Information Governance Toolkit

Working Group

Information Governance Toolkit

Performance Review

January 2013
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Introduction

Information governance is the term used to describe the principles, processes, legal and ethical responsibilities for managing and handling information. It sets the requirements and standards that the NHS and other relevant organisations need to achieve, to ensure it fulfils its obligations to handle information legally, securely, efficiently and effectively.

The NHS Connecting for Health Information Governance Toolkit (IGT) is a performance monitoring tool produced by the Department of Health. It sets out the relevant information management legislation, national and international guidance under a single framework designed to enable an organisation to implement the relevant IG standards, measure performance through an annual self-assessment audit process and report upon their level of compliance. NHS Trusts are required to complete a baseline assessment in July shortly after the latest iteration of the toolkit is issued. A second assessment is reported in October with a final submission, after audit, in March of each year. The final report provides assurance to the Cabinet Office, Care Quality Commission, Monitor, Commissioners and others, providing a basis for establishing whether an organisation is meeting its legal and contractual obligations for effective IG.

All providers of NHS commissioned services are required, by contract, to complete and report an IGT self-assessment audit annually. Completion is mandatory for organisations that access NHS information systems via the NHS IT network (N3).

The NIGB Information Governance Toolkit Working Group is a sub-group of the NIGB. One of their key areas of responsibility is to advise the NIGB on the analysis of the Information Governance Toolkit (IGT) results in order to:

- identify trends and monitor performance;
- identify aspects which organisations find particularly difficult, with a view to recommending what additional support organisations may need;
- identify organisations which are performing particularly well and which could be used to partner those organisations identified as less able to meet the requirements.

The following report is a comprehensive analysis of the results for NHS Trusts over three versions of the IGT, versions 7 (2009/2010), 8 (2010/2011) and 9 (2011/2012), which was undertaken at the request of the Group. Figures were unavailable for Social Care and Independent sector organisations at the time of writing. A basic summary report of Social Care Activity is provided at Addendum Social Care using publicly available data subsequently acquired from the IG Toolkit reports.
Executive Summary

Detailed analysis of the Information Governance Toolkit (IGT) shows a wide range of results across regions and different organisations. The changes introduced in version 8 and the current restructuring of commissioning organisations introduced a significant downward trend in self-assessment. This was particularly acute in Primary Care Trusts, which merged into the current PCT Clusters in 2011. By version 9 most organisations regained the lost ground.

- Only 22% of the 641 organisations analysed managed to consistently improve their performance in key requirements from version 7 through to version 9;¹
- 172 of the 292 NHS Trusts (59%) declared a “Satisfactory” standard in IGT version 9.

Analysis of the Toolkit against other indicators, such as Care Quality Commission (CQC) Outcomes, demonstrates that organisations performing well in other indicators tend to score well with the IG Toolkit.

Three of the four NHS Organisations fined by the Information Commissioner’s Office and fourteen of the twenty-three that signed an Undertaking had assessed themselves as Satisfactory on IG Toolkit v9. An analysis of the ICO reports into these breaches of the Data Protection Act demonstrates systematic failures across a number of key controls that are standards set and measured in the Toolkit. The number of relevant organisations is a small sample and this needs to be considered when drawing conclusions.

The NHS Commissioning Board is currently consulting on the future of the Toolkit and its role in performance measurement and assurance within the new NHS organisational structures. The review is due to be concluded in February 2013 following an extensive consultation process a final report and recommendations will be presented to the NHS Commissioning Board IG Professional Leadership Group in March 2013. The NI GB’s response to the consultation is available on our website at www.nigb.nhs.uk/pubs/responses. It is worthwhile analysing some of the key points of the IG Toolkit to inform the Information Governance Toolkit Working Group about its current use, performance and issues. This reflects the Terms of Reference for the IGT working Group which are noted in the introduction above.

The paper reflects on how the IG Toolkit is used, the requirements for audit and what it tells us about an organisation ability to deliver safe, secure and appropriate use of information.

