	0.3	2789.0	32.8	2962.0	34.8	2709.0	31.8	0.0	0.0	0.0	0.0
	10-318	61.0	0.7	49.0	0.6	3307.0	38.9	2296.0	27.0	2720.0	32.0	0.0	0.0	74.0	0.9
	10-319	15.0	0.2	39.0	0.5	3424.0	40.2	2314.0	27.2	2715.0	31.9	0.0	0.0	0.0	0.0
	10-320	8.0	0.1	19.0	0.2	2784.0	32.7	2983.0	35.1	2713.0	31.9	0.0	0.0	0.0	0.0
Average		21.5	0.3	35.3	0.4	2989.2	35.1	2723.3	32.0	2712.5	31.9	12.8	0.2	12.3	0.1

IGTK V11 — Self Assessment Scores — GPs															
5894 organisations (BUT NO BLANKS INCLUDED IN THE REPORT)															
		L0	%	L1	%	L2	%	L3	%	Blanks	%	NRs	%	EX	%
Information Governance Management	10-114	6.0	0.1	22.0	0.3	3903.0	45.9	1962.0	23.1	0.0	0.0	0.0	0.0	0.0	0.0
	10-115	9.0	0.1	5.0	0.1	3534.0	41.5	2345.0	27.6	0.0	0.0	0.0	0.0	0.0	0.0
	10-116	7.0	0.1	5.0	0.1	3626.0	42.6	2255.0	26.5	0.0	0.0	0.0	0.0	0.0	0.0
	10-117	4.0	0.0	16.0	0.2	3852.0	45.3	2021.0	23.8	0.0	0.0	0.0	0.0	0.0	0.0
Average		6.5	0.1	12.0	0.1	3728.8	43.8	2145.8	25.2	0.0	0.0	0.0	0.0	0.0	0.0
Confidentiality and Data Protection Assurance	10-211	6.0	0.1	7.0	0.1	3744.0	44.0	2136.0	25.1	0.0	0.0	0.0	0.0	0.0	0.0
	10-212	3.0	0.0	7.0	0.1	4221.0	49.6	1662.0	19.5	0.0	0.0	0.0	0.0	0.0	0.0
	10-213	4.0	0.0	25.0	0.3	4302.0	50.6	1562.0	18.4	0.0	0.0	0.0	0.0	0.0	0.0
Average		4.3	0.1	13.0	0.2	4089.0	48.1	1786.7	21.0	0.0	0.0	0.0	0.0	0.0	0.0
Information Security Assurance	10-304	5.0	0.1	18.0	0.2	3760.0	44.2	2045.0	24.0	0.0	0.0	65.0	0.8	0.0	0.0
	10-316	6.0	0.1	23.0	0.3	3409.0	40.1	2455.0	28.9	0.0	0.0	0.0	0.0	0.0	0.0
	10-317	10.0	0.1	9.0	0.1	3548.0	41.7	2326.0	27.3	0.0	0.0	0.0	0.0	0.0	0.0
	10-318	7.0	0.1	23.0	0.3	3840.0	45.1	1607.0	18.9	0.0	0.0	416.0	4.9	0.0	0.0
	10-319	6.0	0.1	18.0	0.2	3901.0	45.9	1968.0	23.1	0.0	0.0	0.0	0.0	0.0	0.0
	10-320	1.0	0.0	12.0	0.1	3465.0	40.7	2415.0	28.4	0.0	0.0	0.0	0.0	0.0	0.0
Average		5.8	0.1	17.2	0.2	3653.8	43.0	2136.0	25.1	0.0	0.0	80.2	0.9	0.0	0.0

For General Practices the following judgements may be made for the changes in information governance practice between V10 and V11 of the toolkit.

- Information Governance Management: the % on the lowest two bands fell from 0.5% to 0.2% of the returns
- Confidentiality and Data Protection Assurance: the % on the highest two bands had increased from 67.8% to 69.1%
- Information Security Assurance: the % on the highest two bands had increased from 67.1 to 68.1%
- These changes suggest a slight improvement, but the significant reduction in total number of practices and the lack of blank returns in V11 raises questions about the reliability of the data.

Care Commissioning Groups & Contract Support Units

IGTK V10 — Self Assessment Scores — CCGs and CSUs													
		267 organisations											
		L0	%	L1	%	L2	%	L3	%	Blanks	%	NRs	%
Information Governance Management	10-101	0.0	0.0	2.0	0.7	6.0	2.2	0.0	0.0	259.0	97.0	0.0	0.0
	10-105	0.0	0.0	3.0	1.1	4.0	1.5	1.0	0.4	259.0	97.0	0.0	0.0
	10-110	0.0	0.0	2.0	0.7	4.0	1.5	0.0	0.0	261.0	97.8	0.0	0.0
	10-111	0.0	0.0	2.0	0.7	4.0	1.5	0.0	0.0	261.0	97.8	0.0	0.0
	10-112	0.0	0.0	4.0	1.5	2.0	0.7	0.0	0.0	261.0	97.8	0.0	0.0
	10-130	20.0	7.5	30.0	11.2	122.0	45.7	12.0	4.5	81.0	30.3	0.0	0.0
	10-131	37.0	13.9	37.0	13.9	97.0	36.3	13.0	4.9	81.0	30.3	0.0	0.0
	10-132	34.0	12.7	39.0	14.6	106.0	39.7	4.0	1.5	82.0	30.7	0.0	0.0
	10-133	34.0	12.7	39.0	14.6	108.0	40.4	2.0	0.7	82.0	30.7	0.0	0.0
	10-134	31.0	11.6	48.0	18.0	100.0	37.5	4.0	1.5	82.0	30.7	0.0	0.0
Average		**15.6**	5.8	**20.6**	7.7	**55.3**	20.7	**3.6**	1.3	**170.9**	64.0	**0.0**	0.0
Confidentiality and Data Protection Assurance	10-200	0.0	0.0	4.0	1.5	2.0	0.7	0.0	0.0	261.0	97.8	0.0	0.0
	10-201	0.0	0.0	2.0	0.7	4.0	1.5	0.0	0.0	261.0	97.8	0.0	0.0
	10-202	0.0	0.0	3.0	1.1	2.0	0.7	1.0	0.4	261.0	97.8	0.0	0.0
	10-203	0.0	0.0	3.0	1.1	3.0	1.1	2.0	0.7	261.0	97.8	0.0	0.0
	10-205	0.0	0.0	2.0	0.7	4.0	1.5	0.0	0.0	261.0	97.8	0.0	0.0
	10-206	1.0	0.4	3.0	1.1	2.0	0.7	1.0	0.4	261.0	97.8	0.0	0.0
	10-207	0.0	0.0	3.0	1.1	2.0	0.7	1.0	0.4	261.0	97.8	0.0	0.0
	10-209	0.0	0.0	1.0	0.4	0.0	0.0	0.0	0.0	261.0	97.8	4.0	1.5
	10-210	0.0	0.0	3.0	1.1	2.0	0.7	1.0	0.4	261.0	97.8	0.0	0.0
	10-230	34.0	12.7	28.0	10.5	113.0	42.3	8.0	3.0	82.0	30.7	0.0	0.0
	10-231	34.0	12.7	40.0	15.0	108.0	40.4	1.0	0.4	82.0	30.7	0.0	0.0
	10-232	35.0	13.1	34.0	12.7	114.0	42.7	0.0	0.0	82.0	30.7	0.0	0.0
	10-233	44.0	16.5	43.0	16.1	94.0	35.2	2.0	0.7	82.0	30.7	0.0	0.0
	10-234	34.0	12.7	33.0	12.4	115.0	43.1	1.0	0.4	82.0	30.7	0.0	0.0
	10-235	45.0	16.9	32.0	12.0	102.0	38.2	4.0	1.5	82.0	30.7	0.0	0.0
	10-236	15.0	5.6	17.0	6.4	44.0	16.5	0.0	0.0	82.0	30.7	107.0	40.1
	10-237	43.0	16.1	45.0	16.9	94.0	35.2	1.0	0.4	82.0	30.7	0.0	0.0
Average		**16.7**	**6.3**	**17.6**	**6.6**	**47.8**	**17.9**	**1.5**	**0.6**	**176.4**	**66.1**	**6.2**	**2.3**

