Minutes
Strategic Information Governance Network (SIGNs) Chairs Meeting
Location VC Leeds (Vantage House Boardroom) London (Tavistock House VC Blake Room)
Date 1 September 2014 Time 1-4pm

Attendees

London VC

Phil Walker (DH) Interim Chair
Stephen Elgar (HSCIC/IGA)
Barry Moult (Eastern)
James Sheldrake (Kent & Medway/CSU South)
Adam Tuckett (South West)
Ranisha Dhamu (London)
Robin Burgess (NHS E)
Stephen Moore (London Amb)
Karen Thomson (NHS E)
Helen Thorn (Devon & Cornwall)
Nicola Gould (Surrey)
Jo Andrews (London/Acute)

Leeds VC

Vanessa Kaliapermall (HSCIC)
Marie Greenfield (HSCIC) Interim Deputy Chair
Liane Cotterill (North CSU)
Michael Goodson (NHS E)
Tim Dalby (Caldicott2 Implementation)
Linda Pickup (Lancashire CSU)
Jenny Spiers (Greater Manchester)
Sue Meakin (Yorks & Humberside)
Sarah Lawson (NPEU)
Richard Birmingham(HSCIC) Minutes
Stephen Curtis (Centre of Excellence)
Jenny Pope(HSCIC)
Ruth Stott (HSCIC) Minutes
Ralph McNally (Leeds CC/PSN)
Shane Dark (HSCIC/IGA)
Charlotte Piper (Centre of Excellence)
Bridget Francis (W Midlands)
Nicola Undertown (Centre of Excellence)
David Stone (London CSU)
Hayden Thomas (NHS E)

Apologies

Andrew Harvey (Sussex)

Peter Hall (IGA)
Carol Mitchell (NHS E)
Alison Baylis (West Midlands)
Jonathan McKee (London)
Cora Suckley (Cheshire & Merseyside)
Andrew Babicz (London Social Care)
Helen Speed (Lancs and Cumbria)

Agenda Item	**Presented by**	**Paper**
1. Introduction and Chair's Welcome	Phil Walker (DH IG & Standards Policy Lead)	
The Chair welcomed the representatives to the meeting which is the first time for two years that the Strategic IG Network (SIGN) had met. Initially group would meet every two months.		
2. Apologies		
Apologies are listed above		
3. Terms of Reference	Phil Walker (DH IG & Standards Policy Lead)	Yes
The terms of reference were discussed and agreed in principle. It was agreed that the chair and deputy chair should be determined by a vote. The Sample SIGN Terms of reference were written not for imposition for regional groups but as an example of good practice. It was stressed that the meetings were designed as a two way conduit to allow messages and issues to be circulated and to allow the Information Governance Alliance (IGA) or other central teams to provide, collectively, a single point of truth for the health and social care services in England. Care was defined as inclusive of adult and children's services but the DH remit was for social care only. The governance arrangements were discussed and it was explained that the Group would report into the IGA Board. There was some confusion regarding the role of the numerous central IG groups which it would be important to resolve asap. The relation of SIGNS to other sectors was discussed and SIGNs were encouraged to be inclusive and to allow 3rd sector and Social Care and Local Authority membership. Whilst it is intended that SIGN groups should be regionally based where practicable, it was understood that certain organisations might be better represented by a national chair due to the nature of their business or geographical spread. Two such groups – Ambulance Trusts and the Higher Education research community were recognised as falling within this category and their representatives were welcomed onto the SIGN chair's group. Actions: i. Secretariat to circulate updated ToR.		

ii. Any Comments on the ToR should be sent to the Secretariat by end of September with a view to sign off at the next meeting. iii. Nominations from SIGN Chairs for the roles of Chair and Deputy Chair to be sent to the Secretariat by 19/9. Nominations received will be circulated for votes in w/c 22/9		
4. Introduction to the Information Governance Alliance (IGA)	Stephen Elgar (IG Alliance)	Presentation

Stephen Elgar gave a presentation on the Information Governance Alliance. The group were encouraged to disseminate the slides and provide feedback to the IGA.

Currently the IGA consisted of the DH, NHS England, The HSCIC and Public Health England. There was a membership model and it is anticipated that other relevant organisations working in Health and Social Care would join over time and provide resources. Other interested parties which attend the IGA Board include Caldicott 2 representation and the Office of the Information Commissioner. Member organisations provide a core team of permanent staff.