Throughout our review of the toolkit, the issues of measuring success and failure in the Toolkit, or in a specific requirement, poses a question. In considering the future and value of the measure, does failure reflect an inability to meet a standard, an inability to meet the precise

¹ Not all organisations could be considered as the data for Independent and Social Care sectors was not available for version 9. This analysis is based on those with data available for version 7, 8, and 9 predominately NHS Trusts. For a full list of organisations considered see Annexe G.
requirements of that standard, a lack of supporting evidence or a lack of organisational engagement with an aspect of Information assurance? In the evolution of the assurance model and the Toolkit this fundamental issue must be a guide.
Key Aspects of the IG Toolkit

The Toolkit does ensure:

- Board level involvement with the Information Governance agenda at least once a year through sign off of the self-assessment by the Board prior to submission;
- Establishment of key posts and senior management responsibility in each organisation such as the Caldicott Guardian, Senior Information Risk Owner (SIRO), Information Asset Owners, etc.;
- Inclusion of IG in an organisation’s audit programme which provides independent scrutiny of key controls and oversight through the relevant board delegated committee responsible for audit;
- Engagement with the broader organisation on key elements of the information governance agenda, such as training and induction;
- A framework for assurance on the Information Governance agenda that requires the engagement of the entire organisation, through requirements such as Information Flow Mapping and Information Asset Register;
- An annual programme of work refreshed through the issue of a revised Toolkit (June) and baseline assessment (July) ensuring the maintenance of standards and, where possible, year-on-year improvement.

The annual Toolkit report however:

- Is a self-assessment and, where audited, the conclusions of the audit are not required to be reflected in the final submission to assure the publicly declared result;
- Is not a pre-indicator of risk or breaches of the Data Protection Act, with those receiving monetary fines from ICO scoring comparable scores to the average Trust;
- Does not enable reports to be extracted in a format that allows a collective comparison of organisational scores.

In addition,

- The move to a Satisfactory/Unsatisfactory model may have impacted on each organisation’s approach to the self-assessment;
- The requirement for Foundation Trusts to complete the Toolkit or undertake an independent audit is not clearly stated but dependent upon inclusion in commissioning contracts and local decisions;
- Basic information acquired from the public view of the Toolkit assessment reports indicates an inconsistent approach to annual reporting by Social Care organisations.

The Independent and Social Care sectors approach to the Toolkit could not be assessed as the data was not provided to us. It is not possible to extract comprehensive results from the publicly accessible reports within the IG Toolkit website.

Variations in the Toolkit
There is regional and sector variation in Toolkit scores with particular regions routinely scoring higher than others throughout the history of the Toolkit. Possible factors could include:

- An active and engaged Information Governance Forum;
- Innovative approaches and organisational commitment;
- Higher levels of involvement of SIROs and Caldicott Guardians;
- Leadership of the Information Governance community from experienced members of staff within Trusts and Strategic Health Authority IG leads;
- Identification and recognition of expertise within the organisation, feedback from projects, s.251 applications and anecdotal discussions with leaders in the IG community suggest that early and open engagement with the right people makes a real impact on the success of assurance and projects.

Key Recommendations

- The limits of self-assessment and internal audit need to be understood and mitigated against, with a clear instruction for internal audit findings to be reflected in the final submission and consideration of whether the audit report must be made available alongside the submitted self-assessment;
- The Toolkit must aim for clarity and consistency across all health and care organisations around a single core set of requirements, or view, that all organisations complete. As requirements, both in terms of organisational views and required evidence standards, continue to be inconsistent it is difficult to appropriately measure ongoing performance;
- This single model could be used across all health and social care providers to provide transparency for the service user and those that rely on the IGT for assurance of compliance. It would allow comparisons to be made with clearer measurement of quality and assurance;
- Clarity on Department of Health expectations and the method of selecting the appropriate “organisational view” for each organisation, whether this is better aligned with functions (which do not change) or organisational remits (which frequently do);
- Emphasis may be better placed on legal compliance, risk management and decentralising assurance throughout the organisation in the Toolkit to provide better value to organisations. This would assist those completing the Toolkit, those monitoring performance and would generate greater professional ownership of the relevant issues by each individual member of staff;
- By emphasising value to the organisations completing the Toolkit, the standard would avoid the “tick box” exercise culture that can develop with such assessments and support information governance becoming embedded throughout organisations;
- Ensure that the Toolkit builds on the evidence requirement to ensure assurance in the declared scores, through clearer reporting and requirements on reflecting audit results in the final submission, mitigating against the “tick box” culture and aligned with adding value to the organisation;
• The increased emphasis on Commissioners to monitor performance through contract management processes could be supported through an integrated reporting model. For example, Commissioners detailing a list of key service providers and this being reflected in the overview of both organisations’ Toolkit performance.