		L0	%	L1	%	L2	%	L3	%	Blanks	%	NRs	%
Information Security Assurance	10-300	2.0	0.7	0.0	0.0	4.0	1.5	0.0	0.0	261.0	97.8	0.0	0.0
	10-301	1.0	0.4	4.0	1.5	2.0	0.7	0.0	0.0	260.0	97.4	0.0	0.0
	10-302	1.0	0.4	3.0	1.1	2.0	0.7	1.0	0.4	261.0	97.8	0.0	0.0
	10-303	1.0	0.4	2.0	0.7	3.0	1.1	1.0	0.4	261.0	97.8	0.0	0.0
	10-304	0.0	0.0	2.0	0.7	4.0	1.5	0.0	0.0	261.0	97.8	0.0	0.0
	10-305	0.0	0.0	2.0	0.7	4.0	1.5	0.0	0.0	261.0	97.8	0.0	0.0
	10-307	0.0	0.0	3.0	1.1	2.0	0.7	1.0	0.4	261.0	97.8	0.0	0.0
	10-308	0.0	0.0	3.0	1.1	2.0	0.7	1.0	0.4	261.0	97.8	0.0	0.0
	10-309	1.0	0.4	3.0	1.1	2.0	0.7	1.0	0.4	261.0	97.8	0.0	0.0
	10-310	1.0	0.4	2.0	0.7	4.0	1.5	0.0	0.0	261.0	97.8	0.0	0.0
	10-311	0.0	0.0	1.0	0.4	3.0	1.1	1.0	0.4	262.0	98.1	0.0	0.0
	10-313	0.0	0.0	1.0	0.4	3.0	1.1	1.0	0.4	262.0	98.1	0.0	0.0
	10-314	0.0	0.0	2.0	0.7	4.0	1.5	0.0	0.0	262.0	98.1	0.0	0.0
	10-323	0.0	0.0	1.0	0.4	3.0	1.1	1.0	0.4	262.0	98.1	0.0	0.0
	10-324	0.0	0.0	1.0	0.4	4.0	1.5	0.0	0.0	262.0	98.1	0.0	0.0
	10-340	39.0	14.6	29.0	10.9	113.0	42.3	3.0	1.1	81.0	30.3	0.0	0.0
	10-341	45.0	16.9	44.0	16.5	95.0	35.6	0.0	0.0	81.0	30.3	0.0	0.0
	10-342	21.0	7.9	7.0	2.6	88.0	33.0	1.0	0.4	79.0	29.6	69.0	25.8
	10-343	24.0	9.0	19.0	7.1	99.0	37.1	0.0	0.0	79.0	29.6	44.0	16.5
	10-344	38.0	14.2	36.0	13.5	108.0	40.4	1.0	0.4	82.0	30.7	0.0	0.0
	10-345	33.0	12.4	56.0	21.0	93.0	34.8	1.0	0.4	82.0	30.7	0.0	0.0
	10-346	53.0	19.9	48.0	18.0	80.0	30.0	2.0	0.7	82.0	30.7	0.0	0.0
	10-347	39.0	14.6	27.0	10.1	116.0	43.4	1.0	0.4	82.0	30.7	0.0	0.0
	10-348	35.0	13.1	41.0	15.4	106.0	39.7	0.0	0.0	83.0	31.1	0.0	0.0
	10-349	25.0	9.4	48.0	18.0	109.0	40.8	1.0	0.4	82.0	30.7	0.0	0.0
	10-350	62.0	23.2	32.0	12.0	89.0	33.3	0.0	0.0	82.0	30.7	0.0	0.0
	10-351	46.0	17.2	37.0	13.9	100.0	37.5	0.0	0.0	82.0	30.7	0.0	0.0
	10-352	60.0	22.5	45.0	16.9	78.0	29.2	0.0	0.0	82.0	30.7	0.0	0.0
Average		**18.8**	**7.0**	**17.8**	**6.7**	**47.1**	**17.7**	**0.6**	**0.2**	**177.8**	**66.6**	**4.0**	**1.5**