The IGA would initially focus on helping the 14 pioneer integration sites with IG. A ministerial letter was in draft about the IGA which would include a set of 5 rules for information sharing aimed at Health and Care community condensed into a single page. At present there were not enough care representatives in the IGA membership and this would be addressed.

The IGA work programme would create products that the health and care community and front line staff want. There was a pipeline model for producing products. The work programme will become clear in the next three months. The IG Oversight Group has made the first commission from the IGA for clear guidance for frontline staff. Frontline staff included both professional IG staff and all staff working in health and care settings.

The main issue for the guidance was that implied consent was not sufficient to allow information to be shared between health and care teams. A lawful basis must be identified for all sharing and that explicit consent remained primary basis for sharing between health and care.

The two important communications elements were firstly to provide top down guidance and secondly to speak to people on the ground with the first round of regional presentations as SIGNs meeting nearing completion. The IGA would provide regular membership of the SIGNs chairs meetings.

Action

For All. Provide comments and feedback to IGA and to disseminate the slides to those who have not seen them yet.

5. Centre of Excellence	Stephen Curtis/Charlotte Piper (Centre of Excellence for Information Sharing)	

A presentation was delivered by the Centre for Excellence (CoE) for Information Sharing. The CoE was set up in April 2014 with the focus being multi agency working and to build capacity in localities and to change attitudes using three key pillars;

1 Technology adoption

2 IG guidance

3 Cultural/organisational change of attitudes

The CoE was recruiting staff and there would be a complement of 17 staff who would work with local teams on specific projects and case studies. They would gather evidence and deal with problems as they happen. The CoE was positioned work with the ICO, DH and The Ministry of Justice. The DH is a sponsor as well as DWP and the Department of Communities. If a common problem is encountered there can be a conversation with the national team about finding a solution. The team was currently focused on 7 or 8 locations with experts embedded locally. The Cof E cannot work with everyone. Health and care integration pioneers were the first to receive help.

There was a lot of scope to work with SIGNs and IGA on sharing matters and to collaborate on issuing joint guidance. The CofE work was focused in information for service delivery by identifying the barriers in leadership that exist and overcoming those barriers.

6. Department of Health Policy Update	Phil Walker (DH IG & Standards Policy Lead)	

The primary focus at DH was consultation over the draft regulations. These would allow progress from interim accredited safe haven (ASH) status and remove the need for S251 authorisation to process weakly pseudonymised and identifiable patient data. The regulations were designed as a medium term solution with the goal to process information through a consent based model or other lawful basis for processing. They were now looking at;

1 ASH and how many. Too many ASHs would create another risk whilst too few would create problems locally.

2 Disclosure of Information for other purposes. What controls are acceptable?

3 Access to information for case management (this was a direct result of the enquiry into Winterbourne View)

Accreditation of full ASH status will be down to the HSCIC with a data of January 2015. Any processing of information not intended for direct care will be done through an ASH.
Any other instances would need a specific lawful basis to be identified or to go through S251 approval to process.

Other DH business of interest included and extension of the legal cover for sexual health information to be processed by foundation trusts where current regulations do not apply. Specific safeguarding guidance was being considered and the SIGNs would be consulted at the appropriate point.

7. Information Governance Assurance Framework (IGAF) - Health and Social Care Information Centre	Marie Greenfield (HSCIC Head of External IG Delivery)	

The primary focus of the Information Governance Assurance Framework (IGAF) remained the IG toolkit as the primary delivery vehicle for DH IG policy. Since the separation of DH and CFH teams three years ago the IG toolkit was hosted in the HSCIC External IG Delivery team with a core team of 11 whole time equivalent staff. The Exeter helpdesk remains the primary means of contacting the team to get advice on IG matters by the NHS and Social Care teams. Currently there are 40,000 organisations providing IG assurance through completion of the IG toolkit assessment.

IG Toolkit Development V13 and beyond

Work was in the planning stage to fundamentally review the IG toolkit platform to look at how the look and feel can be improved. The IG toolkit and IGAF was a central part of the data handling review which started in 2008. It will take 2 or 3 years to modernise the platform and update the guidance and links. A project mandate will be produced by the end of the year. Initial work will be with the large NHS organisations such as Acute Trusts. The toolkit would be updated to include Caldicott 2 and a subgroup would look at this. SIGNs will be consulted.

Work on the policy content of the toolkit would require a DH to change policy and NHS England to commission the changes in the toolkit.