Further Research and Analysis
If the NIGB had the remit and time available, the following additional research would be recommended:
• Review of audit reports of a cross-sample of organisations to confirm or deny our concerns about the reliability of self-assessed information in the absence of independent assurance;
• Analysis across all Health and Social Care services is required but the data is not available and we cannot assess how far the IGT is embedded across all the relevant institutions;
• Benchmarking of level of staffing in information governance across organisations;
• Analysis of information governance incidents reported and related IG Toolkit standards;
• Review of the impact and value to “small” organisations completing the Toolkit such as GPs, Pharmacies, Dentists and Voluntary Organisations;
• Review of the value and impact of the IG Toolkit on organisations pre-commencement, transition or during initialisation and whether this is the best measure;
• Detailed analysis of performance against other indicators.
1 Background

1.1 The NIGB Information Governance Toolkit Working Group

1.1.1 The NIGB Information Governance Toolkit Working Group is a sub-group of the NIGB. One of the key areas of responsibility is to advise on the analysis of the Information Governance Toolkit (IGT) results in order to:

- identify trends and monitor performance;
- identify aspects which organisations find particularly difficult, with a view to recommending what additional support organisations may need;
- identify organisations which are performing particularly well and which could be used to support those organisations identified as struggling with the requirements;
- reflect on how the IG Toolkit is used, the requirements for audit and what it tells us about an organisation ability to deliver safe, secure and appropriate use of information.

A comprehensive analysis of the results for NHS Trusts over three versions of the IGT, versions 7 (2009/2010), 8 (2010/2011) and 9 (2011/2012) was undertaken. Figures were unavailable for Social Care and Independent sector organisations at the time of writing. A brief analysis from publicly available data was undertaken for Social Care and can be found in the Addendum Social Care.

1.2 The Information Governance Toolkit

1.2.1 The Information Governance Toolkit (IGT) is a performance tool produced by the Department of Health (DH). It draws together the relevant information legislation, national and international guidance under a single framework designed to enable an organisation to implement the relevant IG standards (referred to as an “organisational view”), measure performance through an annual self-assessment audit process and report their level of compliance. Larger health organisations are required to complete a baseline assessment in June/July, an update in October with final submission, after audit, in March of each year.

1.2.2 All providers of NHS commissioned services are required by contract to complete and report an IGT self-assessment audit. This requirement is interpreted differently by some Foundation Trusts with guidance issued by Monitor.

1.2.3 Completion is mandatory as a Statement of Compliance (SOC) for organisations that access NHS information systems via the NHS IT network (N3). However, there is evidence to suggest that in the majority of cases following N3 connection, a subsequent annual submission is not completed by all of these organisations especially in the commercial and Social Care sector. Neither the incentive, penalty nor who is responsible for ensuring compliance in these circumstances is clear.
1.2.4 There are different “organisational views” of the Toolkit denoting a range of IG standards applicable for different sectors and types of organisation. This results in each type of organisation providing a response to a different set of requirements. These requirements, though similar in intention, may significantly or slightly differ in detail. For example, the standard measuring the IG assurance framework is standard 101 for the majority of organisations; 130 for Clinical Commissioning Groups and 151 in Local Authorities but 101 for Social Care.

The standard description “There is adequate Information Governance Management Framework to support the current and evolving Information Governance agenda” is the same for all. Similarly, for those organisations where this standard does not apply (e.g. commercial third party, Community Pharmacy, GP, Voluntary services etc) there is still a need for someone to take responsibility for IG and the corresponding standard “Responsibility for IG has been assigned to an appropriate member of members of staff” with this standard variously numbered 114, 120 or 140.

The purpose of the different numbering system is seen in the fine detail of the supporting guidance, for example terminology may differ between organisations, but this makes analysing or assessing the performance across different care providers very difficult.