		L0	%	L1	%	L2	%	L3	%	Blanks	%	NRs	%
Clinical Information Assurance	10-400	1.0	0.4	2.0	0.7	3.0	1.1	1.0	0.4	262.0	98.1	0.0	0.0
	10-401	0.0	0.0	0.0	0.0	4.0	1.5	0.0	0.0	262.0	98.1	0.0	0.0
	10-402	1.0	0.4	1.0	0.4	2.0	0.7	0.0	0.0	262.0	98.1	0.0	0.0
	10-404	2.0	0.7	0.0	0.0	3.0	1.1	1.0	0.4	262.0	98.1	0.0	0.0
	10-406	1.0	0.4	2.0	0.7	2.0	0.7	0.0	0.0	262.0	98.1	0.0	0.0
	10-420	42.0	15.7	23.0	8.6	112.0	41.9	6.0	2.2	82.0	30.7	0.0	0.0
	10-421	76.0	28.5	24.0	9.0	81.0	30.3	1.0	0.4	82.0	30.7	0.0	0.0
Average		**17.6**	**6.6**	**7.4**	**2.8**	**29.6**	**11.1**	**1.3**	**0.5**	**210.6**	**78.9**	**0.0**	**0.0**
Secondary Use Assurance	10-501	0.0	0.0	2.0	0.7	3.0	1.1	1.0	0.4	262.0	98.1	0.0	0.0
	10-502	1.0	0.4	2.0	0.7	3.0	1.1	1.0	0.4	262.0	98.1	0.0	0.0
	10-504	0.0	0.0	3.0	1.1	2.0	0.7	1.0	0.4	262.0	98.1	0.0	0.0
	10-515	0.0	0.0	2.0	0.7	3.0	1.1	1.0	0.4	262.0	98.1	0.0	0.0
Average		**0.3**	**0.1**	**2.3**	**0.8**	**2.8**	**1.0**	**1.0**	**0.4**	**262.0**	**98.1**	**0.0**	**0.0**
Corporate Information Assurance	10-601	0.0	0.0	3.0	1.1	2.0	0.7	1.0	0.4	262.0	98.1	0.0	0.0
	10-603	0.0	0.0	2.0	0.7	2.0	0.7	0.0	0.0	262.0	98.1	1.0	0.4
	10-604	1.0	0.4	3.0	1.1	2.0	0.7	1.0	0.4	262.0	98.1	0.0	0.0
Average		**0.3**	**0.1**	**2.7**	**1.0**	**2.0**	**0.7**	**0.7**	**0.2**	**262.0**	**98.1**	**0.3**	**0.1**

IGTK V11 — Self Assessment Scores — CCGs and CSUs														
227 organisations														
		L0	%	L1	%	L2	%	L3	%	Blanks	%	NRs	%	EX
Information Governance Management	10-101	0	0.0	0	0.0	10	4.4	8	3.5	209	92.1	0	0.0	0
	10-105	0	0.0	0	0.0	10	4.4	8	3.5	209	92.1	0	0.0	0
	10-110	0	0.0	0	0.0	16	7.0	2	0.9	209	92.1	0	0.0	0
	10-111	0	0.0	0	0.0	10	4.4	8	3.5	209	92.1	0	0.0	0
	10-112	0	0.0	0	0.0	11	4.8	7	3.1	209	92.1	0	0.0	0
	10-130	0	0.0	0	0.0	137	60.4	72	31.7	18	7.9	0	0.0	0
	10-131	0	0.0	0	0.0	152	67.0	57	25.1	18	7.9	0	0.0	0
	10-132	0	0.0	2	0.9	182	80.2	25	11.0	18	7.9	0	0.0	0
	10-133	0	0.0	1	0.4	179	78.9	29	12.8	18	7.9	0	0.0	0
	10-134	0	0.0	4	1.8	186	81.9	19	8.4	18	7.9	0	0.0	0
Average		**0.0**	0.0	**0.7**	0.3	**89.3**	39.3	**23.5**	10.4	**113.5**	50.0	**0.0**	0.0	**0.0**
Confidentiality and Data Protection Assurance	10-200	0	0.0	0	0.0	9	4.0	9	4.0	209	92.1	0	0.0	0
	10-201	0	0.0	0	0.0	16	7.0	2	0.9	209	92.1	0	0.0	0
	10-202	0	0.0	0	0.0	17	7.5	1	0.4	209	92.1	0	0.0	0
	10-203	0	0.0	0	0.0	17	7.5	1	0.4	209	92.1	0	0.0	0
	10-205	0	0.0	0	0.0	16	7.0	2	0.9	209	92.1	0	0.0	0
	10-206	0	0.0	0	0.0	14	6.2	4	1.8	209	92.1	0	0.0	0
	10-207	0	0.0	0	0.0	15	6.6	1	0.4	209	92.1	0	0.0	2
	10-209	0	0.0	0	0.0	8	3.5	2	0.9	209	92.1	8	3.5	0
	10-210	0	0.0	0	0.0	17	7.5	1	0.4	209	92.1	0	0.0	0
	10-230	0	0.0	0	0.0	169	74.4	40	17.6	18	7.9	0	0.0	0
	10-231	0	0.0	2	0.9	206	90.7	1	0.4	18	7.9	0	0.0	0
	10-232	0	0.0	1	0.4	206	90.7	2	0.9	18	7.9	0	0.0	0
	10-233	0	0.0	1	0.4	194	85.5	14	6.2	18	7.9	0	0.0	0
	10-234	0	0.0	3	1.3	182	80.2	24	10.6	18	7.9	0	0.0	0
	10-235	0	0.0	1	0.4	106	46.7	4	1.8	18	7.9	98	43.2	0
	10-236	0	0.0	4	1.8	192	84.6	13	5.7	18	7.9	0	0.0	0
	10-237	0	0.0	1	0.4	200	88.1	8	3.5	18	7.9	0	0.0	0
Average		**0.0**	0.0	**0.8**	0.3	**93.2**	41.0	**7.6**	3.3	**119.1**	52.5	**6.2**	2.7	**0.1**

		L0	%	L1	%	L2	%	L3	%	Blanks	%	NRs	%	EX
Information Security Assurance	10-300	0	0.0	0	0.0	13	5.7	5	2.2	209	92.1	0	0.0	0
	10-301	0	0.0	0	0.0	16	7.0	2	0.9	209	92.1	0	0.0	0
	10-302	0	0.0	0	0.0	16	7.0	2	0.9	209	92.1	0	0.0	0
	10-303	0	0.0	0	0.0	15	6.6	3	1.3	209	92.1	0	0.0	0
	10-304	0	0.0	0	0.0	15	6.6	2	0.9	209	92.1	1	0.4	0
	10-305	0	0.0	0	0.0	16	7.0	2	0.9	209	92.1	0	0.0	0
	10-307	0	0.0	0	0.0	16	7.0	2	0.9	209	92.1	0	0.0	0
	10-308	0	0.0	0	0.0	17	7.5	1	0.4	209	92.1	0	0.0	0
	10-309	0	0.0	0	0.0	17	7.5	1	0.4	209	92.1	0	0.0	0
	10-310	0	0.0	0	0.0	17	7.5	1	0.4	209	92.1	0	0.0	0
	10-311	0	0.0	0	0.0	17	7.5	1	0.4	209	92.1	0	0.0	0
	10-313	0	0.0	0	0.0	16	7.0	2	0.9	209	92.1	0	0.0	0
	10-314	0	0.0	0	0.0	17	7.5	1	0.4	209	92.1	0	0.0	0
	10-323	0	0.0	0	0.0	16	7.0	2	0.9	209	92.1	0	0.0	0
	10-324	0	0.0	0	0.0	15	6.6	2	0.9	209	92.1	0	0.0	1
	10-340	0	0.0	0	0.0	187	82.4	22	9.7	18	7.9	0	0.0	0
	10-341	0	0.0	4	1.8	191	84.1	14	6.2	18	7.9	0	0.0	0
	10-342	1	0.4	2	0.9	93	41.0	0	0.0	18	7.9	113	49.8	0
	10-343	1	0.4	1	0.4	163	71.8	4	1.8	18	7.9	40	17.6	0
	10-344	1	0.4	1	0.4	205	90.3	2	0.9	18	7.9	0	0.0	0
	10-345	0	0.0	7	3.1	183	80.6	19	8.4	18	7.9	0	0.0	0
	10-346	2	0.9	6	2.6	199	87.7	2	0.9	18	7.9	0	0.0	0
	10-347	1	0.4	4	1.8	182	80.2	2	0.9	18	7.9	0	0.0	20
	10-348	0	0.0	5	2.2	203	89.4	1	0.4	18	7.9	0	0.0	0
	10-349	0	0.0	1	0.4	196	86.3	12	5.3	18	7.9	0	0.0	0
	10-350	2	0.9	5	2.2	196	86.3	6	2.6	18	7.9	0	0.0	0
	10-351	3	1.3	3	1.3	194	85.5	9	4.0	18	7.9	0	0.0	0
	10-352	2	0.9	19	8.4	152	67.0	0	0.0	18	7.9	0	0.0	36
Average		**0.5**	0.2	**2.1**	0.9	**92.3**	40.6	**4.4**	1.9	**120.3**	53.0	**5.5**	2.4	**2.0**