PSN/Local Authorities

Users have already seen work on the integration of organisations who complete the public service network (PSN) code of Connection in version 12. This included the extension of the IG toolkit from the focus of social care delivery to the entire Local Authority. The purpose has been to improve standards of IG in local government.

Small Organisations

Many organisations have a contractual obligation to complete the IG toolkit and part of the review will look at how small organisations are better served by the IG toolkit. This area had changed significantly from 2004 when the IG toolkit was created. Small organisation covered Dentist GPs Pharmacy and Optometry as well as AQP and single handed contractors. This would be subject to professional consultation where appropriate.

SIRI Tool

An update on the reporting of Serious Incidents Requiring Investigation (SIRI) was given. There would be an in year change in October 2014 called V12.2 following consultation on the sensitivity factors and the information reporting requirements of ICO and other central teams.

Cyber Security

By March 2015 there would be a change to include Cyber security incidents as a separate reporting category in V13. This has come about following the National Cyber Security Programme and will include consultation with the GP IT committee.

Higher Education

A representative of the Higher Education IG forum was present and commented on how the IG toolkit has improved standards in the HE sector and allowed researchers to access NHS and Social Care information for research purposes. This was done under S251 authorisation. The Group has produced a knowledgebase for the HE sector to use when completing the IG toolkit and improving their data handling. Terminology remained an issue for non IG specialists getting to grips with IG assurance for their research projects.

IG Training Tool (IGTT)

The IG training tool platform is used by 1.1 million users and there was a waiting list of non NHS organisations to access the free training. This does not include those staff who complete the training via the National Management Learning System Platform (NMLS) which can be accessed via the Electronic Staff Record. Organisations can use their own IG training where it has been approved by and auditor as being comparable to NHS training and there is a comprehension test. To ease pressure on the training tools there will be a cull of inactive accounts. Any redevelopment of the IGTT would require a commission and a decision on the future of IG training. It is recognised that the material needed updating some limited work would be done in Autumn 2014 eg Caldicott principles. Some of the main users of the tool are small primary care providers who would not be able to provide their own training if the tool were withdrawn. At present there is no equivalent product to replace it.

8. NHS England	Karen Thomson (NHS England Head of IG)	

The Head of Strategic IG at NHS England gave an update on current IG work. Some overlaps with other areas. Work areas include: a fair processing implementation plan. Directions for HSCIC to collect data, citizen identity verification guidance to support patient access to their records online, input into the HQIP clinical audit process and the national standard contract terms, and the GMS contract. Most of the work of the Strategic IG team has been around transition management. Guidance on the use of personal devices by clinicians and also recordings by patients had been identified as needed and we were doing some work to look at what had already been produced. Members were asked to send anything they had to Jenny Spiers. The implementation of the 20 year rule was also still on the agenda and a lot of work had been done on ASH stage 1 and risk stratification and invoice validation as part of the IG Programme.

The Health Research Authority (HRA) was being consulted on the data needs of commissioners and the consideration of solutions. Future work will be around fair processing and the coding of objections to processing and how to implement these throughout the service. The long term plan is to have the HSCIC as the main safe haven and the current draft regulations are a medium term response. There is a shift towards giving consent more prominence as a primary solution to processing for secondary purposes.

During the discussion, it was felt that there would emerge too many ASHs following the current regulations and that national fair processing notices, where helpful, would not substitute local fair processing notices as being the most important means of informing patients and clients of services.

9. Caldicott2 Implementation	Tim Dalby (HSCIC Caldicott 2 Implementation Monitoring Group)	

A representative of the Caldicott 2 Monitoring and Implementation Group (CMIG) talked about the 26 recommendations and the 84 commitments accepted by DH as part of Caldicott 2. The CMIG report to the Information Governance Oversight Panel (IGOP) and the Information Governance Steering Group (IGSG) and there is an annual report to the Secretary of State. There is a small

team and a project manager looking at how organisations can implement to recommendations hosted by the HSCIC. The group are looking at alternative ways of monitoring Caldicott 2 implementation to move away from the direct reporting tool currently in use.
The CMIG will be working with the IGA to make sure that best practice is in line with central IG policy and guidance. There is an intention to work with individual organisations that have difficulty meeting the recommendations.

CQC and Monitor are interested parties in implementation of Caldicott 2. CQC have the National Information Governance Committee (NIGC) but as yet no report on IG has been included in the draft CQC annual report. There has only been limited evidence that inspections have looked at IG and given the work programmes of CQC their priority is on clinical or care service delivery.