1.2.5 There is also evidence of some inconsistency in the approach, particularly for example in Community Health assessment, where some are subsumed within Acute or Mental Health returns, some are independent through either the Any Qualified Provider – Clinical Services submission or Community Health Provider views. Similarly, Independent organisations could be matched against one of several views depending upon the configuration of services they provide and there is again some inconsistency in the allocation. For Commissioners and others relying on the results for assurance purposes, it is not clear if like is being compared with like, leading to confusion and additional complexity in commissioning and performance management. In addition, it is necessary to know which view an organisation has completed in order to find their published report.

1.2.6 The content of the Toolkit is reviewed annually to ensure that it is kept up to date with changes in policy, standards or legislation. The current toolkit is in its 10\textsuperscript{th} iteration. Significant changes were introduced in version 8 issued in June 2010. The previous 62 standards were revised down to 45 with the removal of obsolete standards and merger of duplicate standards. Two new standards were introduced, 323 concerned Information Assets and the supporting managerial structure whilst 324 measured the impact of the Pseudonymisation project. To achieve the mandated level 2 in standard 324 required level 2 to be attained in all other requirements within the view as well as progressing the pseudonymisation plans. It was not clear what the declared score actually reflected.\footnote{See www.igt.connectingforhealth.nhs.uk} This has been changed in version 10 to measure the implementation

\footnotetext{See www.igt.connectingforhealth.nhs.uk}
of pseudonymisation and anonymisation to protect personal information where appropriate, requiring at level 2 evidence to show:

- that the planned business process changes have been fully implemented, and pseudonymised and/or anonymised data is used for all secondary purposes where patient consent has not been granted or permission to process confidential service user data is not provided by law and
- there are formal safe haven processes, and pseudonymisation and/or anonymisation functionality in line with DH guidelines, including multiple pseudonym generation where appropriate.

This is a significant improvement, enabling a clear measure of the overall success of the Pseudonymisation Implementation Project to be taken since its introduction in 2009. The results of compliance with this standard will not be available until April 2013.

1.2.7 Version 8 also introduced the requirement to upload evidence and the 3 stage reporting model, with self-assessment measures being reported in July (baseline), October (improvement) and March (final). Alongside the technical and content changes, the NHS Operating Framework 2010/11 (Gateway 14988) through the NHS Informatics Planning Guidance Annex 1 (National Expectations) stated that “An IG Audit utilising the centrally provided audit methodology should be included within the work plans of each organisation’s auditors” with the intention of introducing consistency in the independent assurance of an organisations’ self-assessed performance levels.

1.2.8 The changes introduced in subsequent versions are minimal, mainly updating guidance and reference materials plus the establishment of additional organisational views to reflect new or changing organisational structures.

1.2.9 Each Information Governance Toolkit requirement is marked out of 3. Level 0 (zero) indicates no action taken to meet the required standard and level 1 that some work has started e.g. to implement an action plan. Level 2 is considered to be the satisfactory standard with level 3 demonstrating a clear process of continuing review and improvement. Specific requirements can be self-determined as “Not Relevant” or an organisation can make an application to the Connecting for Health IG Team to have any standard marked as “Not Applicable” where they can show good evidence for an exemption. The most frequent use of the “Not Relevant” option is standard 209 “All person identifiable data processed out of the UK complies with the Data Protection Act 1998 and Department of Health guidelines”. Over 100 NHS organisations in version 9 claimed that “All data flows have been reviewed and no overseas processing is carried out” marking the requirement Not Relevant.

Unlike a claim of a standard not being applicable to an organisation, there is no indication that a claim of “Not Relevant” has been independently assessed as an accurate statement, for example by internal audit.

1.2.10 In 2011 the Department of Health conducted a “Deep Dive” review of Acute Trust’s submitted evidence to support
• Quality assurance of the evidence submitted;
• Test the effectiveness of the audit methodology;
• Provide feedback to the NHS;
• Make recommendations for improvement;
• Identify examples of best practice.