		L0	%	L1	%	L2	%	L3	%	Blanks	%	NRs	%	EX
Clinical Information Assurance	10-400	0	0.0	0	0.0	14	6.2	4	1.8	209	92.1	0	0.0	0
	10-401	0	0.0	0	0.0	4	1.8	1	0.4	209	92.1	13	5.7	0
	10-402	0	0.0	0	0.0	3	1.3	1	0.4	209	92.1	14	6.2	0
	10-404	0	0.0	0	0.0	2	0.9	0	0.0	209	92.1	16	7.0	0
	10-406	0	0.0	0	0.0	3	1.3	0	0.0	209	92.1	15	6.6	0
	10-420	1	0.4	2	0.9	189	83.3	17	7.5	18	7.9	0	0.0	0
	10-421	2	0.9	0	0.0	81	35.7	2	0.9	18	7.9	0	0.0	124
Average		**0.4**	0.2	**0.3**	0.1	**42.3**	18.6	**3.6**	1.6	**154.4**	68.0	**8.3**	3.7	**17.7**
Secondary Use Assurance	10-501	0	0.0	0	0.0	14	6.2	1	0.4	209	92.1	0	0.0	3
	10-502	0	0.0	0	0.0	15	6.6	1	0.4	209	92.1	0	0.0	2
	10-504	0	0.0	0	0.0	15	6.6	1	0.4	209	92.1	0	0.0	2
	10-515	0	0.0	0	0.0	14	6.2	1	0.4	209	92.1	0	0.0	3
Average		**0.0**	0.0	**0.0**	0.0	**14.5**	6.4	**1.0**	0.4	**209.0**	92.1	**0.0**	0.0	**2.5**
Corporate Information Assurance	10-601	0	0.0	0	0.0	17	7.5	1	0.4	209	92.1	0	0.0	0
	10-603	0	0.0	0	0.0	12	5.3	1	0.4	209	92.1	5	2.2	0
	10-604	0	0.0	0	0.0	17	7.5	1	0.4	209	92.1	0	0.0	0
Average		**0.0**	0.0	**0.0**	0.0	**15.3**	6.8	**1.0**	0.4	**209.0**	92.1	**1.7**	0.7	**0.0**

For Care Commissioning Groups & Contract Support Units (267 returns for V10 and 227 for V11) the following judgements may be made for the changes in information governance practice between V10 and V11 of the toolkit.

- Information Governance Management: the % on the highest two levels has increased from 21.3% to 49.7%
- Confidentiality and Data Protection Assurance: the % on the highest two levels has increased from 18.5% to 44.3%
- Information Security Assurance: the % on the highest two levels has increased from 19.9% to 42.5%
- Clinical Information Assurance: the % on the highest two levels has increased from11.6% to 20.2%
- Secondary Use Assurance: the % on the highest two levels has increased from 1.4% to 15.5%
- Corporate Information Assurance: the % on the highest two levels has increased from 2.7% to 7.2%
- These changes appear to show a significant improvement, as would be expected from new organisations. However the very high % of blanks (60.0% to 98.1% for V10 and 50% to92.1% for V11 are a significant cause for concern.

Commercial Third Parties

IGTK V10 — Self Assessment Scores — CTPs															
1254 organisations															
		L0	%	L1	%	L2	%	L3	%	Blanks	%	NRs	%	EX	%
Information Governance Management	10-114	7.0	0.6	18.0	1.4	160.0	12.8	224.0	17.9	845.0	67.4	0.0	0.0	0.0	0.0
	10-115	5.0	0.4	7.0	0.6	151.0	12.0	243.0	19.4	847.0	67.5	0.0	0.0	1.0	0.1
	10-116	7.0	0.6	10.0	0.8	171.0	13.6	212.0	16.9	854.0	68.1	0.0	0.0	0.0	0.0
	10-117	3.0	0.2	7.0	0.6	185.0	14.8	199.0	15.9	859.0	68.5	0.0	0.0	1.0	0.1
Average		5.5	0.4	10.5	0.8	166.8	13.3	219.5	17.5	851.3	67.9	0.0	0.0	0.5	0.0
Confidentiality and Data Protection Assurance	10-202	3.0	0.2	5.0	0.4	209.0	16.7	154.0	12.3	858.0	68.4	0.0	0.0	25.0	2.0
	10-206	5.0	0.4	7.0	0.6	173.0	13.8	200.0	15.9	860.0	68.6	0.0	0.0	9.0	0.7
	10-209	2.0	0.2	4.0	0.3	42.0	3.3	73.0	5.8	886.0	70.7	247.0	19.7	0.0	0.0
	10-210	7.0	0.6	4.0	0.3	230.0	18.3	146.0	11.6	863.0	68.8	0.0	0.0	4.0	0.3
	10-211	3.0	0.2	7.0	0.6	163.0	13.0	205.0	16.3	862.0	68.7	0.0	0.0	14.0	1.1
Average		4.0	0.3	5.4	0.4	163.4	13.0	155.6	12.4	865.8	69.0	49.4	3.9	10.4	0.8
Information Security Assurance	10-305	4.0	0.3	6.0	0.5	201.0	16.0	176.0	14.0	865.0	69.0	0.0	0.0	2.0	0.2
	10-313	6.0	0.5	5.0	0.4	196.0	15.6	180.0	14.4	866.0	69.1	0.0	0.0	1.0	0.1
	10-314	3.0	0.2	7.0	0.6	222.0	17.7	149.0	11.9	865.0	69.0	0.0	0.0	8.0	0.6
	10-316	3.0	0.2	5.0	0.4	119.0	9.5	262.0	20.9	863.0	68.8	0.0	0.0	2.0	0.2
	10-317	3.0	0.2	6.0	0.5	169.0	13.5	210.0	16.7	864.0	68.9	0.0	0.0	2.0	0.2
	10-319	5.0	0.4	7.0	0.6	183.0	14.6	197.0	15.7	861.0	68.7	0.0	0.0	1.0	0.1
	10-320	4.0	0.3	6.0	0.5	198.0	15.8	185.0	14.8	861.0	68.7	0.0	0.0	0.0	0.0
Average	10-323	4.0	0.3	6.0	0.5	184.0	14.7	194.1	15.5	863.6	68.9	0.0	0.0	2.3	0.2