Action
To All. Circulate the Caldicott 2 presentation to SIGNs.

10. SIGN Chairs Update Current Local Issues	Round Table	

Jo Andrews (London/ Acute Trust rep) The London forum is 10 year old and regularly gets 50+ representatives. Useful presentations were given to the group by The National Archives (TNA) on the 20 year rule implementation. The NHS representative to the European Commission also briefed the group on the difficulties implementing the proposed new European data protection directive. This was some time off but it will present a challenge for the future.

Ranisha Dhamu (London Social Care rep) is co-chair and briefed the group on how Care Act had created difficulties in sharing information in Adult social Care settings.

Stephen Moore (London Ambulance and National Ambulance IG rep) talked about the difficulties of sharing information with ambulance services including cross border sharing and access to GP records for ambulance staff in attendance to patients. Training a mobile workforce in IG also created difficulties.

Nicola Gould (Surrey) The Surrey group was originally IT managers but expanded to IG. They are looking at increasing membership. Sharing created an issue and sharing protocols were part of the solution. Pseudonymisation was an issue for CCGs and there was local variability around sharing.

Barry Moult (Eastern) the Eastern IG SIGN meeting had 40+ attendance at meetings and the group recently had Caldicott Guardians attend and in December SIROs being invited to attend. We have set up an email network for CGs and SIROs. Members of the SIGN conducted peer review for another Trust, and has a health records sub group which discussed issues like the troubled families initiative. Bring your own device created issues, as does sharing with the third sector. Sharing information for admission avoidance work also was problematic i.e. Volunteers requiring information and access to clinical systems was flagged up i.e. Stroke Association. There was also a gap about where to escalate IG issues.

Helen Thorn (Devon and Cornwall) The group is inclusive and welcomes new member in Devon and Cornwall. Sharing and sharing protocols was an issue. The pioneer site at Torbay had worked closely with GP/BMA/LMC representatives to be a success. A local mortality tool was creating sharing issues. Training in IG is an issue.

Adam Tuckett (Bristol and Southwest) A renewed SIGN meeting will take place on 2 September. The group included NHS and Social care representation and also had the National Blood and Transplant Authority.

Jamie Sheldrake (Kent and Medway) The forum was very active and had good representation from CCGs and the CSU as well as NHS Trusts and social care. Sharing was an issue. Sharing platforms are creating IG issues. Clarity over how the Government Classification scheme applied to health was an issue that had not been resolved locally.

Jenny Spiers (Greater Manchester) membership is mainly provider NHS Trusts. It has been operating for 10 years but relies on the goodwill of member trusts to provide venues and secretariat. Sharing was an issue as was cross working between organisations such as third sector and hospices for stroke prevention. IG training was an issue. The group held an event on subject access to records with 75 in attendance. Email is extensively used to communicate between the group.

Sue Meakin (Yorkshire and the Humber) The group had been around for 10 years and the IG group is a subgroup of the Directors of Information. It is inclusive of social care and other interested parties. Sharing was identified as an issue.

Linda Pickup (Lancs and Cumbria) Issues identified were sharing and the use of protocols. Joint project working was also an issue.

Bridget Francis (West Midlands) The group had a wide membership. Incident reporting was felt onerous as they have to complete a report 3 times for each incident. Patients using mobile phones to make recordings/filming was an issue.

Michael Goodson (NHS England Regions) Sharing was an issue as was compliance with the IG toolkit.

Ralph McNally (Local Authority PSN) Several Local Authority national groups existed that were already working with LAs and there is some overlap in representation of social care. Local Authority groups tend to be quite strong on security issues and the Cyber security programme was an area that local government wanted to work closely with the health sector. The 14 pioneer sites for integration were a priority for local government and national funding had been provided to help integration. Again this overlaps with the remit of the IGA.

Liane Cotterill (CSUs North) The CSUs have not met frequently and some are represented through local groups. NHS England have now picked up some of the IG functions of SHAs to fill a gap.

David Stone (London and South CSUs) There was some work on sharing between health and the justice system. Role based access was an issue. CSU sharing with health and wellbeing boards was an issue. The NHS England IG regional groups were very useful with issues of risk stratification and integration identified. Some CCGs were independent of CSUs and they did not seem to be represented anywhere for IG.

11. Any Other Business	Phil Walker (DH IG & Standards Policy Lead)	
None		
12. Dates of the next meetings 3 November 13 January		