1.2.11 The final report was not published, however, a summary of the findings was reported to
the SHA IG Leads meeting on the 6 December 2011\(^3\). It was reported that the
recommendations of several IG Toolkit Deep Dive evidence reports were in conflict with
internal audit reports that had been signed off by Trust Boards. In addition, a small
number of organisations were unable to provide evidence to support the declared
score. It was asserted that Internal audit teams are of variable quality particularly
around the IG agenda which may explain any contradictions within the Deep Dive
reports. Nevertheless, this raises questions about the audit and assurance process to
substantiate the published self-assessment reports, which is inconsistent and not
evident to those relying on the information to evaluate an organisation’s compliance.

1.3 Scope

1.3.1 The current Toolkit, version 10, comprises of 24 “organisational views” which denote
the different organisation types, including independent, third sector, commercial
business partners as well as public sector organisations. They are designed to include all
of the IG standards relevant to that particular sector or organisation.
The full list is provided in Annexe C.

1.3.2 There is no single requirement that is included in every view across the IGT. It is
therefore not possible to compare like-for-like results across all organisation types for
any single requirement. The approach within this review was to look at the most
common requirements, relevant to the most organisation types, plus those that are
good indicators of performance and compliance accounting for any indicators that were
introduced in version 8. The analysis also uses the requirements most relevant to the
principles identified in the Care Record Guarantee.\(^4\)

1.3.3 Up to and including version 7, an organisation’s overall result was indicated by a
percentage score and RAG (Red Amber Green) rating. A Green rating was achieved by
scoring 70 percent or higher. In version 8 however, this changed to either a “Satisfactory
– Green” rating or a “Not Satisfactory – Red” rating, determined by the achievement or
non-achievement of the mandated compliance for every standard at level 2. It is
possible for an organisation to achieve a high percentage score but still return a Not

\(^3\) https://www.igt.connectingforhealth.nhs.uk/Meetings/SHAIG%20Minutes%20(06%20Dec%202011)\%20Vers%201.0. pdf
\(^4\) See Annexe C Key Requirements
Satisfactory rating for failing to reach the required level 2 in just one standard. For the purpose of comparison we have used the percentage scores for this report.

1.3.4 Data has not been made available for the following organisation types, therefore, they are excluded from the analysis:

- Independent sector
- Social Care
- Defence medical services
- Arm’s Length Bodies

There is a brief analysis of Social Care data in Addendum Social Care.
2 Key Conclusions and details from the Analysis of IG Toolkit Performance

2.1 Overall Indicators

2.1.1 The analysis of organisations’ performance in the Information Governance Toolkit illustrates a number of issues with the standard and how it is being used. This section highlights key points from the detailed analysis that can be found in Annexe A.

2.1.2 As noted above a change of model of the Information Governance Toolkit occurred between version 7 and version 8 of the standard. This saw over 69% organisations suffering a dip in their IG Toolkit score. Over 20% of organisations continued to decline through version 9 of the Toolkit. This period coincided with a significant reorganisation of the NHS with the Clustering of Primary Care Trusts and Strategic Health Authorities which may explain any decline.

2.1.3 This is the most dramatic demonstration of the impact of a lack of consistency in the IGT as a model of measuring performance in Information Governance year-on-year. Further evidence is provided by the inability to compare providers, across all sectors, or organisations on key requirements. Even where the same requirements are in place for two different types of organisation, for example Acute and Mental Health Trusts, the measure is often different. This undermines the ability to establish performance comparators, identify good practice and support competitive improvement.

2.2 Impact of Version 8 of the IGT Toolkit and beyond

2.2.1 The higher standard introduced in version 8 resulted in a fall in the performance in over half of the organisations. After the move to the Satisfactory/Unsatisfactory (Pass or Fail) model a small number of organisations opted out or provided a very limited response. Under version 7 of the Toolkit, those opting out were often organisations new to the Information Governance Toolkit, from version 8 these included NHS Trusts that had previously submitted a return within the expected range. As illustrated in the table below a small number of organisations continue to provide a limited response to the Toolkit, although the analysis for version 9 is limited by the previously mentioned absence of Social Care and Independent sector data.