IGTK V11 — Self Assessment Scores — CTPs 355 organisations (BUT NO BLANKS INCLUDED IN THE REPORT)															
		L0	%	L1	%	L2	%	L3	%	Blanks	%	NRs	%	EX	%
Information Governance Management	10-114	1	0.3	5	1.4	144	40.6	205	57.7	0	0.0	0	0.0	0	0.0
	10-115	1	0.3	2	0.6	141	39.7	211	59.4	0	0.0	0	0.0	0	0.0
	10-116	1	0.3	3	0.8	151	42.5	200	56.3	0	0.0	0	0.0	0	0.0
	10-117	1	0.3	5	1.4	155	43.7	194	54.6	0	0.0	0	0.0	0	0.0
Average		1	0.3	3.75	1.1	147.75	41.6	202.5	57.0	0	0.0	0	0.0	0	0.0
Confidentiality and Data Protection Assurance	10-202	1	0.3	2	0.6	180	50.7	151	42.5	0	0.0	0	0.0	21	5.9
	10-206	1	0.3	5	1.4	145	40.8	200	56.3	0	0.0	0	0.0	4	1.1
	10-209	0	0.0	4	1.1	35	9.9	76	21.4	0	0.0	240	67.6	0	0.0
	10-210	1	0.3	6	1.7	198	55.8	149	42.0	0	0.0	0	0.0	1	0.3
	10-211	1	0.3	4	1.1	149	42.0	192	54.1	0	0.0	0	0.0	9	2.5
Average		0.8	0.2	4.2	1.2	141.4	39.8	153.6	43.3	0	0.0	48	13.5	7	2.0
Information Security Assurance	10-305	1	0.3	4	1.1	163	45.9	185	52.1	0	0.0	0	0.0	2	0.6
	10-313	1	0.3	5	1.4	185	52.1	163	45.9	0	0.0	0	0.0	1	0.3
	10-314	1	0.3	5	1.4	182	51.3	159	44.8	0	0.0	0	0.0	8	2.3
	10-316	1	0.3	4	1.1	123	34.6	226	63.7	0	0.0	0	0.0	1	0.3
	10-317	1	0.3	4	1.1	156	43.9	194	54.6	0	0.0	0	0.0	0	0.0
	10-319	1	0.3	4	1.1	168	47.3	182	51.3	0	0.0	0	0.0	0	0.0
	10-320	1	0.3	4	1.1	180	50.7	170	47.9	0	0.0	0	0.0	0	0.0
Average	10-323	1	0.3	4.2857	1.2	165.29	46.6	182.71	51.5	0	0.0	0	0.0	1.7143	0.5

For Commercial Third Parties (returns from 1254 organisations in V10 and 355 for V11, but with high "blanks" in V10 and no "blanks" in V11. the following judgements may be made for the changes in information governance practice between V10 and V11 of the toolkit.

- Information Governance Management: the % on the highest two levels has increased from 30.8% to 98.6%
- Confidentiality and Data Protection Assurance: the % on the highest two levels has increased from 25.4% to 83.1%
- Information Security Assurance: the % on the highest two levels has increased from 30.2% to 98.1%
- Clinical Information Assurance: the % on the highest two levels has increased from No Requirements
- Secondary Use Assurance: No Requirements
- Corporate Information Assurance: No Requirements
- For the organisations making a return, this appears to be a significant improvement, but blanks in V10 and much lower number of organisations in V11 suggests much smaller improvement and concern about fall in returns.