<table>
<thead>
<tr>
<th></th>
<th>No. of Organisations declaring 10 or more scores at Level 1</th>
<th>No. of Organisations declaring 7 or more scores at Level 0</th>
</tr>
</thead>
<tbody>
<tr>
<td>IGT Version 7</td>
<td>20</td>
<td>7</td>
</tr>
<tr>
<td>IGT Version 8</td>
<td>40 (inc. 8 Foundation Trust)</td>
<td>31 (inc. 7 Foundation Trusts)</td>
</tr>
<tr>
<td>IGT Version 9</td>
<td>12</td>
<td>2</td>
</tr>
</tbody>
</table>

2.2.2 In responding to version 9 of the Toolkit, 59% of organisations declared (publicly) that they were meeting a standard that rests on legal, regulatory and operational compliance. The issue of non-compliance, related in policy to the N3 connection, is not drawn out.
2.3 Organisation Types and Organisational Change

2.3.1 In reviewing the response of different types of organisation, there is little difference in the performance of Foundation Trusts, 62% met the target in version 9, and Non-Foundation Trusts, where 59% Acute Trusts met the target in version 9.

2.3.2 Organisational change has a significant impact if the performance of PCTs and SHAs is indicative. A significant downward, and occasionally severe, trend is evidenced in these organisations. Compare PCT performance, 44% met the required standard, against Ambulance Trusts at 91%.

2.4 High and Low Scoring Requirements

2.4.1 Challenging requirements, where a higher than average proportion of organisations fail, coincides with some significant changes and new agendas within the Health Service. The training standard 112, requires that 100% of staff within the organisation receive IG training each year, which continues to be difficult to achieve. This is important in relation to the expectations of the Cabinet Office and the ICO. The requirement around Pseudonymisation and controls on secondary use is another requirement posing a problem, despite its importance to ongoing NHS improvement, effective management of information and the Government’s Open Data agenda.

2.4.2 Clinical Coding and controls, requirement 514 and 516, in Mental Health proved a challenge for those responding to the requirement, with auditing of data being an issue for Commissioning organisations. Critically for the process of transition, handover and closure, the demands of the Records Inventory, requirement 604, is reflected indicating that a number of organisations struggle to have a clear view of the Records within their remit and a system of control over them.

2.4.3 One requirement remained consistently high in performance across Toolkit versions, those related to the Information Governance Framework or resource to support Information Governance. From version 8 requirement 105 which relates to Information Governance policies and strategies also shows higher than average performance. They stand out in having a Mean Level of over 2.7 out of the available 3 Levels. Both require considerable documentation and are in the direct control of an Information Governance Lead or Manager unlike the other requirements. More information is available in the detailed analysis contained within Annexe A.

2.4.4 This poses a question around whether success and failure in the Toolkit, as well as with specific requirements, reflects an inability to meet a standard, an inability to meet the precise requirements of that standard, lack of supporting evidence or a lack of organisational engagement with an aspect of Information assurance.

2.5 Assurance from the IG Toolkit

2.5.1 In addition, the published annual IGT report lacks supporting internal audit evidence to provide transparency and published independent assurance of the self-assessed level of performance and scores. Commissioners are responsible for assuring the IG
performance of their commissioned services, yet there is nothing published to indicate that this has been completed.

2.5.2 During the latter part of 2011, the Department of Health undertook a deep dive audit of Acute Trust end of year report on requirements 101,112, 308, 401, 402. This included reviewing the uploaded evidence or seeking evidence from Trusts where supporting documentation was not provided. The conclusions of the report are provided in Annexe B but overall the audit identified some inconsistencies between the self-declared level of compliance and the evidence the Trust relied on to support that score.

2.5.3 Above average success in the Toolkit score, by all measures, is evidenced in particular regions and sectors. The reasons for this are not known and cannot be drawn out of the Toolkit reports. Further detailed analysis of the performance of these regions, for example by identifying the kind of leadership undertaken and a view of the internal audit reports would be a useful tool in assessing what works well. This would enable a comparison to be made to determine how best to support organisations struggling with the issues and how to develop the IGT standard.

2.6 Reviewing the IGT against ICO investigations

2.6.1 Detailed analysis of ICO enforcement action suggests that self-assessed high scores and returns that meet the Satisfactory standard do not ensure that organisations are meeting the standard they declare. Three of the four NHS Organisations fined by the ICO have declared a high-score and compliance with Information Governance Toolkit version 9. An analysis of the ICO reports into these breaches of the Data Protection Act demonstrates systematic failures across a number of key controls measured in the Toolkit. The number of relevant organisations is a small sample and this needs to be considered when drawing conclusions.

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Fine</th>
<th>IGTv9 (Mean%)</th>
<th>IGTv9 (Key Req. Mean%)</th>
<th>IGTv9 Pass or Fail</th>
<th>IGTv8 (Mean%)</th>
<th>IGTv7 (Mean%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brighton and Sussex University Hospitals NHS Trust</td>
<td>£325,000</td>
<td>68.15%</td>
<td>66.67%</td>
<td>Pass</td>
<td>66.67%</td>
<td>80.00%</td>
</tr>
<tr>
<td>Central London Community Healthcare NHS</td>
<td>£90,000</td>
<td>71.54%</td>
<td>72.22%</td>
<td>Pass</td>
<td>67.57%</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>
### Table 3 Comparison of “Average” Trusts

<table>
<thead>
<tr>
<th>Organisation Name</th>
<th>Pass or Fail</th>
<th>IGTv9 (Mean%)</th>
<th>IGTv9 (Key Req. Mean%)</th>
<th>IGTv9 Pass or Fail</th>
<th>IGTv8 (Mean%)</th>
<th>IGTv7 (Mean%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Trust With ICO Undertakings</td>
<td>Fail (1.8)</td>
<td>73.49%</td>
<td>70.92%</td>
<td></td>
<td>69.03%</td>
<td>76.81%</td>
</tr>
<tr>
<td>Average Trust</td>
<td>Fail (2)</td>
<td>73.26%</td>
<td>70.89%</td>
<td></td>
<td>69.95%</td>
<td>77.91%</td>
</tr>
</tbody>
</table>

Listed after the Pass or Fail measure is number of requirements that an “average” Trust declared at Level 1 or 0.

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5 See the Acute “organisational view” of the Toolkit, at https://nww.igt.connectingforhealth.nhs.uk

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2.6.2 Following notification of a data loss incident, the ICO will undertake an investigation and provide a report that details the findings and their concerns and basis for imposing a monetary penalty or requiring an undertaking. The ICO reports that training, specifically detailed training about data handling, (which is requirement 112 of the Toolkit) is frequently absent or inadequate when the ICO consider taking action. The lack of a written contract or the failure of the contract to meet the expected standard is another re-occurring issue; this is requirement 110 within the Toolkit. Failure to have systems to identify risks and failure to meet procedure or standards, a key component underlining many of the IG Toolkit requirements, is the third most frequent and significant finding.

2.6.3 Analysis of NHS organisations that have signed undertakings with the ICO, to address failure to comply with the expected standards of the Data Protection Act, indicates that 14 of the 23 had assessed themselves as Satisfactory on IG Toolkit v9. The performance of the average of these Trusts, with ICO undertakings, is very close to the performance of an “average” Trust.
3 Conclusions

3.1.1 The analysis of the IG Toolkit does not provide clear answers on underlying causes for success, failure or accuracy. It does highlight the strengths and weaknesses in the Toolkit and the self-assessment assurance model. The Toolkit provides the potential for organisational and senior management engagement with the information governance assurance framework through a series of controls over systems and functions where personal data is being obtained, processed and shared. The requirements act as a driver for the implementation and improvement of best practice standards and clarity on data processing with staff and for engagement with patients.

3.1.2 Evaluating performance where ICO undertakings or penalties occur suggests that systematic failures across significant risks at an organisational level exist and are not identified through the Toolkit self-assessment.

3.1.3 It will continue to be difficult to evaluate performance without a core set of requirements to compare all providers or commissioners and difficulty in extracting reports. It also impedes those attempting to answer and audit the requirements in developing an understanding of how Toolkit scores should be assessed and answered.

3.1.4 Overall, the Toolkit ensures that the vast majority of NHS organisations engage with the Information Governance agenda but does not ensure organisational ownership or an accurate depiction of risk or provide an aid to addressing systemic failure.