Community Health Providers

IGTK V10 — Self Assessment Scores — CHPs															
		34 organisations													
		L0	%	L1	%	L2	%	L3	%	Blanks	%	NRs	%	EX	%
Information Governance Management	101.0	0.0	0.0	1.0	2.9	10.0	29.4	20.0	58.8	2.0	5.9	0.0	0.0	0.0	0.0
	105.0	0.0	0.0	0.0	0.0	18.0	52.9	13.0	38.2	2.0	5.9	0.0	0.0	0.0	0.0
	110.0	0.0	0.0	0.0	0.0	29.0	85.3	2.0	5.9	2.0	5.9	0.0	0.0	0.0	0.0
	111.0	0.0	0.0	0.0	0.0	23.0	67.6	8.0	23.5	2.0	5.9	0.0	0.0	0.0	0.0
	112.0	0.0	0.0	3.0	8.8	26.0	76.5	2.0	5.9	2.0	5.9	0.0	0.0	0.0	0.0
Average		0.0	0.0	0.8	2.4	21.2	62.4	9.0	26.5	2.0	5.9	0.0	0.0	0.0	0.0
Confidentiality and Data Protection Assurance	200.0	0.0	0.0	0.0	0.0	22.0	64.7	9.0	26.5	2.0	5.9	0.0	0.0	0.0	0.0
	201.0	0.0	0.0	1.0	2.9	28.0	82.4	2.0	5.9	2.0	5.9	0.0	0.0	0.0	0.0
	202.0	0.0	0.0	0.0	0.0	31.0	91.2	0.0	0.0	2.0	5.9	0.0	0.0	0.0	0.0
	203.0	0.0	0.0	1.0	2.9	30.0	88.2	0.0	0.0	2.0	5.9	0.0	0.0	0.0	0.0
	205.0	0.0	0.0	0.0	0.0	26.0	76.5	5.0	14.7	2.0	5.9	0.0	0.0	0.0	0.0
	206.0	0.0	0.0	0.0	0.0	27.0	79.4	4.0	11.8	2.0	5.9	0.0	0.0	0.0	0.0
	207.0	0.0	0.0	0.0	0.0	31.0	91.2	0.0	0.0	2.0	5.9	0.0	0.0	0.0	0.0
	209.0	0.0	0.0	0.0	0.0	13.0	38.2	3.0	8.8	2.0	5.9	15.0	44.1	0.0	0.0
	210.0	0.0	0.0	0.0	0.0	30.0	88.2	1.0	2.9	2.0	5.9	0.0	0.0	0.0	0.0
Average		0.0	0.0	0.2	0.7	26.4	77.8	2.7	7.8	2.0	5.9	1.7	4.9	0.0	0.0
Information Security Assurance	300.0	0.0	0.0	0.0	0.0	26.0	76.5	5.0	14.7	2.0	5.9	0.0	0.0	0.0	0.0
	301.0	0.0	0.0	0.0	0.0	30.0	88.2	1.0	2.9	2.0	5.9	0.0	0.0	0.0	0.0
	302.0	0.0	0.0	0.0	0.0	29.0	85.3	2.0	5.9	2.0	5.9	0.0	0.0	0.0	0.0
	303.0	0.0	0.0	0.0	0.0	26.0	76.5	2.0	5.9	2.0	5.9	3.0	8.8	0.0	0.0
	304.0	0.0	0.0	0.0	0.0	28.0	82.4	3.0	8.8	2.0	5.9	0.0	0.0	0.0	0.0
	305.0	0.0	0.0	0.0	0.0	31.0	91.2	0.0	0.0	2.0	5.9	0.0	0.0	0.0	0.0
	307.0	0.0	0.0	1.0	2.9	29.0	85.3	1.0	2.9	2.0	5.9	0.0	0.0	0.0	0.0
	308.0	0.0	0.0	2.0	5.9	27.0	79.4	2.0	5.9	2.0	5.9	0.0	0.0	0.0	0.0
	309.0	1.0	2.9	1.0	2.9	27.0	79.4	2.0	5.9	2.0	5.9	0.0	0.0	0.0	0.0
	310.0	0.0	0.0	0.0	0.0	31.0	91.2	0.0	0.0	2.0	5.9	0.0	0.0	0.0	0.0
	311.0	0.0	0.0	0.0	0.0	31.0	91.2	0.0	0.0	2.0	5.9	0.0	0.0	0.0	0.0
	313.0	0.0	0.0	0.0	0.0	31.0	91.2	0.0	0.0	2.0	5.9	0.0	0.0	0.0	0.0
	314.0	0.0	0.0	0.0	0.0	30.0	88.2	1.0	2.9	2.0	5.9	0.0	0.0	0.0	0.0
	323.0	0.0	0.0	0.0	0.0	31.0	91.2	0.0	0.0	2.0	5.9	0.0	0.0	0.0	0.0
	324.0	0.0	0.0	1.0	2.9	30.0	88.2	0.0	0.0	2.0	5.9	0.0	0.0	0.0	0.0
Average		0.1	0.2	0.3	1.0	29.1	85.7	1.3	3.7	2.0	5.9	0.2	0.6	0.0	0.0

		L0	%	L1	%	L2	%	L3	%	Blanks	%	NRs	%	EX	%
Clinical Information Assurance	400.0	0.0	0.0	0.0	0.0	26.0	76.5	5.0	14.7	2.0	5.9	0.0	0.0	0.0	0.0
	401.0	0.0	0.0	0.0	0.0	29.0	85.3	2.0	5.9	2.0	5.9	0.0	0.0	0.0	0.0
	402.0	0.0	0.0	0.0	0.0	29.0	85.3	2.0	5.9	2.0	5.9	0.0	0.0	0.0	0.0
	404.0	0.0	0.0	0.0	0.0	26.0	76.5	5.0	14.7	2.0	5.9	0.0	0.0	0.0	0.0
	406.0	0.0	0.0	1.0	2.9	28.0	82.4	2.0	5.9	2.0	5.9	0.0	0.0	0.0	0.0
Average		0.0	0.0	0.2	0.6	27.6	81.2	3.2	9.4	2.0	5.9	0.0	0.0	0.0	0.0
Secondary Use Assurance	501.0	0.0	0.0	0.0	0.0	28.0	82.4	3.0	8.8	2.0	5.9	0.0	0.0	0.0	0.0
	502.0	0.0	0.0	0.0	0.0	26.0	76.5	4.0	11.8	2.0	5.9	0.0	0.0	1.0	2.9
Average		0.0	0.0	0.0	0.0	27.0	79.4	3.5	10.3	2.0	5.9	0.0	0.0	0.5	1.5
Corporate Information Assurance	601.0	0.0	0.0	0.0	0.0	30.0	88.2	1.0	2.9	2.0	5.9	0.0	0.0	0.0	0.0
	603.0	0.0	0.0	0.0	0.0	13.0	38.2	4.0	11.8	2.0	5.9	14.0	41.2	0.0	0.0
	604.0	0.0	0.0	0.0	0.0	31.0	91.2	0.0	0.0	2.0	5.9	0.0	0.0	0.0	0.0
Average		0.0	0.0	0.0	0.0	24.7	72.5	1.7	4.9	2.0	5.9	4.7	13.7	0.0	0.0

IGTK V11 — Self Assessment Scores — CHPs

41 organisations

		L0	%	L1	%	L2	%	L3	%	Blanks	%	NRs	%	EX	%
Information Governance Management	101.0	1.0	2.4	1.0	2.4	17.0	41.5	21.0	51.2	1.0	2.4	0.0	0.0	0.0	0.0
	105.0	1.0	2.4	0.0	0.0	15.0	36.6	24.0	58.5	1.0	2.4	0.0	0.0	0.0	0.0
	110.0	1.0	2.4	2.0	4.9	31.0	75.6	4.0	9.8	3.0	7.3	0.0	0.0	0.0	0.0
	111.0	0.0	0.0	0.0	0.0	26.0	63.4	12.0	29.3	3.0	7.3	0.0	0.0	0.0	0.0
	112.0	0.0	0.0	3.0	7.3	31.0	75.6	5.0	12.2	2.0	4.9	0.0	0.0	0.0	0.0
Average		0.6	1.5	1.2	2.9	24.0	58.5	13.2	32.2	2.0	4.9	0.0	0.0	0.0	0.0
Confidentiality and Data Protection Assurance	200.0	0.0	0.0	1.0	2.4	22.0	53.7	16.0	39.0	2.0	4.9	0.0	0.0	0.0	0.0
	201.0	0.0	0.0	1.0	2.4	35.0	85.4	3.0	7.3	2.0	4.9	0.0	0.0	0.0	0.0
	202.0	0.0	0.0	0.0	0.0	35.0	85.4	3.0	7.3	2.0	4.9	0.0	0.0	1.0	2.4
	203.0	0.0	0.0	1.0	2.4	35.0	85.4	2.0	4.9	2.0	4.9	0.0	0.0	1.0	2.4
	205.0	0.0	0.0	2.0	4.9	29.0	70.7	8.0	19.5	2.0	4.9	0.0	0.0	0.0	0.0
	206.0	0.0	0.0	2.0	4.9	30.0	73.2	6.0	14.6	2.0	4.9	0.0	0.0	1.0	2.4
	207.0	1.0	2.4	2.0	4.9	34.0	82.9	2.0	4.9	2.0	4.9	0.0	0.0	0.0	0.0
	209.0	0.0	0.0	2.0	4.9	14.0	34.1	3.0	7.3	3.0	7.3	19.0	46.3	0.0	0.0
	210.0	0.0	0.0	1.0	2.4	31.0	75.6	5.0	12.2	3.0	7.3	0.0	0.0	1.0	2.4
Average		0.1	0.3	1.3	3.3	29.4	71.8	5.3	13.0	2.2	5.4	2.1	5.1	0.4	1.1

		L0	%	L1	%	L2	%	L3	%	Blanks	%	NRs	%	EX	%
Information Security Assurance	300.0	1.0	2.4	1.0	2.4	26.0	63.4	9.0	22.0	4.0	9.8	0.0	0.0	0.0	0.0
	301.0	0.0	0.0	1.0	2.4	35.0	85.4	1.0	2.4	4.0	9.8	0.0	0.0	0.0	0.0
	302.0	0.0	0.0	3.0	7.3	29.0	70.7	7.0	17.1	2.0	4.9	0.0	0.0	0.0	0.0
	303.0	0.0	0.0	0.0	0.0	28.0	68.3	3.0	7.3	2.0	4.9	8.0	19.5	0.0	0.0
	304.0	0.0	0.0	0.0	0.0	33.0	80.5	3.0	7.3	3.0	7.3	2.0	4.9	0.0	0.0
	305.0	0.0	0.0	1.0	2.4	35.0	85.4	0.0	0.0	4.0	9.8	0.0	0.0	1.0	2.4
	307.0	0.0	0.0	1.0	2.4	31.0	75.6	6.0	14.6	3.0	7.3	0.0	0.0	0.0	0.0
	308.0	0.0	0.0	3.0	7.3	31.0	75.6	3.0	7.3	4.0	9.8	0.0	0.0	0.0	0.0
	309.0	1.0	2.4	3.0	7.3	30.0	73.2	3.0	7.3	4.0	9.8	0.0	0.0	0.0	0.0
	310.0	1.0	2.4	1.0	2.4	33.0	80.5	2.0	4.9	4.0	9.8	0.0	0.0	0.0	0.0
	311.0	0.0	0.0	0.0	0.0	36.0	87.8	1.0	2.4	4.0	9.8	0.0	0.0	0.0	0.0
	313.0	0.0	0.0	1.0	2.4	32.0	78.0	3.0	7.3	4.0	9.8	0.0	0.0	1.0	2.4
	314.0	0.0	0.0	0.0	0.0	35.0	85.4	1.0	2.4	4.0	9.8	0.0	0.0	1.0	2.4
	323.0	1.0	2.4	2.0	4.9	31.0	75.6	2.0	4.9	4.0	9.8	0.0	0.0	1.0	2.4
	324.0	1.0	2.4	1.0	2.4	34.0	82.9	0.0	0.0	4.0	9.8	0.0	0.0	1.0	2.4
Average		0.3	0.8	1.2	2.9	31.9	77.9	2.9	7.2	3.6	8.8	0.7	1.6	0.3	0.8
Clinical Information Assurance	400.0	0.0	0.0	0.0	0.0	29.0	70.7	8.0	19.5	4.0	9.8	0.0	0.0	0.0	0.0
	401.0	1.0	2.4	1.0	2.4	31.0	75.6	4.0	9.8	3.0	7.3	0.0	0.0	1.0	2.4
	402.0	0.0	0.0	0.0	0.0	34.0	82.9	2.0	4.9	4.0	9.8	0.0	0.0	1.0	2.4
	404.0	0.0	0.0	0.0	0.0	27.0	65.9	9.0	22.0	4.0	9.8	0.0	0.0	1.0	2.4
	406.0	0.0	0.0	0.0	0.0	31.0	75.6	5.0	12.2	4.0	9.8	0.0	0.0	1.0	2.4
Average		0.2	0.5	0.2	0.5	30.4	74.1	5.6	13.7	3.8	9.3	0.0	0.0	0.8	2.0
Secondary Use Assurance	501.0	0.0	0.0	0.0	0.0	32.0	78.0	4.0	9.8	4.0	9.8	0.0	0.0	1.0	2.4
	502.0	0.0	0.0	0.0	0.0	32.0	78.0	4.0	9.8	4.0	9.8	0.0	0.0	1.0	2.4
Average		0.0	0.0	0.0	0.0	32.0	78.0	4.0	9.8	4.0	9.8	0.0	0.0	1.0	2.4
Corporate Information Assurance	601.0	0.0	0.0	0.0	0.0	35.0	85.4	1.0	2.4	4.0	9.8	0.0	0.0	1.0	2.4
	603.0	0.0	0.0	0.0	0.0	16.0	39.0	4.0	9.8	4.0	9.8	17.0	41.5	0.0	0.0
	604.0	0.0	0.0	0.0	0.0	37.0	90.2	0.0	0.0	3.0	7.3	0.0	0.0	1.0	2.4
Average		0.0	0.0	0.0	0.0	29.3	71.5	1.7	4.1	3.7	8.9	5.7	13.8	0.7	1.6

For Community Health Providers (34 organisations V10 and 41 for V11) the following judgements may be made for the changes in information governance practice between V10 and V11 of the toolkit.

- Information Governance Management: the % on the highest two levels has increased from 88.9% to 90.7%
- Confidentiality and Data Protection Assurance: the % on the highest two levels has fallen from 85.6% to 84.8%
- Information Security Assurance: the % on the highest two levels has fallen from 89.4% to 85.1%
- Clinical Information Assurance: the % on the highest two levels has fallen from 90.6% to 87.8%
- Secondary Use Assurance: the % on the highest two levels has fallen from 89.7% to 87.8%
- Corporate Information Assurance: the % on the highest two levels has fallen from 77.4% to 75.6%
- At first glance this appears to be a slight decrease in performance, but new entries to the system could not achieve level three in their first year; so the change is not significant.

Acute Trusts

IGTK V10 — Self Assessment Scores — Acute Trusts					
	L0	L1	L2	L3	?
Information Governance Management	0	3	59	215	1
Information Governance Management	4	9	211	50	4
Information Governance Management	0	5	142	127	4
Information Governance Management	3	56	154	61	4
Information Governance Management	0	0	42	232	4
Average	**1.4**	**14.6**	**121.6**	**137**	**2.4**
%	**0.51**	**5.27**	**43.90**	**49.46**	**0.87**
Confidentiality and Data Protection Assurance	0	1	95	178	1
Confidentiality and Data Protection Assurance	0	5	193	76	1
Confidentiality and Data Protection Assurance	1	6	101	74	93
Confidentiality and Data Protection Assurance	1	8	213	52	1
Confidentiality and Data Protection Assurance	2	7	156	108	2
Confidentiality and Data Protection Assurance	1	4	219	40	11
Confidentiality and Data Protection Assurance	0	3	222	49	1
Confidentiality and Data Protection Assurance	1	6	216	51	1
Confidentiality and Data Protection Assurance	0	5	124	145	1
Average	**0.6**	**5**	**171**	**85.8**	**12.4**
%	**0.22**	**1.81**	**61.73**	**30.97**	**4.48**
Information Security Assurance	0	3	158	113	1
Information Security Assurance	1	6	230	37	1
Information Security Assurance	0	0	6	4	265
Information Security Assurance	3	12	213	46	1
Information Security Assurance	0	7	210	57	1
Information Security Assurance	1	2	215	56	1
Information Security Assurance	0	4	236	34	1
Information Security Assurance	2	15	234	23	1
Information Security Assurance	3	4	206	61	1
Information Security Assurance	0	0	0	0	275

	L0	L1	L2	L3	?
Information Security Assurance	4	27	224	9	11
Information Security Assurance	0	15	212	47	1
Information Security Assurance	2	5	175	92	1
Information Security Assurance	2	8	216	48	1
Information Security Assurance	1	9	143	121	1
Information Security Assurance	0	5	193	76	1
Information Security Assurance	0	3	209	62	1
Average	**1.1**	**7.3**	**181**	**52**	**33**
%	**0.40**	**2.66**	**65.96**	**18.95**	**12.03**
Secondary Use Assurance	0	1	154	66	54
Secondary Use Assurance	1	5	191	66	12
Secondary Use Assurance	1	3	160	57	54
Secondary Use Assurance	0	3	113	105	54
Secondary Use Assurance	2	2	170	88	13
Secondary Use Assurance	0	0	44	118	113
Secondary Use Assurance	1	5	146	69	55
Secondary Use Assurance	0	4	108	50	113
Average	**0.625**	**2.875**	**135.75**	**77.375**	**58.5**
%	**0.23**	**1.04**	**49.34**	**28.12**	**21.26**
Corporate Information Assurance	1	8	25	24	217
Corporate Information Assurance	2	6	32	2	233
Corporate Information Assurance	2	2	42	12	217
Corporate Information Assurance	0	12	230	32	1
Corporate Information Assurance	0	2	128	144	1
Corporate Information Assurance	3	16	242	13	1
Average	**1.33**	**7.67**	**116.5**	**37.83**	**111.67**
%	**0.48**	**2.79**	**42.36**	**13.76**	**40.61**

IGTK V11 — Self Assessment Scores — Acute Trusts					
	L0	L1	L2	L3	?
Information Governance Management	0	0	28	200	0
Information Governance Management	0	1	34	193	0
Information Governance Management	0	3	167	58	0
Information Governance Management	0	0	97	131	0
Information Governance Management	1	23	128	76	0
Average	**0.2**	**5.4**	**90.8**	**131.6**	**0**
%	**0.09**	**2.37**	**39.82**	**57.72**	**0.00**
Confidentiality and Data Protection Assurance	1	0	70	157	0
Confidentiality and Data Protection Assurance	0	0	148	80	0
Confidentiality and Data Protection Assurance	0	0	166	62	0
Confidentiality and Data Protection Assurance	0	2	166	60	0
Confidentiality and Data Protection Assurance	0	1	89	138	0
Confidentiality and Data Protection Assurance	0	1	122	105	0
Confidentiality and Data Protection Assurance	0	0	179	39	10
Confidentiality and Data Protection Assurance	0	1	80	68	79
Confidentiality and Data Protection Assurance	0	2	182	44	0
Average	**0.11**	**0.78**	**133.56**	**83.67**	**9.89**
%	**0.05**	**0.34**	**58.58**	**36.70**	**4.34**
Information Security Assurance	1	2	112	113	0
Information Security Assurance	0	4	168	56	0
Information Security Assurance	0	3	103	122	0
Information Security Assurance	2	1	148	77	0
Information Security Assurance	1	0	163	64	0
Information Security Assurance	0	4	176	48	0
Information Security Assurance	1	3	130	94	0
Information Security Assurance	0	2	185	41	0
Information Security Assurance	0	3	182	43	0
Information Security Assurance	0	3	181	44	0
Information Security Assurance	1	1	166	60	0

	L0	L1	L2	L3	?
Information Security Assurance	0	2	165	61	0
Information Security Assurance	0	0	194	34	0
Information Security Assurance	0	0	8	2	218
Information Security Assurance	0	5	200	23	0
Information Security Assurance	1	5	199	13	10
Average	**0.44**	**2.38**	**155**	**55.94**	**14.25**
%	**0.19**	**1.04**	**67.98**	**24.53**	**6.25**
Secondary Use Assurance	0	2	155	60	11
Secondary Use Assurance	0	1	134	82	11
Secondary Use Assurance	0	1	153	63	11
Secondary Use Assurance	1	3	116	40	68
Secondary Use Assurance	1	2	144	70	11
Secondary Use Assurance	0	3	111	103	11
Secondary Use Assurance	0	1	155	61	11
Secondary Use Assurance	0	0	42	118	68
Secondary Use Assurance	1	1	28	27	171
Secondary Use Assurance	1	1	45	10	171
Average	**0.4**	**1.5**	**108.3**	**63.4**	**54.4**
%	**0.18**	**0.66**	**47.50**	**27.81**	**23.86**
Corporate Information Assurance	0	5	188	35	0
Corporate Information Assurance	0	0	96	132	0
Corporate Information Assurance	2	3	212	11	0
Average	**0.67**	**2.67**	**165.33**	**59.33**	**0**
%	**0.29**	**1.17**	**72.51**	**26.02**	**0.00**

- Acute Trusts
  - Information Governance Management: the % on the highest two levels has increased from 93% to 97%
  - Confidentiality and Data Protection Assurance: the % on the highest two levels has increased from 63% to 95%
  - Information Security Assurance: the % on the highest two levels has increased from 85% to 92%
  - Secondary Use Assurance: the % on the highest two levels has fallen from 77% to 75%
  - Corporate Information Assurance: the % on the highest two levels has increased from 56% to 98%
  - This appears to be a real increase in performance, however changes in number of requirements and the number of blank entries means that caution in interpreting the results is necessary.

Overall, it is difficult to come to a clear conclusion about any improvement in performance in relation to the IG Toolkit between V10 and V11. There are concerns about the significant, and unexplained, fall in number of organisations completing the toolkit for GP practices and Commercial Third Parties. In theory the reduction in “blanks” represents an improvement, provided it does not reflect a failure to return. Acute Trusts do appear to have improved overall.

2903123 December 2014
Produced by Williams Lea for the Department of Health